DIS PORTAL – USERS GUIDE

An overview of the Drug Information System for DIS Portal Users. This contains key information for users when accessing the DIS Portal.

Province of Nova Scotia
Department of Health and Wellness

Version 3.3 (May 2021)

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EDUCATION PREREQUISITES

Before accessing the DIS Portal you are required to complete the following:

COMPLETE *the following modules:*

- **DIS Module 1: Introduction to the Drug Information System**
- **DIS Module 2: Functions**
- **DIS Module 3: Privacy and Access**

http://novascotia.ca/dhw/ehealth/DIS/education-training-materials-DIS.asp

REVIEW

- **DIS Portal Overview** video demonstation
  http://novascotia.ca/dhw/ehealth/DIS/education-training-materials-DIS.asp
- **How to Issue an e-Prescription** video demonstation (prescribers only)
  http://novascotia.ca/dhw/ehealth/DIS/education-training-materials-DIS.asp
- **DIS Portal - Users Guide** (this document)

GETTING HELP

Throughout the Drug Information System, you will see question mark (?) icons on various screens and headings. Clicking the question mark will bring you to the Help feature of that particular screen.

Support for the Drug Information System (DIS) is provided by NSHA Health IM/IT. When you call for support, the phone will be answered 'NSHA Service Desk'.

What to Say When You Call:

- Say that you have a question about the **Drug Information System Portal** (they need to know that you are calling specifically about the Drug Information System Portal)
- Give them your name and telephone number where you can be reached

Support Hours:

The Drug Information System (DIS) is supported by a team of clinical application specialists at the Health IT Service Desk.

- The Health IT Service Desk is open to log calls for the Support Team 24/7/365

- The DIS Support Team's hours of operations are:
    - **Monday to Friday, 8:00am – 4:00 pm**

DIS Downtime:

If the Drug Information System is down unexpectedly, a notice will appear on the DIS Portal Login screen.

The maintenance window for the Drug Information System (DIS) is on **Thursdays** from **12:30 am - 8:00 am.** The DIS may be unavailable during this time.

NSHA Service Desk - Phone Number:

1-866-224-2555*

PRIVACY & CONSENT: WHAT YOU NEED TO KNOW

The *Personal Health Information Act* (*PHIA*) sets out the requirements for privacy and consent regarding the collection, use and disclosure of personal health information.

All information in an individual's Drug Information System profile is considered to be personal health information.

CONSENT

Knowledgeable implied consent is consent that can be assumed through an individual's actions.

Express consent occurs when an individual explicitly gives you permission to do something. Can be given:

- In writing – like signing a consent form
- Verbally – like saying: "Yes, you can look up my information on your computer."

You can rely on Knowledgeable Implied Consent when:

1) Your hospital or clinic has posted the appropriate notice to the public as required under PHIA
2) It is reasonable to believe that the individual understands what is in the notice
3) You are within the individual's circle of care (i.e. s/he is a patient of your hospital or clinic); and
4) You are accessing or using this personal information for the purpose it was collected – to provide or manage patient care.

You need Express Consent when:

5) You wish to view the profile of an individual who is not a patient of your hospital or clinic and you are not within the individual's circle of care (i.e. merely viewing their information).
6) You want to access an individual's masked profile.

You can also rely on knowledgeable implied consent to disclose information from a medication profile to another health care provider if the 4 statements to the left are true and if the other provider is also within the individual's circle of care. However, you must validate the identity of the provider and ensure that the individual is under their care

LOGGING IN TO THE DRUG INFORMATION SYSTEM

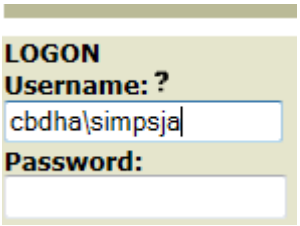
If connecting to the DIS remotely, ensure you are setup to access. You would need a Microsoft Azure VDI for a Private Health Care Organization or Global Protect if you are within NSHA.

To logon to the DIS, you will use your NS Health username and password, also known as Active Directory (AD).

Enter your domain, followed by a backslash (\) and then your username.

If you work in a hospital, your domain is the former district health authority (DHA). Examples of domains are “cdha” for Capital Health, “swdha” for South West District,” or “cbdha” for Cape Breton District. If you work in the community, your domain is “nshealth.”

Example: Janet Simpson works in Cape Breton and her DHA was CBDHA. Her NS Health username is "simpsja". To logon, she would enter CBDHA\simpsja as shown below.



Once you have entered your domain and username, enter your password and click Logon.

Please note that if you enter your password incorrectly three or more times, you may be locked out of your account. In that case, you will need to contact the Service Desk at 1-866-224-2555 so they can unlock your account or reset your password. When choosing a new password, most special characters will not be accepted.

Once you successfully logon, you will be presented with the patient lookup screen.

FINDING YOUR PATIENT

The **Client Lookup** tool allows users to locate a client using a simple search mechanism. The search is performed against the Nova Scotia Client Registry which contains all Nova Scotians. The registry will also contain other individuals that have received a health service in Nova Scotia including out of province and out of country individuals.

There are several ways to look up a client's information in the Portal. At least one of the following search items should be provided:

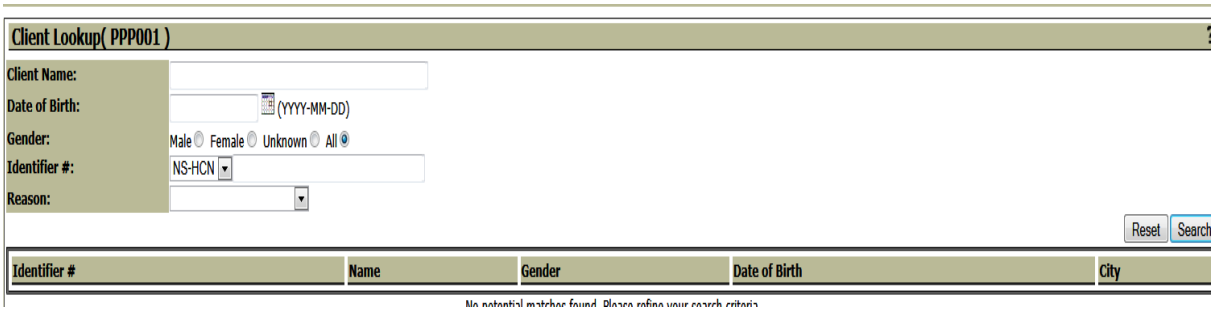
- Identifier type and Identifier # - This will return an exact match
- Client Name - Last Name, First Name or First Name, Last Name

Additionally the following fields can be added to the demographics Search:

- Gender
- Date of Birth

To search for a Client:

1. Once logged in, click **Lookup** in the main navigation menu.



2. Enter the search criteria in the appropriate fields

Identifier #:

- Select the Identifier Type from the drop-down list. The Identifier type defaults to NS Health Card number (NS-HCN).
- Enter the identifier number. This is the recommended method for searching as it will return an exact match if the individual is in the NS Client Registry. All Nova Scotians are in the Client Registry.

OR

Client Name

Enter the client's name in one of the following formats:

- Last Name, First Name (a space is required after the coma and before the first name)
- First Name, Last Name (a space is required after the coma and before the last name)

In addition -

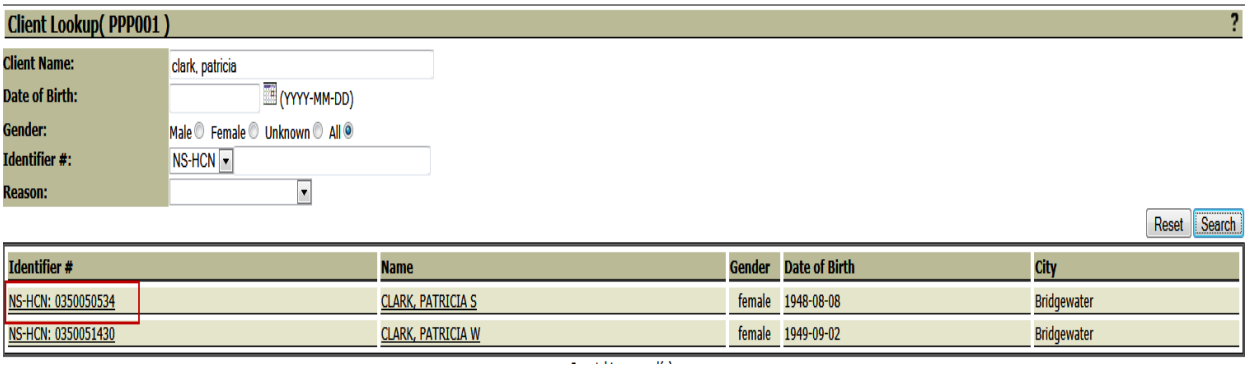
- Enter the client's **Date of Birth** in the format *YYYY-MM-DD*
- Specify the **Gender**

Reason

A reason can be selected but is not required. The typical reason codes would be either PATIENT CARE OR PATIENT REQUEST.

3. Click **Search**.

4. The results of the client lookup will be displayed. Click on the **Identifier #** for the client that you want to access in the DIS.

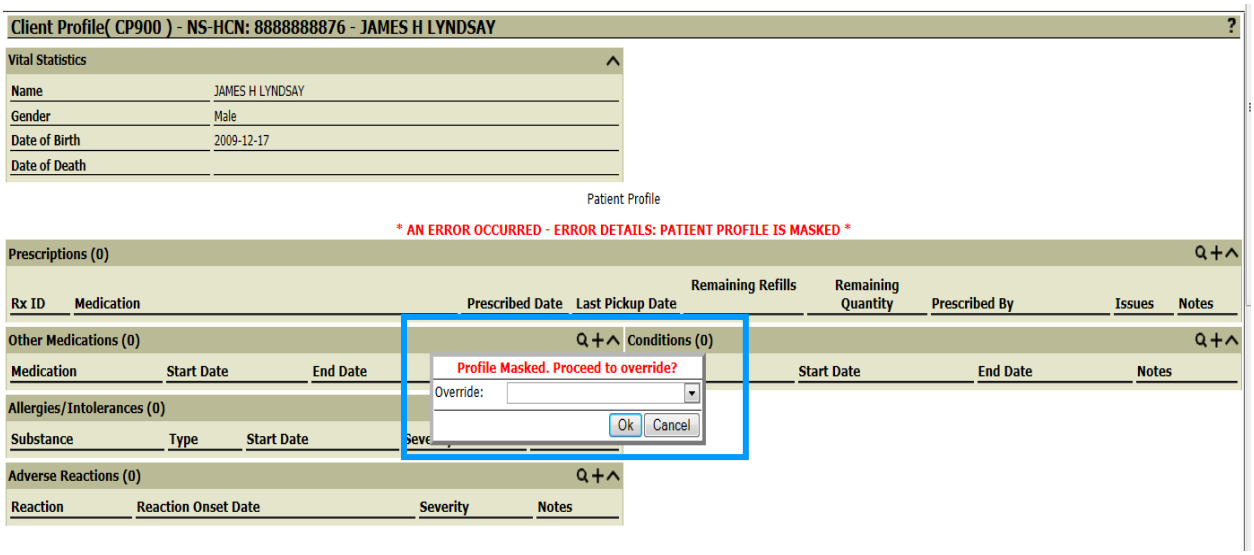


Key Points:

The lookup search will only return up to 10 results; you are not notified that more than 10 results were found. Either refine your search with additional information or search by HCN.

