IntelliDose®

Nursing Manual
University of Miami Clinical Enterprise Technologies

Our Mission:

To design and deliver ongoing support for a network of Business and Clinical Information Management Systems which enhance the academic and research vision while implementing significant improvements in the quality, safety, and profitability of the UM clinical enterprise.

Our Vision:

To improve the processes and outcomes of the clinical enterprise by the widespread adoption of the latest information technology within a digital organization.
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**Course Objectives**

**IntelliDose for Nursing**

*Course Objective:*
- Open Order from Nursing Queue
- Review Order
- Release Order to Pharmacy Queue
- Document on eNurse

*Description:*
This course provides the user with the knowledge to review an order from the nursing queue and release the order to pharmacy. Upon completion of this course the user will be able to release an order and document on IntelliDose.

*Duration:*
2 Hours

*Course Outline:*
1) Lookup a patient using the UMHC MRN
2) Open the order from the Nursing Queue
   a) Open the Order Status - Signed
      i) Update patient’s:
         (1) Height and Weight
         (2) Allergies
      ii) Review lab results (use LabViewer)
   b) Release the order (only if labs meet clinical criteria for treatment)
      i) Verify patient is ready for treatment
      ii) Release order to Pharmacy Queue
3) eNurse Documentation
   a) Document each nursing action
      i) Document time
   b) Post Vital Signs
   c) Document Chemo Drug
      i) Second signature
   d) Enter a Popup Note
   e) Use Toolbar
4) Display Flowchart
IntelliDose Order Process Overview

Fellow/ARNP
- Fellow or ARNP enters chemotherapy order
- Fellow or ARNP saves and queues chemotherapy order to Physician

Physician
- The Attending Physician reviews the order and co-signs it
  - Pending

Charge Nurse
- The Charge Nurse reviews the order and releases it to Pharmacist
  - Signed

Pharmacist
- Pharmacist reviews order and releases it for assigned nurse to execute
  - Written

Assigned Nurse
- Assigned Nurse administers drugs and documents administration. ONLY CTU CHAIRSIDE WILL DOCUMENT IN INTELLIDOSE
  - Executed
IntelliDose training is scheduled following receipt of a complete system access form. A User ID and Password is assigned after training. For security purposes, change your password.

To change your password:

1. Enter your assigned User ID
2. Enter your assigned password
3. Click the Reset Password Check box.
4. Then click Login

Password Rules:

- Minimum 8 characters
- Maximum 10 characters
- Case sensitive
- At least 1 upper case letter
- At least 1 number or special character

Enter the new password twice.
Click OK.

If the OK button is not active, the two entries of the password do not match.
Patient Look-Up

IntelliDose opens to the Find a Patient Screen

You may:
- Enter a complete or partial last name for an alphabetical listing of all patients whose last name meets the criteria entered.
- Enter a UMHC Medical Record Number
- Click on a letter of the alphabet for all patients whose last name begins with that letter.

In this example, last names beginning with ‘Bat’ are displayed.

To select a patient, double click on the name.

When two or more patients have the same last and first names (even though all other fields are different), they are highlighted in red. Using Medical record number, account number and physician, verify that the correct patient is selected.

The Chemotherapy Record for the selected patient opens.
**Pop-Up Note**

The Pop-Up Note should be utilized as a communication tool for incidental information to be shared between physicians, nurses and pharmacy. **The Pop-Up Note is NOT a legal document and NOT a part of the patient's record.** DO NOT USE FOR ORDERS (i.e., "ok to treat", medication orders, lab orders) or other legal documentation in the Pop-Up Note Window.

You may access the Pop-Up Note by clicking on the blue note pad.

Pop-Up Note Window Appears

Click to apply check mark here to show the Pop-Up note when patient's record is retrieved. When note is no longer necessary, simply remove check mark and the Pop-Up note will no longer appear.
**Toolbar and Icons**

- **New:** On Intellidose Toolbar pictured above = Enroll New Patient  
  On Order tab = Additional Order  
  On Diagnosis tab = Assign New Treatment Plan

- Look Up Patient Record
- Post Vital Signs
- Enter Lab Results *(N/A)*
- Post I&Os (Input and Output)
- Document IV Access
- Post Pain Assessment
- Post Drug Verification
- Post Toxicity
- Use a Checklist
- View Treatment Plans
- Prepare / Write Orders – Opens to drug screen for review / sign process

- Log In / Log Out
- Post Height and Weight
- Enter X-ray, Other Results *(N/A)*
- Establish IV Access
- Monitor IV Infusion
- Post Teaching
- Post Double Drug Verification
- Record Performance Status
- Write a Pop-Up Note
- Cosign
Chemotherapy Record

Chemotherapy Record – General

The Chemotherapy Record for a patient opens to the General tab. This contains information entered when the physician enrolled the patient in IntelliDose.

