First Nations Health Authority
Health through wellness

Panorama Guide

Family Health

Version 2.0

panorama@fnha.ca

http://www.fnha.ca/what-we-do/communicable-disease-control/panorama

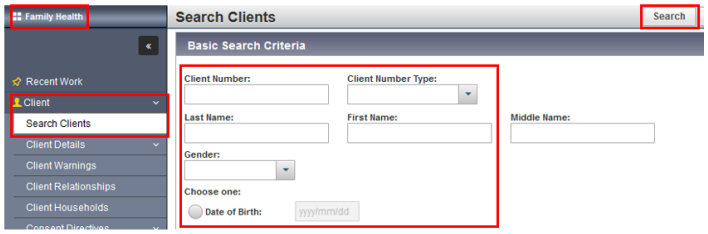
Table of Contents

Glossary / Definitions

Glossary/Definitions

- **LHN**- Left Hand Navigation bar
- **UDF**- User defined Form
- **Client Summary**- > **LHN** -Gives you all the encounter details made on this client
- **Encounters-**> Under **Client Summary**, details on past assessments
- **Focus Area Summary** >Under **Client Summary**, care categories and area of focus, tells you if its still open or has been resolved and closed
- **Care Plans**- > Under **Client Summary**, prioritizes care plan and gives nurses notes on plan
- **Appointments**- > Under **Client Summary**, indicates any appointments client has booked with health care professional.
- **Client Encounter**- > **LHN**- Allows you to create an encounter and document on client
- **Maternal Birth Event**- > **LHN**- A client summary of birth details and link to parent (Public Health Enters)
- **Baby Birth Details**- > **LHN**- A baby birth summary (Public Health enters)
- **View Client Imms Profile**- > **LHN**- Link to Imms profile but keeps you in the FH selection

Navigate the Family Health Client Summary Page



The **client summary** tab will display all of the client encouters, any focus ares, the clients care plan and any appointments documented.

Notes:

- Click on all Client ID hyperlink to view client details.
- Always click on the LHN tabs to navigate to original screen, or close encounter.