MASKING

Purpose: Under the *Personal Health Information Act (PHIA)*, patients have the right to mask their DIS profile. This means that they can limit who has access to their DIS information until consent is given or until there is an emergency situation. However, patients are not able to prevent their information from going to the DIS.



How to recognize a masked profile:

A masked profile displays a box asking if you wish to proceed to override. To proceed click the down arrow in the *Override* field and choose either **Emergency** or **Professional Judgment**.

Key Points:

- All Nova Scotia residents have the right to request masking of their DIS profile.
- All masked profiles that are accessed will be subject to audit.
- There are two situations where a masked record can be accessed:
  1. Express Consent: when the patient gives explicit consent to a healthcare provider to access their information.
  2. Emergency situation: when the patient is in need of healthcare and accessing the Drug Information System will avert or minimize an imminent and significant danger to the health or safety of a patient. This is intended for using in emergency situations so hospital emergency departments can access the Drug Information System medication profile.
- If a patient does not allow you to access their masked profile you have the discretion to refuse to provide service.

Client (Patient) Profile

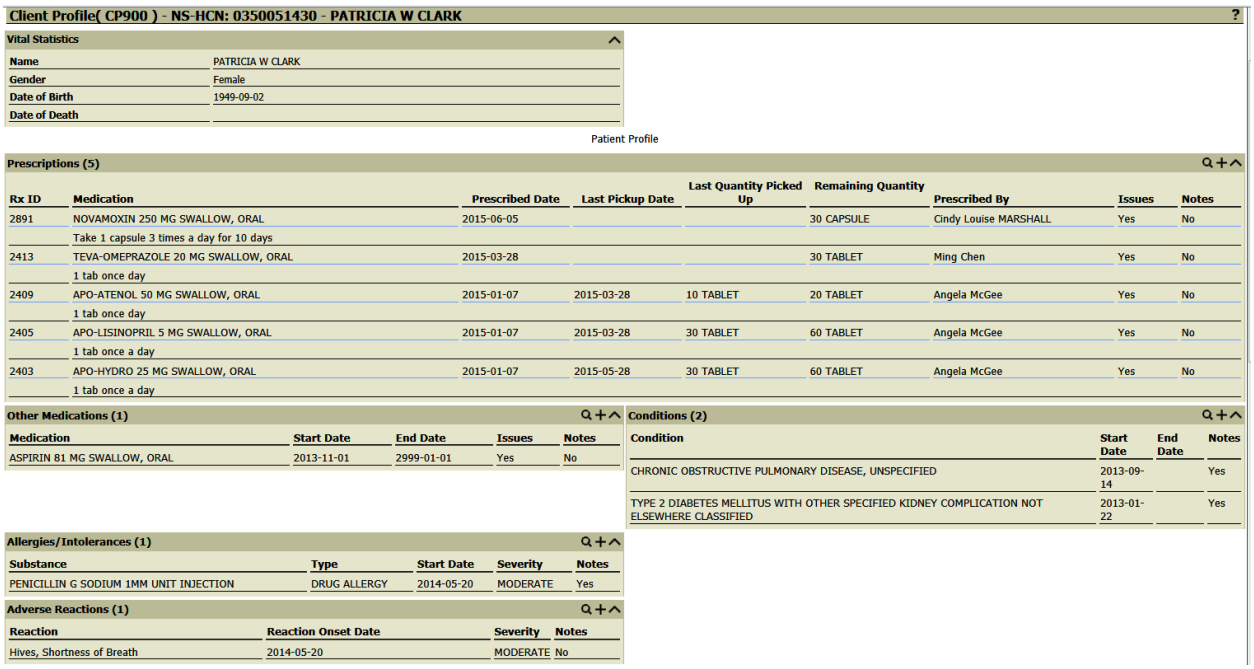
Purpose: The Client profile screen provides a list of "active" clinical records that have been recorded in the Drug Information System for:

- Prescriptions
- Other Medications
- Conditions
- Allergies/Intolerance
- Adverse Reactions

All clinical records for a client can be accessed from the portal menu:

Note:

Not all clients will have a DIS client profile. Only individuals that have had a prescription filled at a community pharmacy in NS will have a client profile.



Client Profile(CP900) - NS-HCN: 0350051430 - PATRICIA W CLARK

Vital Statistics

Name	PATRICIA W CLARK
Gender	Female
Date of Birth	1949-09-02
Date of Death	

Patient Profile

Prescriptions (5)

Rx ID	Medication	Prescribed Date	Last Pickup Date	Last Quantity Picked Up	Remaining Quantity	Prescribed By	Issues	Notes
2891	NOVAMOXIN 250 MG SWALLOW, ORAL	2015-06-05			30 CAPSULE	Cindy Louise MARSHALL	Yes	No
	Take 1 capsule 3 times a day for 10 days							
2413	TEVA-OMEPRAZOLE 20 MG SWALLOW, ORAL	2015-03-28			30 TABLET	Ming Chen	Yes	No
	1 tab once day							
2409	APO-ATENOL 50 MG SWALLOW, ORAL	2015-01-07	2015-03-28	10 TABLET	20 TABLET	Angela McGee	Yes	No
	1 tab once day							
2405	APO-LISINOPRIL 5 MG SWALLOW, ORAL	2015-01-07	2015-03-28	30 TABLET	60 TABLET	Angela McGee	Yes	No
	1 tab once a day							
2403	APO-HYDRO 25 MG SWALLOW, ORAL	2015-01-07	2015-05-28	30 TABLET	60 TABLET	Angela McGee	Yes	No
	1 tab once a day							

Other Medications (1)

Medication	Start Date	End Date	Issues	Notes
ASPIRIN 81 MG SWALLOW, ORAL	2013-11-01	2999-01-01	Yes	No

Conditions (2)

Condition	Start Date	End Date	Notes
CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED	2013-09-14		Yes
TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED KIDNEY COMPLICATION NOT ELSEWHERE CLASSIFIED	2013-01-22		Yes

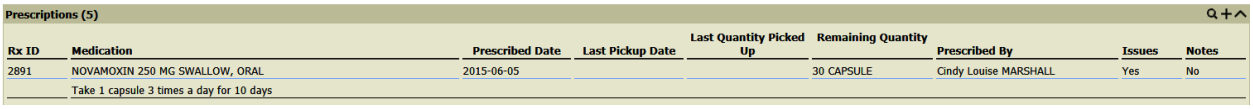
Allergies/Intolerances (1)

Substance	Type	Start Date	Severity	Notes
PENICILLIN G SODIUM 1MM UNIT INJECTION	DRUG ALLERGY	2014-05-20	MODERATE	Yes

Adverse Reactions (1)

Reaction	Reaction Onset Date	Severity	Notes
Hives, Shortness of Breath	2014-05-20	MODERATE	No

Prescriptions:

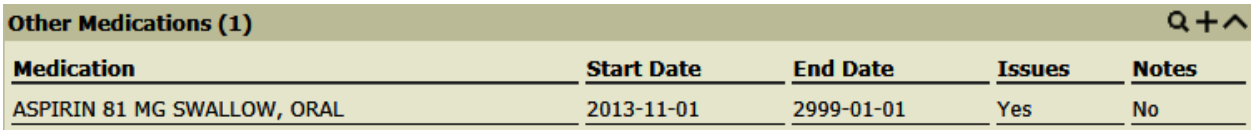


Prescriptions (5)

Rx ID	Medication	Prescribed Date	Last Pickup Date	Last Quantity Picked Up	Remaining Quantity	Prescribed By	Issues	Notes
2891	NOVAMOXIN 250 MG SWALLOW, ORAL	2015-06-05			30 CAPSULE	Cindy Louise MARSHALL	Yes	No
	Take 1 capsule 3 times a day for 10 days							

In the Prescription section of the client profile, “current” is described as the prescription record has a status of “active”; or the prescription record has a status of “completed” or “obsolete” and has been dispensed within the period; or the prescription record has a status of “completed” or “obsolete”, dispensed outside the period, but the days’ supply falls within the period. All “current” prescriptions are displayed. To view all the prescriptions for this patient, select the **magnifying glass** to the right on the **Prescriptions** bar.

Other Medications:

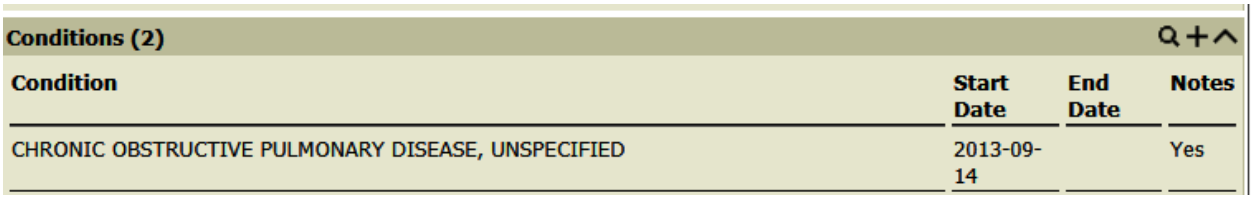


Other Medications (1)

Medication	Start Date	End Date	Issues	Notes
ASPIRIN 81 MG SWALLOW, ORAL	2013-11-01	2999-01-01	Yes	No

On the Other Medications section of the Client Profile, “active” records are defined as those records where there either is no “End Date” value associated with the other medication, or if an “End Date” exists, the date falls after the date the patient profile is being viewed. Only the most recent 5 active records are displayed. To view all the other medications for this patient, select the **magnifying glass** to the right on the **Other Medications** bar.