Chemotherapy Record – Medical

The top portion Medical tab is subdivided into five sections: Problem List, Social History, Past Family History, Past Med History and Miscellaneous.

The bottom portion (Medications and Allergies) displays with all Medical tab sections.

Chemotherapy Record – Medical/Allergies

To add ‘Allergies/Hypersensitivities’:
Click on the first blank line.
As you begin to type a drug, an alphabetical list displays.
Select the desired drug.
In the Dosing Rules column, enter the dose and route.
Chemotherapy Record – Medical/Problem List
Problems are entered by clicking the New Problem button. Then select from the list.

Chemotherapy Record – Medical/Social History
This is a free text field. Double click to open and enter or edit data.

Chemotherapy Record – Medical/Past Family History
This is a free text field. Double click to open and enter or edit data.

Chemotherapy Record – Medical/Past Med History
This is a free text field. Double click to open and enter or edit data.

Chemotherapy Record – Social
Contacts: Includes name, address, phone and relationship
- Click New to add
- Click Edit/View to revise
DNR Status: Includes effective date and who entered information in system
Advance Directives: Includes date and who entered information in system
Miscellaneous: Click the drop-down menu to select
Chemotherapy Record – Dx 1

**Chemotherapy Record**: Information pulls from patient’s enrollment in IntelliDose

**Chemotherapy Record**: Includes all Treatment Plans which have been assigned for this diagnosis

**Chemotherapy Record**: Based upon user security non-malignancy diagnosis may be added

**Chemotherapy Record – Dx 1**

**Dx 2**: This is used for a second primary malignancy. It may also be used for co morbidities (ex. MDS, anemia, thrombocytopenia, etc.). The treatment history is specific to the diagnosis. The secondary diagnosis displays on both Dx 1 and Dx 2

Chemotherapy Record – Orders

Lists all cycles of assigned treatment plans

Chemotherapy Record - eNurse

The eNurse tab is for nursing documentation of nursing care and medication administration. The Nursing Actions are not created until an order is in Written status.

Refer to page 16 for information on eNurse documentation.
Chemotherapy Record - MAR

The MAR list all medications included in the ordered treatment plans once they are in Written status. Documentation entered in eNurse is shown on the MAR.

Chemotherapy Record - Tests

The Test tab is designed to display lab result. This function is not currently used at UMHC/SCCC.

For lab results, please use the Lab Viewer application.

Chemotherapy Record –

Metrics/Height & Weight

The baseline weight is entered by the physician during patient enrollment.

The baseline weight is changed only by the physician.

All entries of the height and weight are displayed.

Vital Signs

Displays all entries of vital signs

I&O

Displays recorded intake and output
Only a physician may sign chemotherapy orders. Orders without chemotherapy drugs may be signed by an ARNP or PA.

A signed order has a status of Pending.

Double click the order in Pending Status

Drugs

Dosing Rules Tab: shows the drugs and dosage scheduled for this cycle.

Dosing Limits: shows the rounding units assigned.

Infusion Rules: shows the fluid for infusion of drugs.

Miscellaneous: shows per drug specific instructions for administration

Tests

Shows lab tests ordered for this cycle.

Review lab results through Lab Viewer.
IV Fluids

Administration Rules
This refers to hydration fluids – not used for the administration of chemotherapy drugs.

Additives & Misc Admin Instructions
Lists any additives and special instructions

eNurse Script
Shows the items for nursing documentation which will be generated when the order is in a Written status

Miscellaneous
Some treatment plans have additional orders. These display here.

When a physician adds orders for a specific cycle, he/she will draw a solid line across the page.
The cycle specific orders are typed below the line.

Scroll to view the additional orders.

If there are any questions regarding the orders or lab results, DO NOT sign the order. Close and contact the physician.