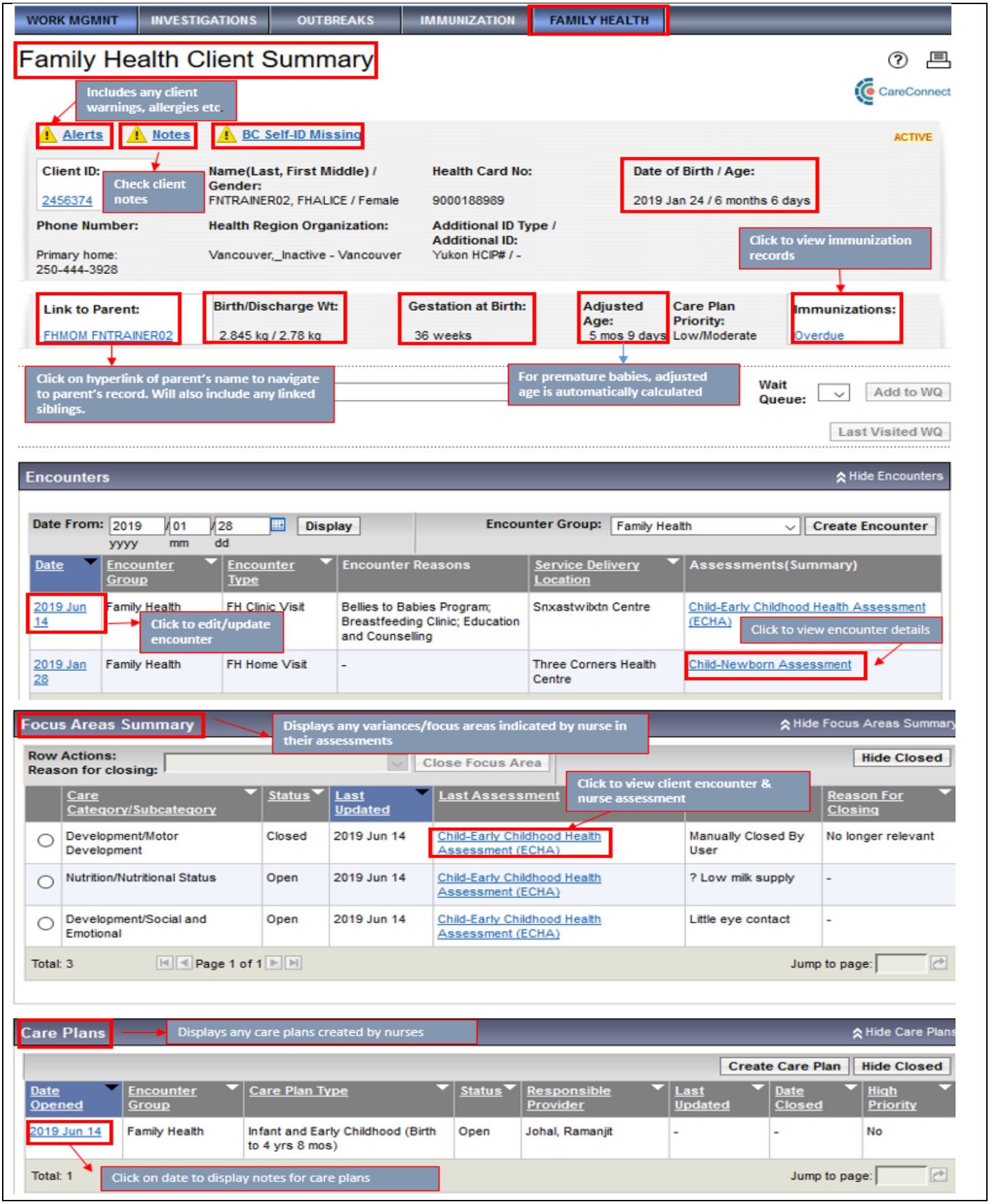
1. Log into panorama
2. Select the **Family Health tab** to set into context
3. **LHN > Search Clients**
   Search your client - Enter available client details last name & first name, PHN, DOB or client ID
4. Click **Search**

5. **Search Results** will appear on bottom of screen.
6. **Check the box** beside your clients name and select the **Family Health Client Summary** tab to set in context.

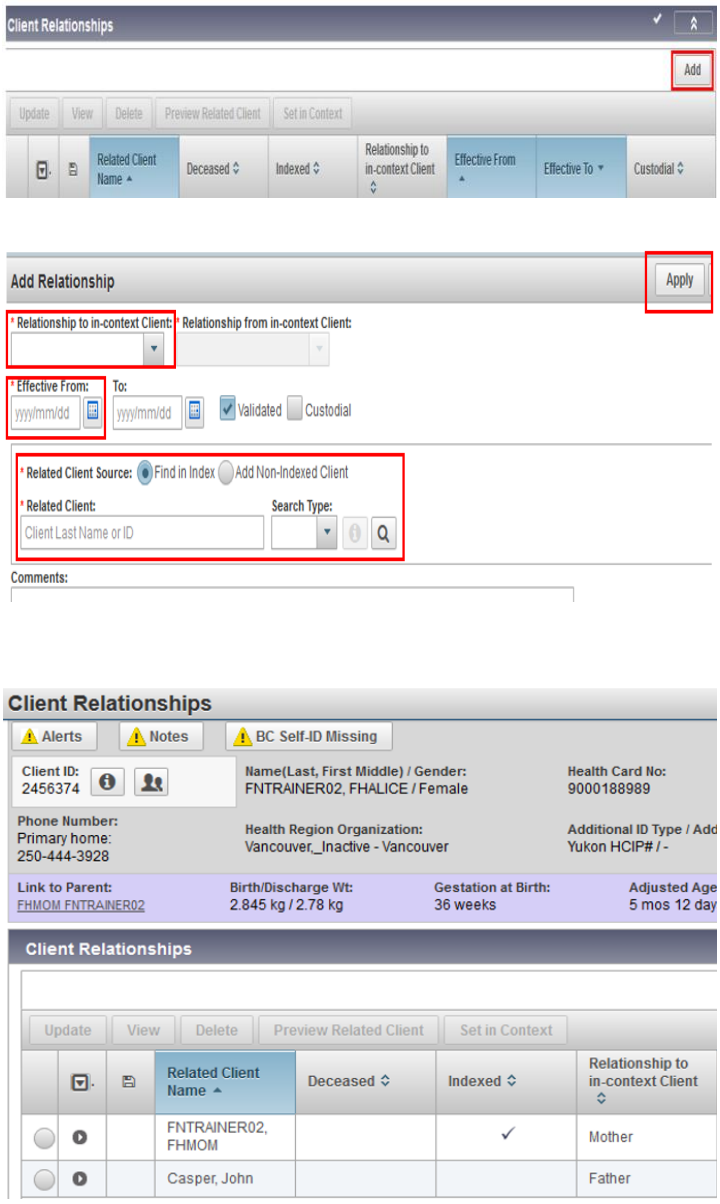
   This brings you to the **Family Health Client Summary** Screen which is summarized in the next page.