Conditions

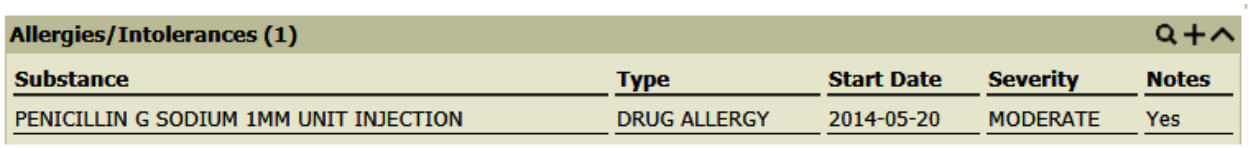


Conditions (2)

Condition	Start Date	End Date	Notes
CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED	2013-09-14		Yes

On the Conditions section of the Client Profile, "active" records are defined as those records where there either is no "End Date" value associated with the condition, or if an "End Date" exists, the date falls after the date the patient profile is being viewed. Only the most recent 5 active records are displayed. To view all the conditions for this patient, click the **magnifying glass** search icon to the right of the **Conditions** section on the profile.

Allergies/Intolerances

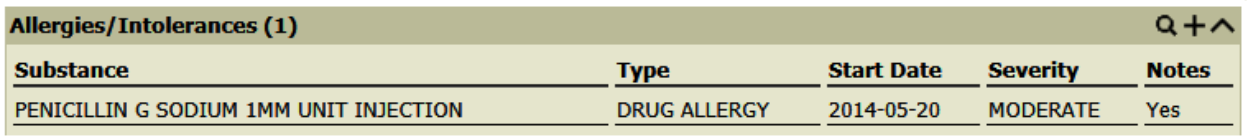


Allergies/Intolerances (1)

Substance	Type	Start Date	Severity	Notes
PENICILLIN G SODIUM 1MM UNIT INJECTION	DRUG ALLERGY	2014-05-20	MODERATE	Yes

On the Allergies/Intolerance section of the Client Profile, "active" records are defined as records that do not have a status of completed. Only the most recent 5 active records are displayed. All Allergies/Intolerance records can be viewed by clicking the **magnifying glass** search icon to the right of the **Allergies/Intolerances** section on the profile

Adverse Reaction



Allergies/Intolerances (1)

Substance	Type	Start Date	Severity	Notes
PENICILLIN G SODIUM 1MM UNIT INJECTION	DRUG ALLERGY	2014-05-20	MODERATE	Yes

On the Adverse Reaction section of the Client Profile, "active" is defined as all Adverse Reactions that are on the Patient's profile. Only 5 reactions will be displayed on the Patient's Profile. Click the **magnifying glass** search icon to the right of the Adverse Reactions section on the profile to see all the reactions on the Patient's profile.

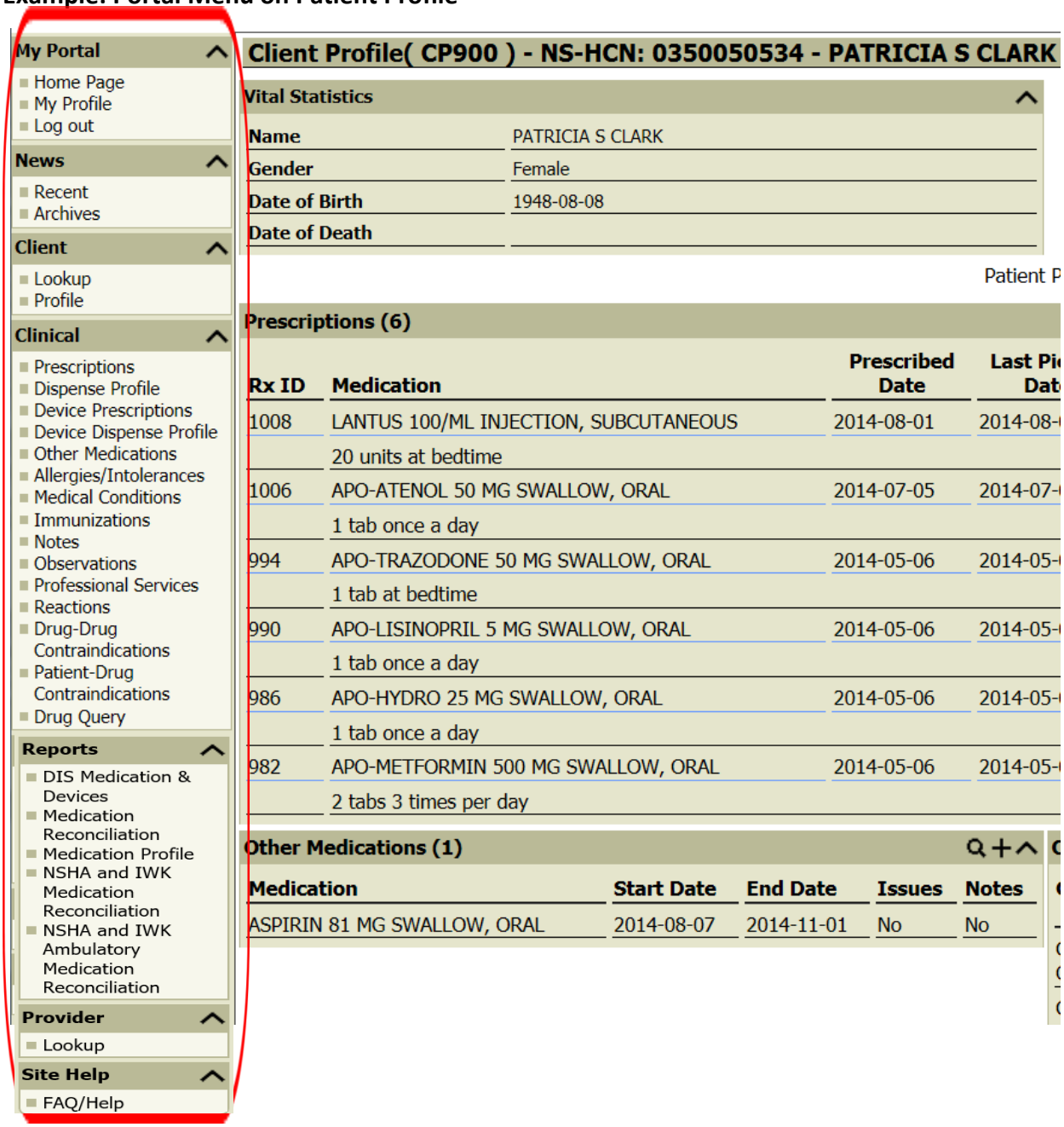
NAVIGATION OVERVIEW

Purpose: To learn about DIS screens and how to access information in the DIS.

1. Portal Menu:

Always displays at the left side of every screen.

Example: Portal Menu on Patient Profile



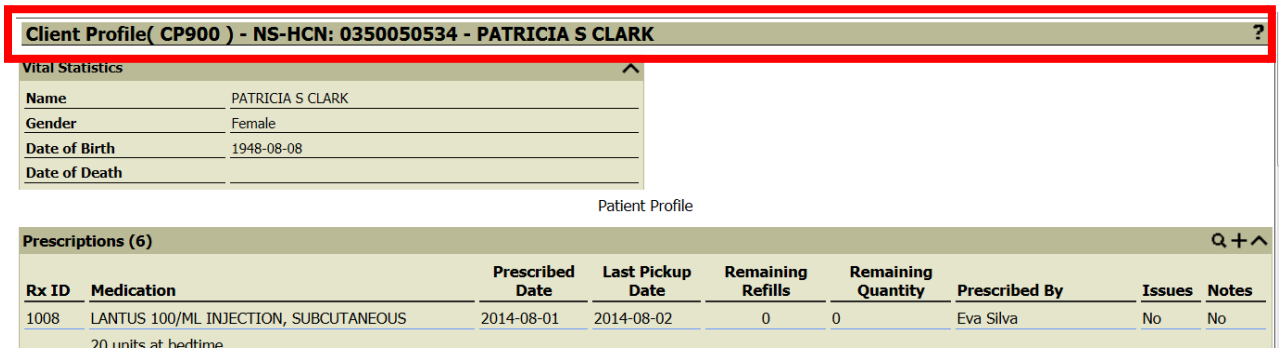
Key Points:

- Portal menu choices are dependent on the screen that is open.
- To open an item on the Portal Menu click on it. A summary screen opens.
- All items on the Patient Profile screen can also be accessed from the **Clinical** section of the Patient Profile Portal menu.

2. Title Bar:

- All screens have a **title bar** at the top.
- The left side of the title bar displays the screen name and screen number, patient health card number and patient name.
- The **Help** icon **(question mark)** is located at the far right of the title bar.
- When you report an issue to the Help Desk you will be asked for the screen name and number (i.e. Client Profile CP900).

Example: Client Profile screen title bar



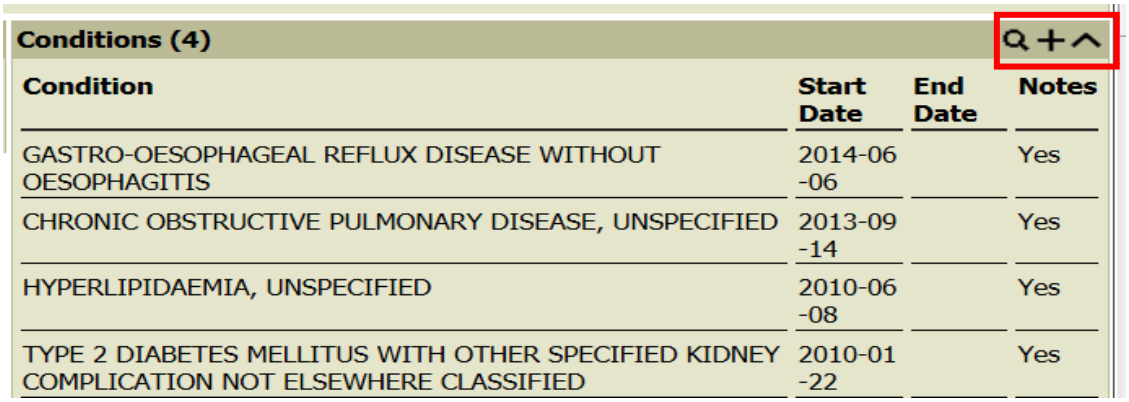
3. Help Icon:

?