If there are no questions regarding the orders or lab results, sign the order by clicking the pen icon.
Choose the site where the chemotherapy is being administered. Then click OK.

A print preview of the order displays.

There are three options:
- Print and Return to Order
- Print & Process Order
- Cancel

Process Order = Sign Order. This will change the order status.

To process the order, select the pharmacy printer.
The status is changed to **Signed**.

When the pharmacist has reviewed and signed the order, the status changes to **Written**.
A copy of the signed order will be printed to the nursing station.
The eNurse documentation is generated when the order is in **Written** status.
Print Order Set

After signing an order and sending (printing) to pharmacy, a non-executable copy may be printed for nursing. This is not the final order. The order becomes final and Nursing Actions created when the order is signed by the pharmacist.

Log On

Log into IntelliDose with your User ID and password

Patient Selection

Using MRN or name, select the patient

Orders

Click the Orders tab to display order cycles and their status

Double click to open the order cycle to be printed.
To print a copy of the orders **before** they have been signed by the pharmacist.

Click File

Select “Print Draft Order Set”

To print a copy of the orders **after** they have been signed by the pharmacist.

Click File

Select “Print Duplicate Order Set”

Select the facility site to print on the orders.

Will this printed order set be executable?

Always select NO
Select the printer
**eNurse Documentation**

Nursing documentation is done from the eNurse tab.

Different documentation screens open based upon the nursing action being documented.

The following will demonstrate several different documentation screens.

> For all documentation, the date/time must be entered/verified.
> The time may be adjusted by:
> 1. Clicking on the time line
> 2. Using the arrows to select the time.
> **NOTE:** A future time may not be used.

**Allergy**

The allergies on the medical tab are pulled. If these are correct, click the sign button.

If the patient reports additional allergies, sign then click the Notes tab.
In the Additional Comments area, enter the new information.

**NOTE:** For any eNurse documentation, the Notes area is used to enter additional documentation.
Assessments are documented using a checklist. These include the Outpatient Screening, Nursing assessment, Patient Education and Discharge. These assessments may also be accessed for the Checklist icon on the toolbar.

When complete, click **Post** to record.

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**Post Vital Signs**

Enter date/time

Enter Vital Signs

Use check boxes for any comments.

For comments not included in the check boxes, type in the blank comments field.

Click to record.

Vital signs may also be entered from the Vital Signs icon on the toolbar.
Establish Access / Post Access Start

- Enter the time
- Indicated if a new insertions, use of an existing device or unsuccessful attempt to insert.
- Select the type of device from the drop-down menu.
- Required fields (based upon access type and device) will be highlighted.
- Complete documentation
- Click **OK**

IV access may be documented from the Establish IV Access icon on the toolbar.

**NOTE:** For multiple lumen port or Groshong
Use eNurse Nursing Action to document access to the first lumen. Use the Access icon to document each additional lumen

Begin IV fluids

- IV Fluid administration opens a screen for Intake & Output with the IV start selected.
- Enter the start date/time.
- The type of fluid cannot be changed.
- The volume may be changed to the bag volume hung.

Post IO Entry may also be accessed from the IO icon on the toolbar.

Choose Start (new IV), intake or output
- Select the type of fluid (from the drop down)
- Enter the amount
**IV Push Drug Administration**

For IV push medications, the start and stop times are documented on the same screen.

If ordered dose administered, double click the dose field.

If less than ordered dose administered, enter the dose given and the reduction reason.

When documentation is complete, click OK to record.

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**Intramuscular / Subcutaneous Administration**

Only one date/time is documented.

If ordered dose administered, double click the dose field.

If less than ordered dose administered, enter the dose given and the reduction reason.

The site of administration must be documented.

Click OK to record.
Begin IV drug administration

For administration of intravenous medications, both the start and stop must be documented. There is a different eNurse action for the start and stop.

Enter the date/time infusion started

Indicate site condition, blood return and access.

Select the check box to document method of infusion

Click OK to record.

Complete IV Drug administration

Enter the date/time infusion completed.

If ordered dose administered, double click the dose field.

If less than ordered dose administered, enter the dose given and the reduction reason

Complete all fields.

Click OK to record.

Chemotherapy Verification

Per policy, chemotherapy drugs must be verified by two nurses.

This is the first verification documentation.

Enter the date/time

Click OK
Chemotherapy Verification

This is the second nurse verification documentation screen.