Note: Update **Client Details.** (See Core User Guide)

- Client Demographics
- Indigenous Information
- Allergies
- Risk Factors


WORK MGMNT
INVESTIGATIONS
OUTBREAKS
IMMUNIZATION
FAMILY HEALTH
Family Health Client Summary
CareConnect
Includes any client warnings, allergies etc.
Alerts
Notes
BC Self-ID Missing
ACTIVE
Client ID:
2456374
Check client notes
Name(Last, First Middle) / Gender:
FNTRAINER02, FHALICE / Female
Health Card No:
9000188989
Date of Birth / Age:
2019 Jan 24 / 6 months 6 days
Phone Number:
Primary home:
250-444-3928
Health Region Organization:
Vancouver,_Inactive - Vancouver
Additional ID Type / Additional ID:
Yukon HCIP# / -
Click to view immunization records
Link to Parent:
FHMOM FNTRAINER02
Birth/Discharge Wt:
2.845 kg / 2.78 kg
Gestation at Birth:
36 weeks
Adjusted Age:
5 mos 9 days
Care Plan Priority:
Low/Moderate
Immunizations:
Overdue
Click on hyperlink of parent's name to navigate to parent's record. Will also include any linked siblings.
For premature babies, adjusted age is automatically calculated
Wait Queue:
Add to WQ
Last Visited WQ
Encounters
Hide Encounters
Date From: 2019 / 01 / 28
yyyy mm dd
Display
Encounter Group: Family Health
Create Encounter
Date
Encounter Group
Encounter Type
Encounter Reasons
Service Delivery Location
Assessments(Summary)
2019 Jun 14
Family Health
FH Clinic Visit
Bellies to Babies Program; Breastfeeding Clinic; Education and Counselling
Snxastwixtn Centre
Child-Early Childhood Health Assessment (ECHA)
Click to edit/update encounter
Click to view encounter details
2019 Jan 28
Family Health
FH Home Visit
-
Three Corners Health Centre
Child-Newborn Assessment
Focus Areas Summary
Displays any variances/focus areas indicated by nurse in their assessments
Hide Focus Areas Summary
Row Actions:
Reason for closing:
Close Focus Area
Hide Closed
Click to view client encounter & nurse assessment
Care Category/Subcategory
Status
Last Updated
Last Assessment
Reason For Closing
Development/Motor Development
Closed
2019 Jun 14
Child-Early Childhood Health Assessment (ECHA)
Manually Closed By User
No longer relevant
Nutrition/Nutritional Status
Open
2019 Jun 14
Child-Early Childhood Health Assessment (ECHA)
? Low milk supply
-
Development/Social and Emotional
Open
2019 Jun 14
Child-Early Childhood Health Assessment (ECHA)
Little eye contact
-
Total: 3
Page 1 of 1
Jump to page:
Care Plans
Displays any care plans created by nurses
Hide Care Plans
Create Care Plan
Hide Closed
Date Opened
Encounter Group
Care Plan Type
Status
Responsible Provider
Last Updated
Date Closed
High Priority
2019 Jun 14
Family Health
Infant and Early Childhood (Birth to 4 yrs 8 mos)
Open
Johal, Ramanjit
-
-
No
Total: 1
Click on date to display notes for care plans
Jump to page:

Create Relationships



If you know who the parent is to the child and have the 5 identifiers (PHN, DOB, first name, last name, address) you can create a relationship.

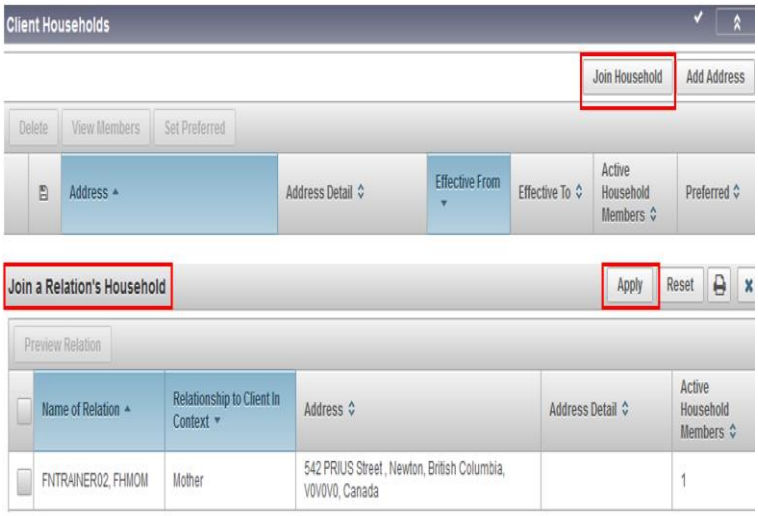
1. **LHN> Client> Client Relationships**
2. Select **Add – Add Relationship**
3. Fill in **Relationship to in context –** scroll from menu to select applicable relationship
    - **Relationship from in-context** client will automatically populate to client in context.
4. **Effective from** date can include baby's DOB
5. **Related Client Source:**
    - Check radio button beside **Find in Index** - includes individuals who are uploaded in Panorama (hyperlink).
        - Can search using NAME, CLIENT ID, or PHN
    - **Not in Index** – includes individuals who are not in Panorama.
        - Enter client details – only last name & first name are mandatory.
6. Select **APPLY**
7. Page will navigate back to client relationship page. You will be able to view relationship on screen. Select **SAVE** on top right hand header.

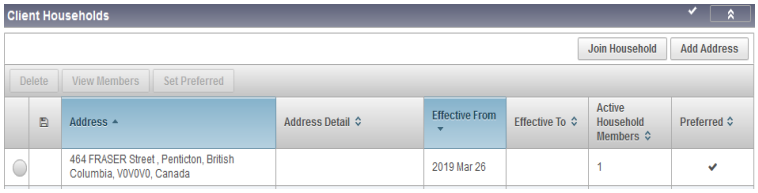
NOTE:

- If relationship client is uploaded in Panorama, the relationship will be displayed with a hyperlink on the client summary screen in client banner. This will allow you to click between client charts directly as desired. You can also add siblings or under mothers chart add all children.
- For those relationship clients not in Panorama they will not display in client banner, however, will still appears when searching Client Relationships through LHN.

Create Households

Panorama allows you to group clients, who reside at the same address, together by adding them into a container called a "household". Each household is defined by its address.