- The Help feature provides further information on a particular screen.
- To access Help click the question mark at the far right side of the window's title bar.

4. Patient Profile Icons:

There are three icons on the right side of the title bar of each section of the Patient Profile.



Conditions (4)

Condition	Start Date	End Date	Notes
GASTRO-OESOPHAGEAL REFLUX DISEASE WITHOUT OESOPHAGITIS	2014-06-06		Yes
CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED	2013-09-14		Yes
HYPERLIPIDAEMIA, UNSPECIFIED	2010-06-08		Yes
TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED KIDNEY COMPLICATION NOT ELSEWHERE CLASSIFIED	2010-01-22		Yes

- **Lookup** button. Click to access a "summary" screen.
- **Add** button**.** Click to add information to the Patient Profile. Users without add/update access will not see this button.
- **Hide** button. Click to hide a section of the Patient Profile. Click to redisplay.

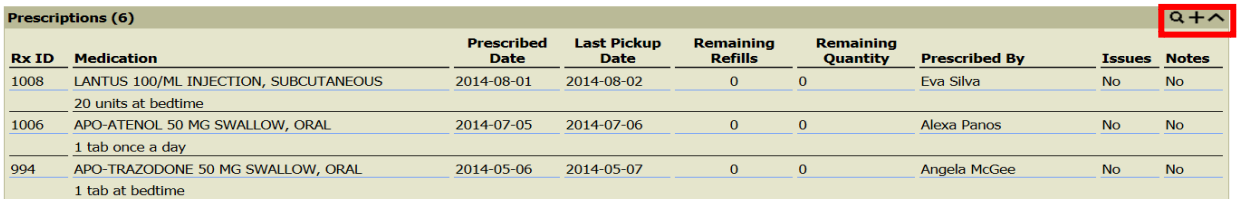
5. Timeout Feature:

Your logon to the DIS will stay active for 20 minutes. If you are navigating another application and DIS, you will only be logged out once you have been inactive for 20 minutes in DIS. When you are logged out, you will be presented with the login screen and you will need to search for your patient again.

6. Summary Screens:

- Summary screens provide an overview of patient information in the DIS for a particular category. An example is all prescriptions for a patient.
- There are two ways to access summary screens:
  1. Click any item in the Clinical Section of the Patient Profile Portal menu.
  2. Click the Lookup button in any section of the Patient Profile screen. This is the "magnifying glass" at the far right of the title bar (circled in red below).

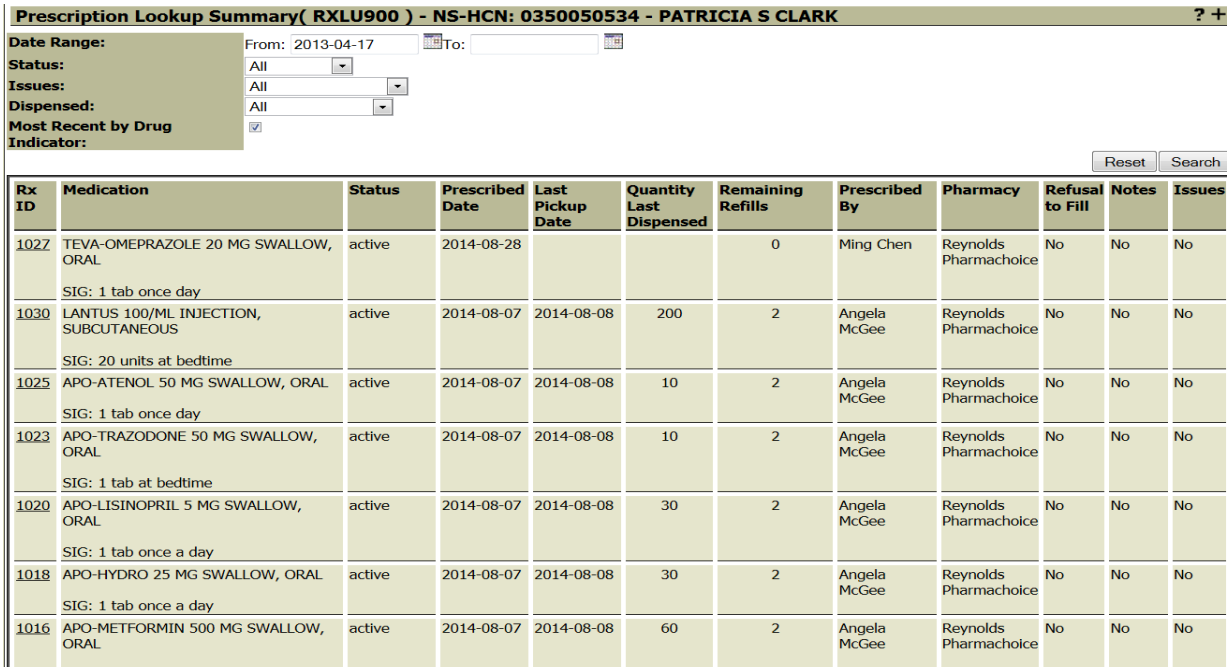
Example: The lookup button on the Prescriptions section of the Patient Profile screen:



Prescriptions (6)

Rx ID	Medication	Prescribed Date	Last Pickup Date	Remaining Refills	Remaining Quantity	Prescribed By	Issues	Notes
1008	LANTUS 100/ML INJECTION, SUBCUTANEOUS 20 units at bedtime	2014-08-01	2014-08-02	0	0	Eva Silva	No	No
1006	APO-ATENOL 50 MG SWALLOW, ORAL 1 tab once a day	2014-07-05	2014-07-06	0	0	Alexa Panos	No	No
994	APO-TRAZODONE 50 MG SWALLOW, ORAL 1 tab at bedtime	2014-05-06	2014-05-07	0	0	Angela McGee	No	No

Clicking the Lookup button from the prescription section of the Patient Profile screen opens the Prescription Summary:



Prescription Lookup Summary(RXLU900) - NS-HCN: 0350050534 - PATRICIA S CLARK

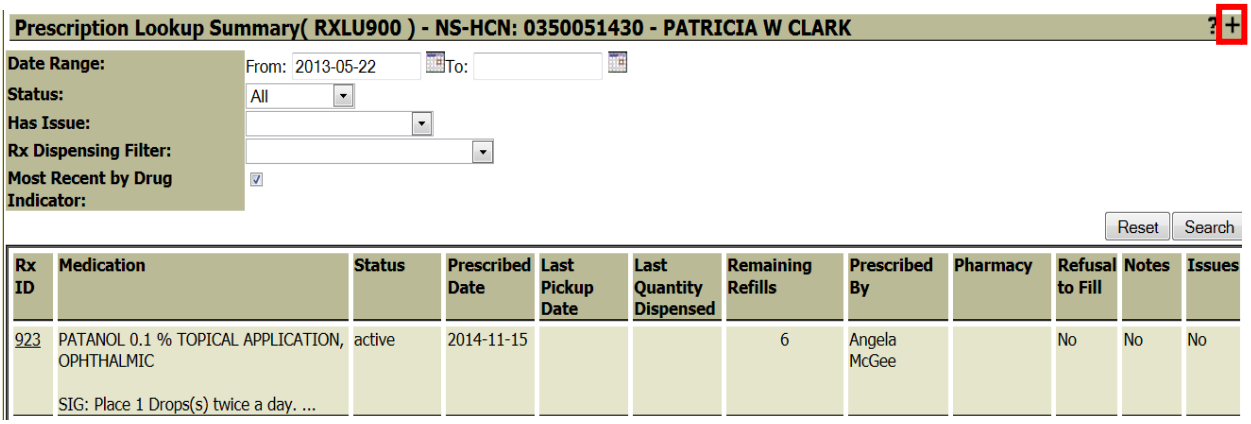
Date Range: From: 2013-04-17 To:
Status: All
Issues: All
Dispensed: All
Most Recent by Drug Indicator:

Reset Search

Rx ID	Medication	Status	Prescribed Date	Last Pickup Date	Quantity Last Dispensed	Remaining Refills	Prescribed By	Pharmacy	Refusal to Fill	Notes	Issues
1027	TEVA-OMEPRAZOLE 20 MG SWALLOW, ORAL SIG: 1 tab once day	active	2014-08-28			0	Ming Chen	Reynolds Pharmachoice	No	No	No
1030	LANTUS 100/ML INJECTION, SUBCUTANEOUS SIG: 20 units at bedtime	active	2014-08-07	2014-08-08	200	2	Angela McGee	Reynolds Pharmachoice	No	No	No
1025	APO-ATENOL 50 MG SWALLOW, ORAL SIG: 1 tab once day	active	2014-08-07	2014-08-08	10	2	Angela McGee	Reynolds Pharmachoice	No	No	No
1023	APO-TRAZODONE 50 MG SWALLOW, ORAL SIG: 1 tab at bedtime	active	2014-08-07	2014-08-08	10	2	Angela McGee	Reynolds Pharmachoice	No	No	No
1020	APO-LISINOPRIL 5 MG SWALLOW, ORAL SIG: 1 tab once a day	active	2014-08-07	2014-08-08	30	2	Angela McGee	Reynolds Pharmachoice	No	No	No
1018	APO-HYDRO 25 MG SWALLOW, ORAL SIG: 1 tab once a day	active	2014-08-07	2014-08-08	30	2	Angela McGee	Reynolds Pharmachoice	No	No	No
1016	APO-METFORMIN 500 MG SWALLOW, ORAL	active	2014-08-07	2014-08-08	60	2	Angela McGee	Reynolds Pharmachoice	No	No	No

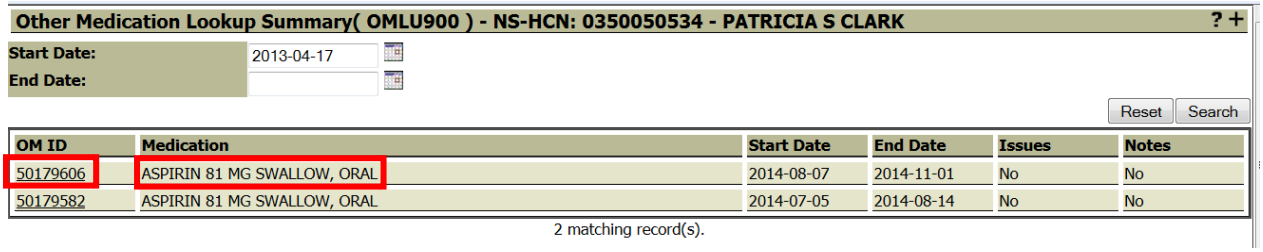
- Every summary screen has filtering capability that varies by screen. This allows you to filter your information.
- By default the "Most Recent by Drug Indicator" field is turned on. This means that only the most recent prescription for that medication will display on the summary screen. If unchecked, all prescriptions will be displayed.