The first verifier does not need to sign out from IntelliDose.

The second verifier enters their IntelliDose User ID and password.

Click OK to record.

NOTE: Do not use the 1st/2nd signature verification icons in the toolbar unless there are not verification actions items in eNurse.

Discontinue IV

When an IV is discontinued, document all fields. Required fields may vary based upon device type.

Click OK to record.
**Baseline Weight**

**Baseline Weight:** When posting a new height/weight entry under the Metrics Tab, users should **NOT** change the baseline weight in the baseline box (as shown below).

The baseline weight should remain the same unless changed by the Provider (Physician or ARNP).

The baseline weight is used to calculate drug dosages. The nursing staff should not change the baseline weight. **Only a physician or their ARNP may change the baseline weight.**

To post the current height and weight:

Click the Post Height & Weight icon either on the Metrics / Height & Weight

Or

Click the Post Height & Weight icon on the main toolbar
eNurse Documentation - Non-Chemo Infusions

A recurring issue has been identified in the documentation of medications by RNs. Non-chemo infusions that are ordered must be documented in eNurse adequately—you must document beginning and end of infusion. Typically, the eNurse steps will prompt you to sign off the completion of the infusion. Due to a system deficit, this prompt does not appear in the script. The following images will demonstrate:

1. A new infusion (Levaquin) is ordered and signed by RN

<table>
<thead>
<tr>
<th>Date</th>
<th>Cycle</th>
<th>Orders</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fri 11-21-08</td>
<td>1</td>
<td>Carboplatin (AUC 5) / Paclitaxel (175 mg/m2)</td>
<td>Executed</td>
</tr>
<tr>
<td>Fri 11-21-08</td>
<td>2</td>
<td>dexamethasone 11/21/2008 Days 01 to 01</td>
<td>Executed</td>
</tr>
<tr>
<td>Fri 02-27-09</td>
<td>1</td>
<td>Levaquin 350 mg IV now to infuse over one hour Days 01 to 21</td>
<td>Written</td>
</tr>
<tr>
<td>Fri 03-20-09</td>
<td>2</td>
<td>Bevacizumab/Carboplatin (21) 3570 Days 01 to 21</td>
<td>Next</td>
</tr>
</tbody>
</table>

2. The RN documents the beginning of the infusion as prompted by the script. However, does not document the completion. The eNurse script reads “Drug” as a result of system error. The RN does not recognize “Drug” as the prompt to document completion of infusion, thus does not. As a result, the flowchart shows that the medication was not given.

3. RN recognizes that “Drug” is where completion of infusion is documented, thus signs off. The dose is documented as given in the flowchart.
RNs: Please remember that for every infusion a beginning and a completion of infusion must be documented. “Drug” is the completion step and you must sign off on this step.
II. Another instance where the RN may neglect to document the completion of an infusion:

1. The MD or ARNP adds a medication to the treatment- in this case Zinecard. In the Drug list, the calculated dose of the medication that was added is highlighted in orange.

![Drug list screenshot showing Zinecard with an orange highlight and the Administer directive signed off as "Drug"]

2. Again, in the eNurse, the Administer directive is signed off by the RN. The completion step in the script is erroneously labeled as “Drug.” The RN must sign off on this step in order to document adequately the administration of the medication.

![Screencapture of eNurse showing Zinecard with an orange highlight and a note: "Drug"]
**e-Nurse Documentation - 12-hour Infusions**

**Scenario:**
A patient is given a 12-hour infusion. It was started at 1pm and ended at 1am of the following day. How do you document the discontinuation?

**Solution:**
When the nurse started the infusion, the documentation started on Day 1. The same nurse or the next shift nurse will need to document the discontinuation of the infusion on Day 2. *Remember this is a 12-hour continuous infusion spanning 2 days.*

Follow this **step-by-step** for documenting the discontinuation:

1. Log into Intellidose
2. Locate the patient- (use the MRN or Last Name)
3. The Chemotherapy Record for Patient window will display.
4. Click on the eNurse tab
Go to the bottom of the screen and click on the *From* date.

Select the previous day.

Click *Search*.

Double-click on the infusion action.

The infusion window opens to enter the documentation.

Click on the date field to document the discontinuation for that day and time. Continue to document the infusion by completing the remaining fields.

Click on OK on the bottom of the screen.