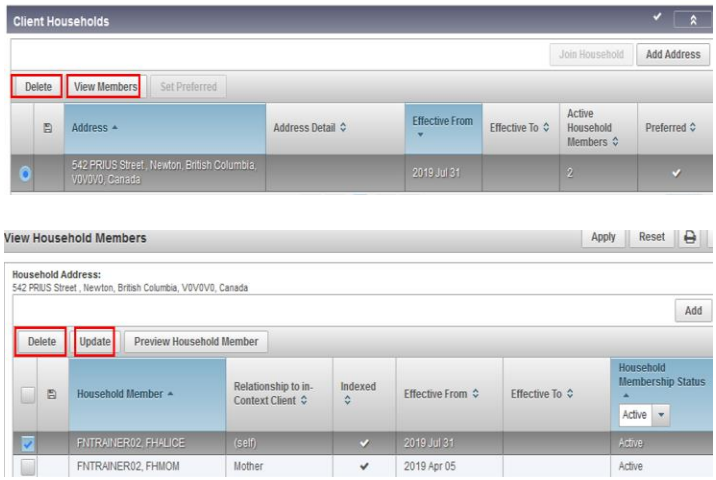
1. LHN > Client > **Client Households**
2. Click **Join Household**- the Join a Relation's Household screen displays, listing the active addresses of the client in context, and the active addresses of the Clients in a Relationship with the Client in Context
3. Select the radio button beside the address you wish to create a household with.
4. Click **APPLY.**

   The *Client Household* screen displays, and the chosen Household address is listed below the Header to confirm the household container has been created and associated to it.

Search/create a Client and Add as a Household Member

Clients who do not have a Relationship record with the client in context can be added to the household through ***Search and Add Client to Household.***

1. Under the sub-heading of *Household* Members, click **Search and Add Client to Household.** The Search Clients screen displays.
2. Click **select and Return,** a yellow band will display that the client has been added successfully to the household.

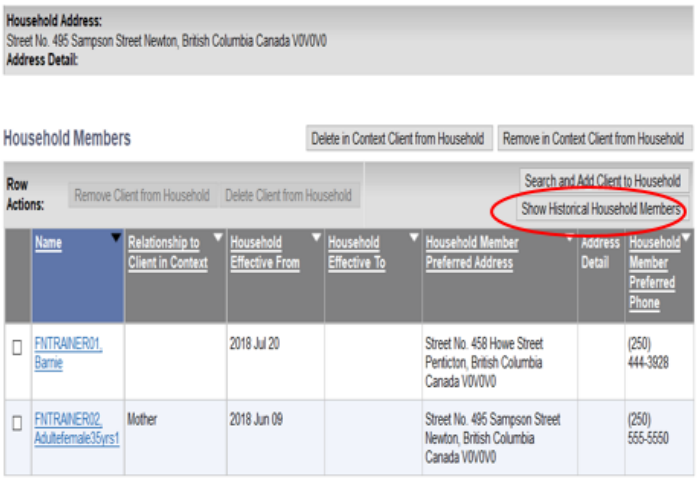


Remove Members from a Household

With the client context:

1. LHN > Client > **Client Households** View Household screen appears
2. Select the radio button next to the **Current Household** you wish to work with.
3. Click **View Members**
4. **View Household Members** will display screen which lists all household members
5. Select the check box next to the Client you wish to update or remove from the Household
6. Click **Update –** only allows you to adjust **Effective from or Effective to date.**
7. Click **DELETE** if wishing to remove client from household.
8. Select **Apply**
9. Click **Save.** A confirmation message "Client Household has been successfully updated".

When members have been removed from a household a history table is created that can be displayed to view historical members of the household.