- The default **Date Range** for items displayed on a summary screen is the previous 18 months, counting back from the current date, and may be changed.
- Click on any column title to order the list. Lists are displayed in descending order when you first click the column heading. Clicking the column heading again sorts in ascending order. For example, clicking on **Last Pickup Date** will sort this field in ascending or descending order. Clicking on **Status** sorts by categories *Completed*, *Active* and *Aborted*.
- Click on the **Add** button (outlined in red on the screenshot below) to add a new item (e.g. clicking the *Add* button on the Prescription Lookup Summary opens the screen for creating a new prescription).
- Further information on some fields can be found by hovering over the field (e.g. hovering on the column titles displays a message tag as shown below).

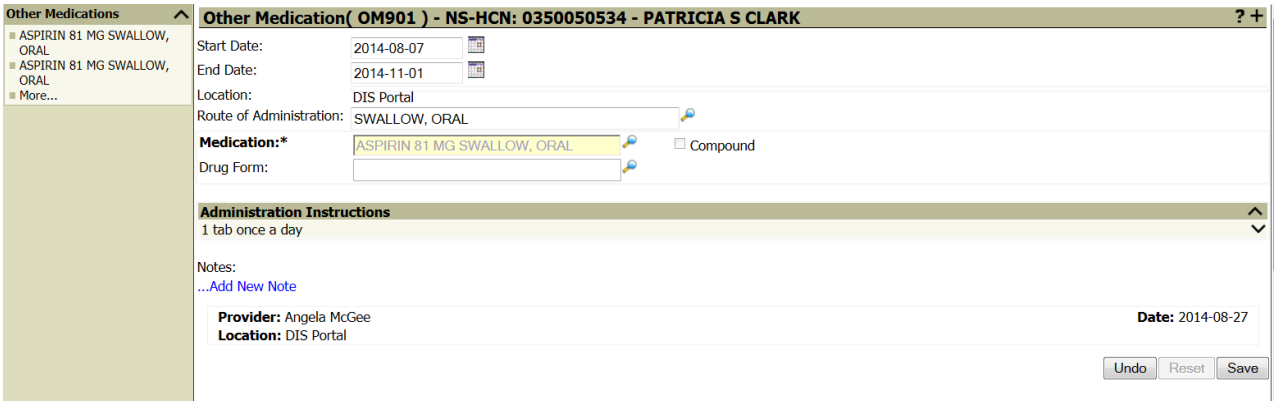


- Summary screens provide access to **Detail** screens: click any item on a Summary Screen to access a Detail screen.
- Detail screens provide information on a selected item.

Example: Below is the Other Medication Summary screen. Click on the specific *OM ID* or *MEDICATION* to open a detail screen:

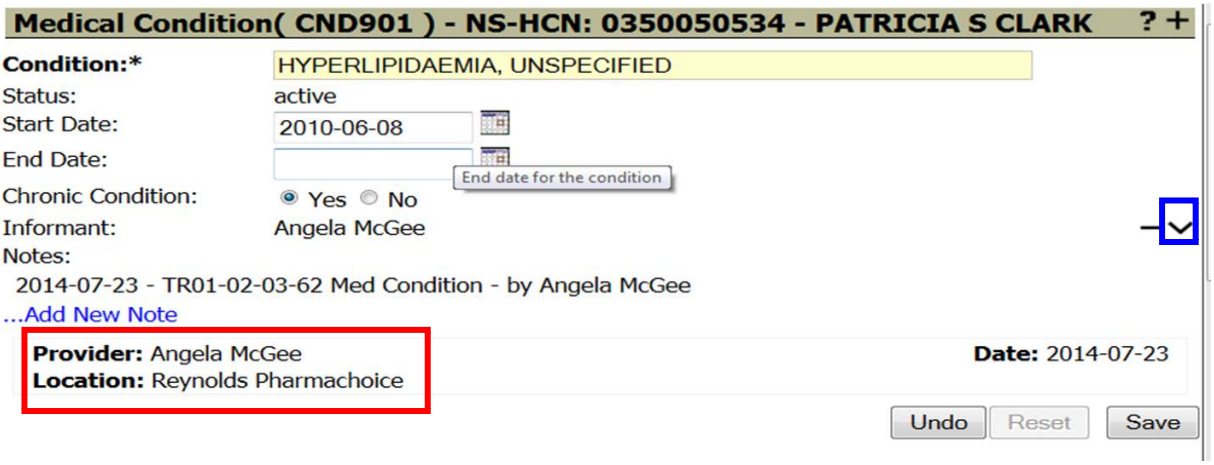


Detail Screen Opens:



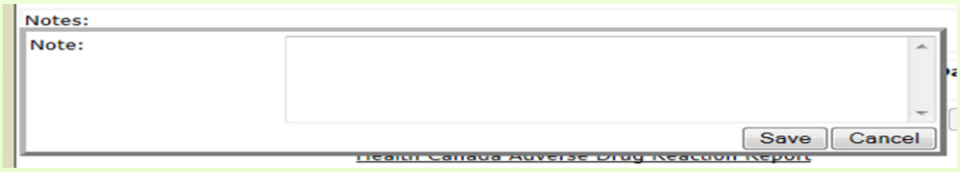
7. Detail Screens:

- Detail screens provide information on a selected item.

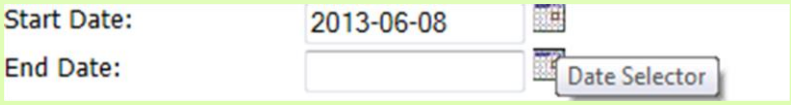


Key Points:

- The bottom of the detail screen displays Provider and Location information regarding the provider who input the data into the DIS (outlined in red above).
- A note related to the open detail screen can be added by clicking **Add New Note**. This opens a box where you can type the note. Click **Save** when done.



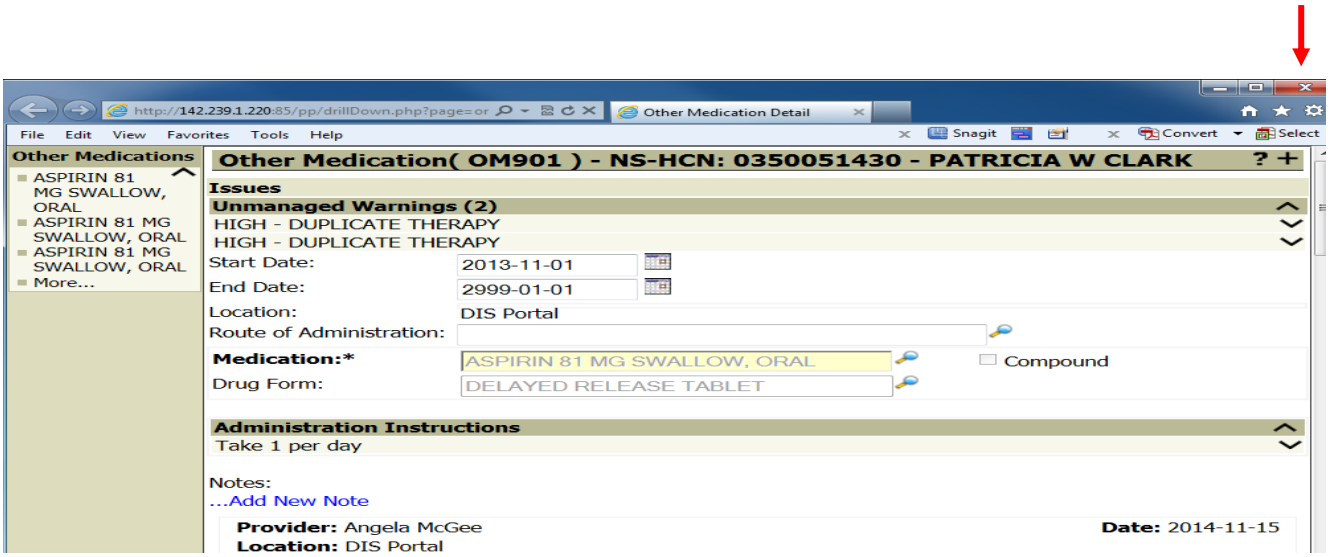
- Faint text on a detail screen means that you cannot alter information in that field.
- Add a new item by clicking the **Add** button on the title bar.
  - e.g. clicking the Add button on a prescription detail screen opens the screen for creating a new prescription
- Obtain further details on certain fields by hovering over the field (e.g. hovering over the Start Date or End Date calendar icons displays a message tag):

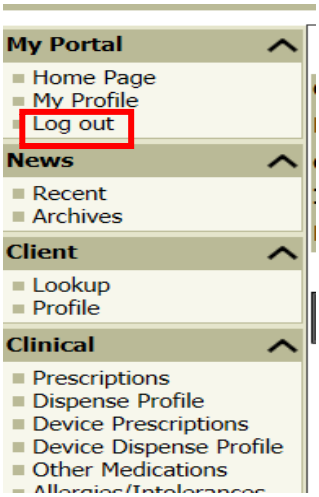


- Obtain further information on the Informant by clicking the V symbol at far right (outlined in blue on screenshot at top)

8. Closing Windows and Tabs:

- DIS items open in a new window or tab.
  - If you try to open an item or screen (e.g. Lookup screen) and it does not open, it is because it is already open.
- Close the window or tab when you are finished working with it by clicking the **X** in upper right corner.





When you are finished with a DIS session, log out of the system to close the Patient Profile by clicking Log out on the Patient Profile Portal menu.

PORTAL FUNDAMENTALS

Purpose: To introduce fundamental concepts of the Drug Information System.

1. ID Numbers in the DIS

All clinical records in the DIS are based on a Drug Information Number (DIN), Natural Product Number (NPN) or OPINIONS PIN (devices only).

An OPINIONS PIN is a number assigned by APSI (Atlantic Pharmaceutical Services Inc.) to uniquely identify a product or device. The DIS generic OPINIONS PIN will be used when a specific OPINIONS PIN does not exist for a product or device.

A prescription must include a valid DIN, NPN or OPINIONS PIN.

2. Prescription Information

The DIS displays information in two ways:

1. The *Patient Profile* screen displays **current prescriptions** for the patient contained in the DIS.
2. The *Summary Screen* provides the ability to display all prescriptions for the patient contained in the DIS.

Current Prescriptions:

Current Prescriptions refers to prescribed medications that were available for the patient to take in the **previous 90 days**. Information is displayed within a **date range** of the current date minus 90 days.

Example:

- Today's date is September 12
- September 12 minus 90 days is June 14
  Therefore, the date range for the medication displayed is June 14 to September 12

The medication displayed includes:

- A prescription that is available for the patient to have filled or has been filled and has refills available.
- A prescription that has been dispensed and was 'completed' in the date range. Completed means the prescription has no refills remaining or has been replaced by another prescription.

- A prescription that has been dispensed and 'completed' prior to the date range, but the days' supply **falls within the date range.** Completed means the prescription has no refills remaining or has been replaced by another prescription.

Note: If you want to see all prescribed medications in the DIS for the patient, click on the **Lookup button** 'magnifying glass' on the title bar of the Prescription section of the Patient Profile. This will take you to the Prescription **Summary screen**.

3. Prescriptions and Dispenses

When a prescription is dispensed by a pharmacy, a dispense record is created. The DIS contains *both* prescription information and dispense details such as pick-up date. Users will be able to view all dispenses issued for each prescription.

Dispense Id	Rx ID	Drug Name	Current State	Dispense Date	Pickup Date	Quantity Dispensed	Location	Issues	Notes
50388206	1527	APO-VENLAFAXINE XR 75 MG SWALLOW, ORAL	Picked up	2015-06-16	2015-06-16	30	Fertility Pharmacy Services Ltd.	Yes	No

4. Drug Utilization Review (DUR)

A Drug Utilization Review (DUR) is triggered when clinical records are added to a patient's medication profile. This includes dispenses, prescriptions and other medications.

If a DUR was identified on a record, it will be noted in the summary screen:

Other Medications (1)

Medication	Start Date	End Date	Issues	Notes
ASPIRIN 81 MG SWALLOW, ORAL	2013-11-01	2999-01-01	Yes	No

Details on the DUR record are available on the clinical record:

HIGH - DUPLICATE THERAPY

Causes:

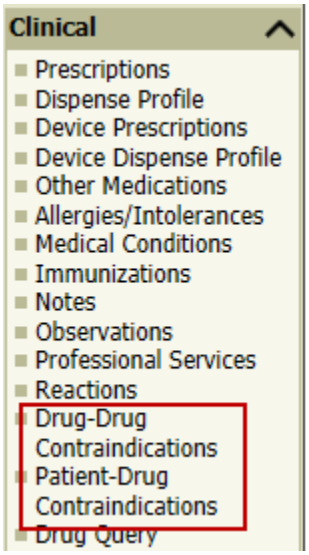
Cause Type	Record Id	Details
Other Active Medication	50307360	ASPIRIN 81 MG SWALLOW, ORAL
Other Active Medication	50302515	ASPIRIN 81 MG SWALLOW, ORAL

The DIS uses the 'First Data Bank' (FDB) tool for performing a DUR. FDB modules are:

1. **Allergy**: Provides detection of potential reactions between drug/drug ingredients and a patient's known allergies
2. **Drug-Disease**: Detects potential interactions between a drug and a patient's known condition(s) either on the patient's profile or indicated by a drug on the patient's profile
3. **Duplicate Therapy**: Checks for potential duplication in drug therapies
4. **Lactation Precaution**: Checks for lactation precaution(s) for a drug. This only applies when medical condition Z391 is in the patient profile.
5. **Pediatric Precaution**: Checks for pediatric precautions of drug(s). This only applies to patients in the age group 0-18.
6. **Pregnancy Precaution**: Checks for pregnancy precautions for a drug. This only applies when medical condition Z33 is in the patient profile.

Suspended prescriptions (i.e. prescribed but no longer valid) are NOT taken into account for DURs.

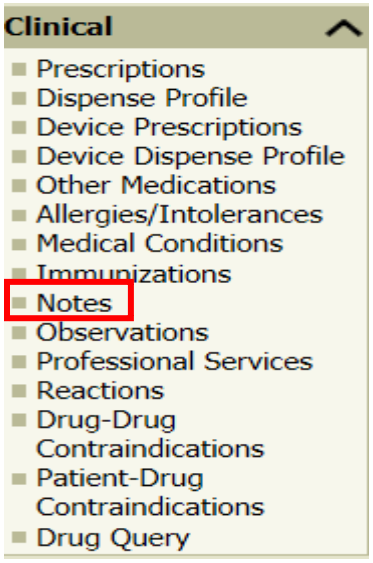
When a DUR is performed, FDB determines the severity and may add a DUR record to the clinical record. The DUR may need to be managed before the record can be added (i.e. high severity will require an override to input a prescription).



The DIS also provides contraindication functionality:

1. Drug — Drug: Checks for drug contraindication between two drugs
2. Patient — Drug: Checks for contraindications for a drug against the patient's profile

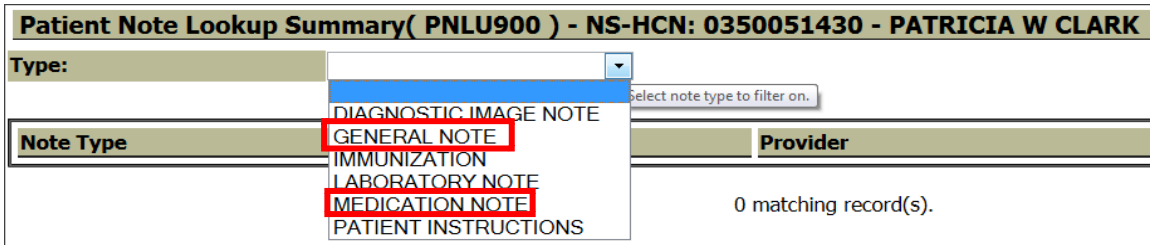
5. Notes



The DIS contains two types of notes:

1. **Record Note:** A note tied to a particular record in the DIS such as an individual prescription or medical condition.
2. **Patient Note:** A note tied to the overall patient file. This type of note would be a general note (e.g. Patient has allergy to red food dye). To add a patient note select Notes from the Clinical section of the Patient Profile Portal Menu:

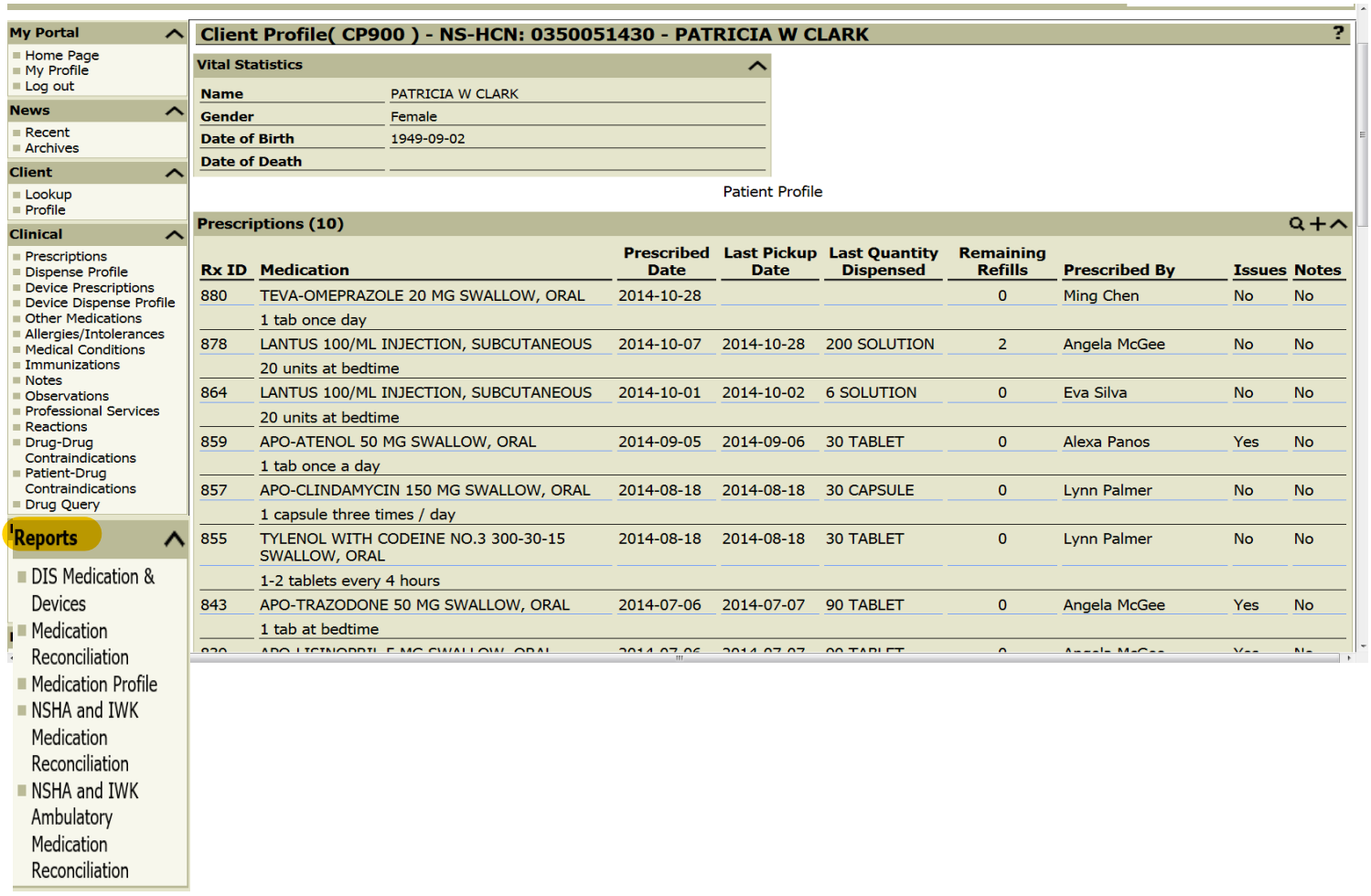
On the Notes screen choose only **General Note** or **Medication Note** in the Type field.