View Historical Members of Household

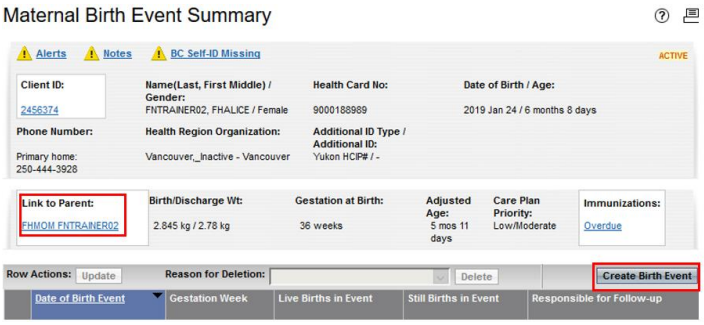
With the client in context:

1. **LHN > Households** View Household screen displays.
2. Select the radio button next to the Current Household you wish to work with.
3. Click **Update Household Members.** Maintain Household Memberships screen displays.
4. Click **Show Historical Household Members.** The Household member's table refreshes to include the members that have been removed. Details include the **Household Effective To** column populated with the date they were removed from the household.

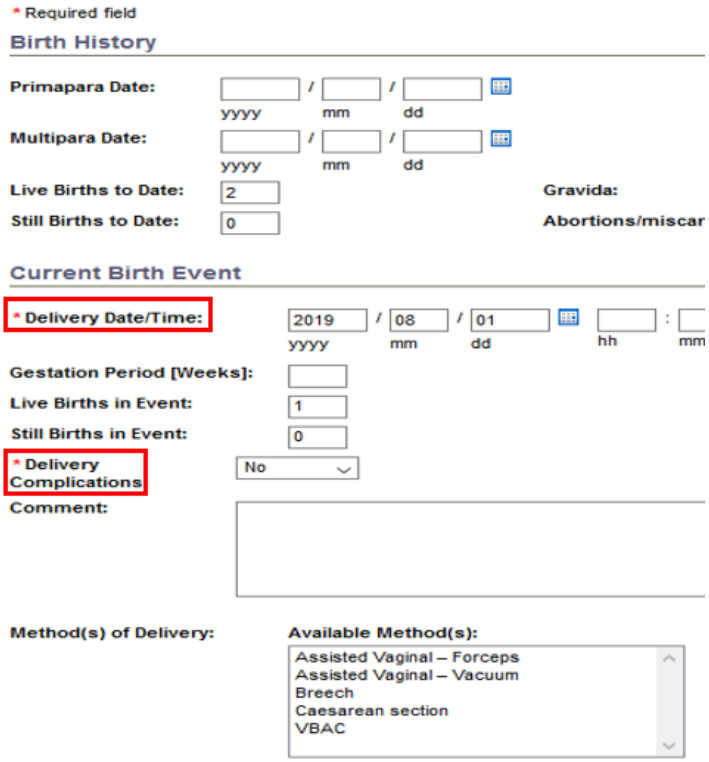
Click **Hide Historical Household Members** to hide those members that were removed.

Create Maternal Birth Event

*A Maternal Birth Event is used to record both live and still birth events and may include multiple births. The **Maternal Birth Event Summary** page displays a list of mother's birth event(s) for the client in context. Use this page to view existing Maternal Birth Events of to create new ones.*



Not: You can go between child's and mothers records by clicking on the Blue Hyperlink



1. **Ensure newborn record has been created** (personal Information etc.)
2. Have the Mothers record in context under the **Family Health tab**.