Keep in mind that the DIS is NOT an electronic medical record, but a capture of the patient's medication history. Therefore only input information that clinicians need to know and is relevant to the patient's medication profile.

6. Portal Reports

- All reports are accessed from the Patient Profile Portal Menu as shown below.
- The reports that are available to you are determined by your security. You will only see the reports that you have access to.
- Reports generate as .pdf files.

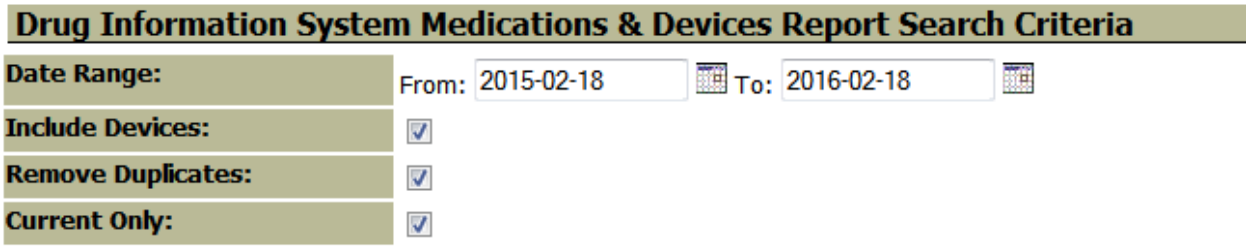


DIS Medications & Devices Report:

This report is intended for the information purposes of the patient. It would be provided to the patient and should be reviewed by a health care provider with the patient. The report contains a list of the patient's medications and devices contained in the DIS. It is intended solely for the patient or health care provider within the patient's circle of care. Any other distribution, disclosure or copy is strictly prohibited.

Selection Criteria

The report results can be modified using the selection criteria below:



Date Range – the date range defaults to six months from the current date. The user can change the date range.

Include Devices – the checkmark indicates that devices will be included in the report. No checkmark indicates devices will not be included in the report. Click inside the box to add or remove the checkmark.

Remove Duplicates – the checkmark indicates that prescription orders that contain duplicate DINS and NPNs will not be included. Only the most recent prescription order will be included in the report. To include prescriptions orders that contain duplicate DINS and NPNs, remove the checkmark. Click inside the box to add or remove the checkmark.

Current Only - If this box is checked, the following prescription orders will appear on the report:

- All prescription orders that have a status of "active"
- All prescription orders that have a status of "completed" or "obsolete" that have a dispense that meets the following criteria:
    - Dispensed within the **Date Range** time period selected; or
    - Dispensed outside of the **Date Range** period, but the patient has been given enough days' supply of medication that falls within the specified **Date Range** period.

- Prescription orders with a status of suspended (On hold) or aborted (Stopped) will not be printed on the report when **Current Only** is selected.

Current Only (no check mark) - The following prescription orders will appear on the report:

- All prescription orders that have a status of "active"
- All prescription orders that have a status of "completed", "obsolete", "suspended" or "aborted" that have a dispense that meet the following criteria:
    - Dispensed within the **Date Range** time period selected; or
    - Dispensed outside of the **Date Range** period, but the patient has been given enough days' supply of medication that falls within the specified **Date Range** period.

Understanding prescription statuses

Aborted - The healthcare provider stopped this prescription order.

Active - A prescription order that has refills remaining and has not reached the prescription's expired end date.

Complete - A prescription order that no longer has refills remaining or has exceeded the prescription expiry end date.

Obsolete - A prescription that was replaced by a more recent prescription order.

Suspended - The prescription has been stopped temporarily and has not been resumed by a healthcare provider.

Medication and Devices Report Contents

Medication Prescription Information – prescriptions that meet the defined criteria for both the **Date Range** and **Current Only** selections.

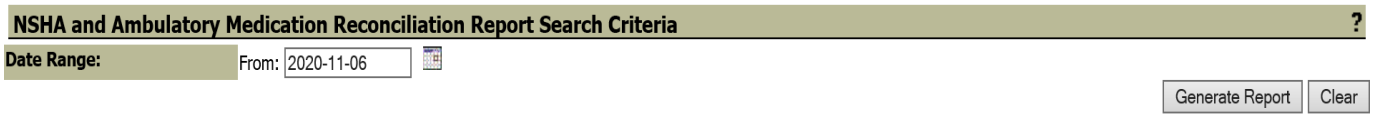
Device Prescription Information - devices that meet the defined criteria for **Include Devices**, the **Date Range** and **Current Only** selections.

Medication Reconciliation Reports:

These reports are intended for health care providers to facilitate Medication Reconciliation with a patient, and provides the DIS user with information contained in the patient's DIS profile. Each report is formatted to support the Medication Reconciliation process. It is intended solely for the health care providers within the patient's circle of care. Any other distribution, disclosure or copy is strictly prohibited.

Selection Criteria

1. Choose which Medication Reconciliation report is suitable for your area and the date range. E.g.:



The report results can be modified using the selection criteria below:

Date Range – the date defaults to six months from the current date. The user can change the date.

Medication Reconciliation Report Contents

Allergy/Intolerance Information with an active status will be printed on this report.

Medication Information: Prescription medication orders that match the below criteria will appear on the reports:

- The most recent prescription for a DIN or NPN. Prescriptions that match the DIN or NPN and are not the most recent, will NOT appear on the report.
- All prescription orders that have a status of "active"
- All prescription orders that have a status of "completed" or "obsolete" that have a dispense that meet the following criteria:
    - Dispensed within the **Date Range** time period selected; or
    - Dispensed outside of the **Date Range** period, but the patient has been given enough days' supply of medication that falls within the specified **Date Range** period.
- Prescriptions with a status of suspended (On hold) or aborted (Stopped) are not displayed on this report.

Other Medication: Current other medications. The end date is in the future.

Understanding prescription statuses

Note: Statuses are not printed on the report but are referenced in the Medication information above.

Aborted - The health care provider stopped this prescription order.

Active - A prescription order that has refills remaining and has not reached the prescription's expired end date.

Complete - A prescription order that no longer has refills remaining or has exceeded the prescription expiry end date.

Obsolete - A prescription that was replaced by a more recent prescription order.

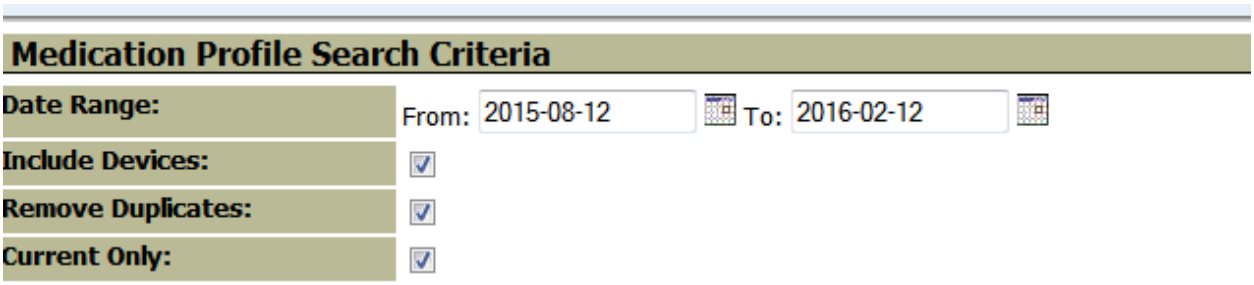
Suspended - The prescription has been stopped temporarily and has not been resumed by a health care provider.

Medication Profile Report:

This report is intended for health care providers and should be discussed with the patient to validate accuracy. It is intended solely for the health care providers within the patient's circle of care and is not a patient report. Any other distribution, disclosure or copy is strictly prohibited

Selection Criteria

The report results can be modified using the selection criteria below:



Date Range – the date range defaults to six months from the current date. The user can change the date range

Include Devices – the checkmark indicates that devices will be included in the report. No checkmark indicates devices will not be included in the report. Click inside the box to add or remove the checkmark.

Remove Duplicates – the checkmark indicates that prescription orders that contain duplicate DINS and NPNs will not be included. Only the most recent prescription order will be included in the report. To include prescriptions orders that contain duplicate DINS and NPNs remove the checkmark. Click inside the box to add or remove the checkmark.

Current Only (with check mark) - The following prescriptions will appear on the report:

- All prescription orders that have a status of "active"
- All prescription orders that have a status of "completed" or "obsolete" that have a dispense that meet the following Date Range criteria:
    - Dispensed within the **Date Range** time period selected; or
    - Dispensed outside of the **Date Range** period, but the patient has been given enough days' supply of medication that falls within the specified **Date Range** period.
- Prescription orders with a status of suspended (On hold) or aborted (Stopped) will not be printed on the report when **Current Only** is selected.

Current Only (no check mark) - The following prescription orders will appear on the report:

- All prescription orders that have a status of "active"
- All prescription orders that have a status of "completed", "obsolete", "suspended" or "aborted" that have a dispense that meet the following criteria:
    - Dispensed within the **Date Range** time period selected; or
    - Dispensed outside of the **Date Range** period, but the patient has been given enough days' supply of medication that falls within the specified **Date Range** period.

Understanding prescription statuses

Aborted - The health care provider stopped this prescription order.

Active - A prescription order that has refills remaining and has not reached the prescription's expired end date.

Complete - A prescription order that no longer has refills remaining or has exceeded the prescription expiry end date.

Obsolete - A prescription that was replaced by a more recent prescription order.

Suspended - The prescription has been stopped temporarily and has not been resumed by a health care provider.

Medication Profile Contents

Prescriptions – Medication prescriptions that meet the defined criteria for both the **Date Range** and **Current Only** selections.

Devices - devices that meet the defined criteria for **Include Devices**, the **Date Range** and **Current Only** selections.

Other Medications – current other medications. The end date is in the future.