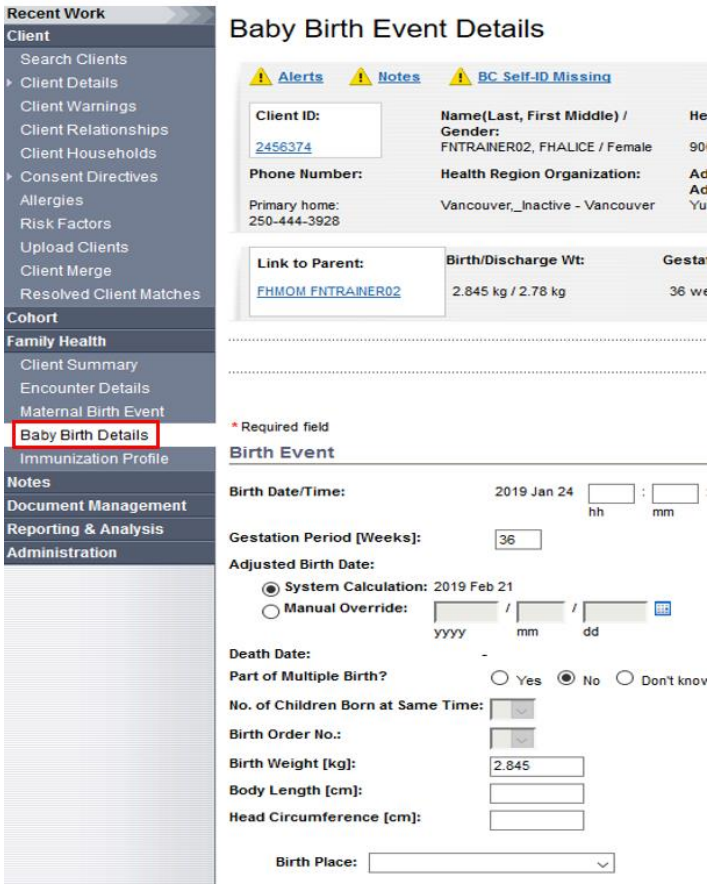
3. **LHN > Maternal Birth Event.**
4. Click on **Create Birth Event.**
5. Enter data in the system required fields (*).
6. Enter your **Responsible Organization** and your **SDL**.
7. **SAVE**
   A message will appear stating that the information was successfully saved.

8. Scroll down to the **Newborn Children** section and select the appropriate child from the drop down list.

You have now linked the child to the mother's record.

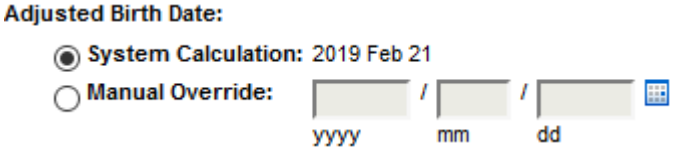
Create Baby Birth Events

The baby Birth Event allows the user to record birth information on a client's birth details.



NOTE:

- **Birth Date** and **Time** auto-populates based on the information entered into the Maternal Birth Event Details screen.
- **Birth weight** is entered in Kilos (KG) on Baby Birth Event Details screen.
- If **Gestation Period (weeks)** < 37 weeks, the **Adjusted Birth** Date fields display where you can either select **System Calculation** or manually enter a date by selecting **Manual Override**.



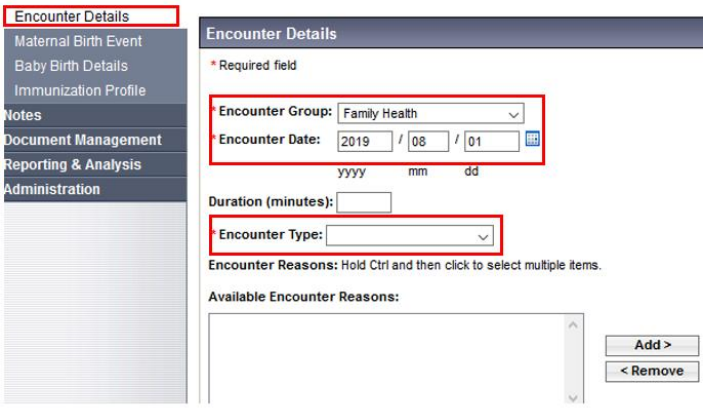
- If **Birth Place** is set to Hospital within Province/Territory, the **Hospital** filter displays.