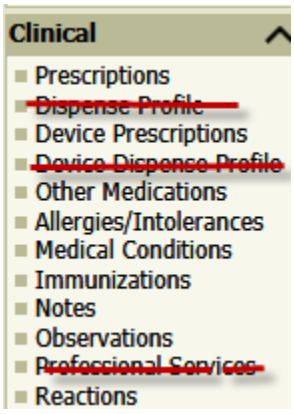
Medical Conditions – medical conditions with a status of active.

Allergies/Intolerances – allergies and intolerances with a status of active.

Adverse Reactions – all adverse reactions

Adding Clinical Information

Clinical information can be added to a client Drug Information System profile through the DIS Portal for the following:

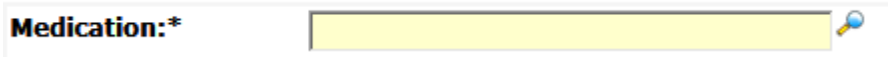


The functions that are crossed out are DIS records that are only created by a community pharmacy.

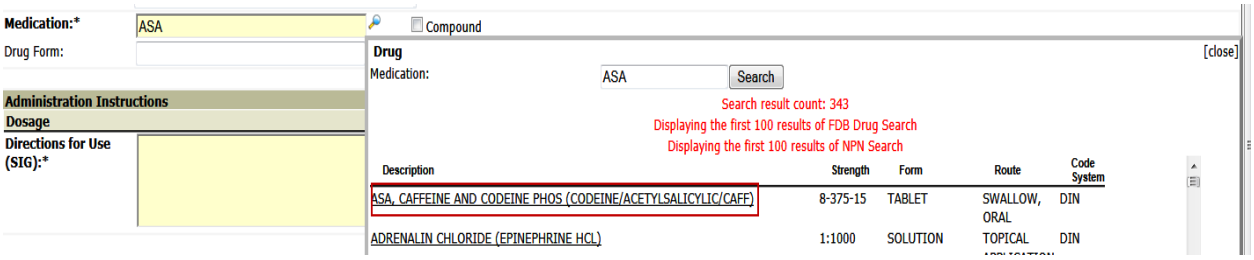
On the client profile screen, the summary screen or the detail screen, click the + sign in the title bar

Adding a clinical record:

1. All required fields have an * to the right of the label and the field is highlighted in yellow



2. Click on the Magnifying Glass to perform a lookup after entering a few characters of the item



Select the item by clicking the description.

3. Action Buttons

- Reset – will clear all the entered field. This is only available before you SAVE.
- Save - will save the clinical record to the Drug Information System

e-Prescribing

Viewing a DIS Prescription

The following table details the minimum fields available in the Portal for a prescription. All fields within a selected Prescription record are read-only, except the Notes section. The status of a prescription can be updated.

Field	Description
Issues	If DUR issues where identified, they will appear at the top of the screen. Click the V on the right hand side of the issue to view details.
Previous Prescription	A reference to the previous prescription which the current prescription replaces.
Prescription Id	The identification number for the prescription.
Status	Aborted - The patient should not be taking this prescription. The prescription can no longer be dispensed. The prescription cannot be renewed. Active - The patient should be taking this prescription. The prescription can be dispensed against. The prescription can be renewed, aborted or suspended.

Field	Description
	Complete - All of the refills on the prescription have been dispensed, or the prescription is over 365 days old and has expired. The prescription cannot be dispensed against. The prescription can be renewed. Obsolete - The prescription was renewed and it can no longer be dispensed against. There is a more current prescription on file. Suspended - The prescription has been stopped temporarily and the patient should not currently be taking this prescription. The prescription cannot be dispensed or renewed currently, but can be resumed in the future.
Prescriber	Displays the name of the prescriber
Non Authoritative	If the Non Authoritative Box is checked, there is a paper copy of the prescription. If the Non Authoritative Box is unchecked, there is no paper copy of the prescription.
Prescription Type	A description of the prescription.
Trial Fill	An indication that a prescription is or is not eligible for trial dispensing from a clinical (not financial) perspective. False = Eligible, True = Not Eligible.
No Substitutions Permitted	The No Substitutions Permitted box indicates that the chosen medication is the one that must be dispensed.
Reason	The reasons for the substitution

Field	Description
*Medication	Medications can be searched by typing in the first few letters of the medication name and then pressing Enter, or by clicking the Search icon next to the Medication field. Select the appropriate Medication from the search results by single-clicking the description, e.g. DIGOXIN (DIGOXIN). Depending on the jurisdictional configuration, users can search using the drug identifier or drug name.
Compound	The prescription is a compound.
Drug Form	Where applicable, this field is automatically populated based on the form of the medication selected.
Container	A coded value denoting a specific kind of a container. Used to identify a requirement for a particular type of compliance packaging.
Drug Description	A free form textual description of a drug.
Ingredients	This section is only displayed for a Compound.
Exclude	Indicates the compound drug does not or should not contain the specified ingredient.
Fill Rx On or After	The prescription is to be filled on or after this date. If not provided, it defaults to the date that the prescription is entered into the Drug Information System (DIS).

Field	Description
Rx Expiry	Indicates the date when the prescription ceases to be a dispensable prescription. If not provided, this defaults to one year from the start date.
Route of Administration	Displays the route code for how to take the drug.
Directions for Use	
SIG	The SIG displays what has been sent to the DIS as the official SIG. This is based on what has been selected in the drop-down values and includes any free text that is added in the Additional Instruction section.
Pharmacy	The pharmacy that is the current owner of the prescription.
Dispensing Instructions	The dispense instructions including the number of refills.
Expected Duration	The expected duration for the prescription
Total Quantity	The overall amount of medication to be dispensed under this prescription. Includes any first fills (trials, aligning quantities), the initial standard fill plus all refills.
Note	Displays Notes pertaining to the prescription order.
Recorded From	This is the location from which the prescription was recorded.
Recorded On	The date at which the prescription order was recorded.

There are five action buttons available to a prescription.

Button	Description
Rx History	The Rx History Button will link to the History of Changes Screen. The History of Changes screen is used for viewing details of changes made to a drug prescription over time.
Renew	Click **Renew** to make a copy of an existing prescription that is currently in the patient's profile history. Renewing a prescription will copy everything from the original prescription except the Refill amount. The User is required to enter a refill amount on a renewed prescription.
Abort	Click **Abort** to permanently inactivate a medication. Aborting a prescription will ensure the prescription can never be renewed unless entered as a new script.
Resume	Clicking **Resume** changes a prescription with a status of **Suspended** to an **Active** status.
Suspend	Click **Suspend** to temporarily suspend a prescription.

Creating an e-Prescription

1. Click the **Add** icon in the top right corner of the title bar on the **Prescription** page or click the **Prescriptions** link under the **Clinical** section. A fresh **Prescription** page is displayed.

2. Ensure the prescription template drop-down is set to **Default** and fill in all the mandatory fields, which are highlighted in yellow and marked with an asterisk (*)

3. Enter the prescription information,

Field	Description
*Prescription Type	Click the drop-down box to select a **Prescription Type**.
No Substitutions Permitted	By selecting the **No Substitutions Permitted** box, this indicates that the chosen medication is the one that must be dispensed. When the **No Substitutions Permitted** box is checked, the **Reason** field appears.
*Reason	A reason is required for the **No Substitutions Permitted**. Click the drop-down list and select an appropriate reason.
*Medication	Medications can be searched by typing in the first few letters of the medication name and then pressing Enter, or by clicking the Search icon next to the Medication field. Select the appropriate Medication from the search results by single-clicking the description, e.g. DIGOXIN (DIGOXIN). Depending on the jurisdictions configuration, users can search using the drug identifier or drug name.
Drug Form	Where applicable, this field is automatically populated based on the form of the medication selected.

Field	Description
Compound	If entering a **Compound**, click the check box next to the **Medication** field. The **Medication** field automatically populates with **Compound**. However, it is also a free-form text field in which a compound name may be entered.
Ingredients	Up to 10 ingredients can be entered by clicking the **Add** icon within the **Ingredients** bar.
Exclude	Click the **Exclude** checkbox to exclude the ingredient from the compound recipe.
Quantity and Unit	Type in the quantity and select the unit of measurement of the ingredient
Fill Rx On orAfter	The prescription is to be filled on or after this date. If not provided, it defaults to the date that the prescription is entered into the Drug Information System (DIS).
Rx Expiry	Indicates the date when the prescription ceases to be a dispensable prescription. If not provided, this defaults to one year from the start date.
Enter as Free Text check-box	Check this box to enter the SIG manually without using the SIG Auto Generator.

Field	Description
Dose	This Dose section contains three data fields. Select the action, quantity and form.
Route	This Route section contains one data field, and is used to describe how to take the drug.
Frequency	The Frequency section will consist of four data fields. Frequency, Fill Duration, Time Unit of Measure and Additional Directions.
*SIG	The SIG will display what will be sent to the DIS as the official SIG. This is based on what has been selected in the drop-down values and include any free text that is added in the Additional Instruction section.
Additional Instructions	This is a free text field to allow additional details to be appended to the SIG.
*Dispense Quantity and Units	Type in the quantity and select the unit of measurement from the drop-down list. ***Note:*** *Dispense quantity may be automatically calculated using the "Calculate Dispense Instructions" button when supported Form of Medication and Frequency are selected.*
*Fill Duration	After "every" type in the duration and select from the drop-down list, the unit of time that one fill is expected to last the patient. ***Note:*** *Fill Duration may be automatically calculated using the Calculate Dispense Instructions button when supported Form of Medication and Frequency are selected.*
*Refills	After "with" select the number of refills from the drop-down list.

Field	Description
	Note: *This is the number of refills of this prescription that can be dispensed. This* ***DOES NOT*** *include the first fill.*
Notes	Type in any Notes pertaining to the prescription order.

There are four action buttons available when Adding a Prescription

Button	Description
Calculate Dispense Instructions	The Calculate Dispense Instructions button can be used in collaboration with the Auto-Generate SIG feature to automatically calculate the Dispense Instructions (excluding refills) when supported Form of Medication and Frequency are selected in the Directions for Use.
Check	Click Check to determine whether a new prescription will return issues as a result of an interaction with another medication in the patient's profile. The user has the ability to save the prescription after it has been checked by clicking Save.
Reset	Click Reset to clear all the fields. This action can only take place before the record is saved.
Prescribe	Click Prescribe to submit the prescription.