1. Under the **Family Health** tab set the mothers record in context.
    - The newborns record should have been created and linked to mother using the **Relationships** link on the LHN. The **Maternal Birth Event** (LHN) has also been created.
2. LHN > select **Maternal Birth Event.** The **Maternal Birth Event Summary screen** displays.
3. From the Client Header section at the top click the **Child's Name** under the **Link to Children** section. The Family Health Client Summary screen for the Newborn Child displays and is in context.
4. Select **Baby Birth Details** from the LHN. The Baby Birth Event Details screen displays.
5. Enter Data for the required fields, marked with an asterisk (*).
6. If **Birth Place** is set to Hospital within Province/Territory, the **Hospital** filter displays.
7. Enter name of Hospital
8. Specify an **Organization**, this is the **Responsible Jurisdictional Organization Unit** *(closest Public Health Branch)* associated to the **Service Delivery Location (SDL)** responsible for the birth event and follow up at the time of delivery.
9. Specify a **SDL**; this is the SDL *where the client resides at the time of delivery.*
10. Enter any optional data and click **SAVE**.
    - The Baby Birth Event Details screen displays with the saved data.

• Part of Multiple Birth, No. of Children Born at the Same Time, Birth Order displays on the Personal Details > Birth Information section • The **Baby's Birth Weight** and **Discharge Weight** will display in the Family Health header when the baby is in context until the baby > 180 days old.	
There are two ways to update or view a Baby Birth Event. ***Option 1*** *starts from the* ***Maternal Birth Event*** *with the mother in context.* ***Option 2*** *starts from the* ***Baby Birth Event*** *with the newborn in context.*	**Update or View a Baby's Birth Event** **Option 1.** 1. Under the **Family Health** tab have the mothers record in context. 2. From the LHN select the **Maternal Birth Event**. The Maternal Birth Event screen displays, listing each of the birth event and details. 3. Select the **Maternal Birth Event** you wish to update and click **Update**. 4. On the Maternal Birth Event screen, view the **Newborn Children** section at the bottom. Select the Child you wish to update and click **Update**. The Baby Birth Event Details screen displays. 5. View or make updates as required and click **SAVE**. 6. To return to the Mothers Birth Event screen, click the Mothers Birth Event button at the top or bottom of the page. **Option 2.** 1. In the **Family Health** tab, have the Newborn record in context. 2. From the left-hand navigation, select **Baby Birth Details**. The *Baby Birth Event Details* screen will display the birth event details for the client that is currently in context. **3.** View and/or update the information as required and select Save.

Create an Encounter in Family Health

Encounters are an integral part of Panorama, used to indicate an interaction between a client and the health care system, whether a visit, phone call, communication sent or other interaction.
An encounter can be created using the Encounter Details screen. With a client and encounter in context, encounter notes can be created on the Encounter Details screen.



1. Select **Family Health tab** > **Encounter Details** from the LHN.
   The **Create Encounter Details** screen displays.
2. Enter required field **(*)** details:
   - **Encounter group**: select Family Health
   - **Encounter date:** Date of encounter
   - **Encounter type:** Select from drop down list ie. clinic visit, home visit, phone call etc
   - **Available Encounter Reasons:** Add applicable reason (not required)
3. Click **Save.**
   The yellow highlighted bar will tell you that encounter has been successfully saved.

You are now ready to fill out the **User Assessment Form (UDF)** to fill in the details of your encounter. The following information describes the entire process followed by the UDF steps.

The following describes the steps required to record assessments on a **User Defined Form (UDF)** in Panorama. Also included are steps to **update, view, and migrate answers on historical UDFs/assessment** forms when form layout changes have been made.

Assessments are made up of pre-configured sets of questions that can be asked during a client visit or screening program. UDFs enable users to record assessments in a configurable questionnaire form for a particular client. Some responses may trigger the creation or update of other records in the system, such as **Focus Areas.**

This Guide also describes where Focus Areas can be viewed and outlines the steps for closing Focus Areas.

Assessments

In the Family Health component, a user's Encounter Group filters the UDFs/Assessment Forms available to a user.

NOTE: Some questions within an assessment are referred to as **Variance Questions** in Panorama. The Variance Questions can be answered to indicate an outcome outside of the norm, and that follow-up may be necessary. ***For these Variances, Panorama automatically creates and tracks a Focus Area related to the Variance.***

Variance Questions

Family Health uses a special type of categorical question called a **Variance Question** to support the expression of a variance on an Assessment. Variance Question support is an important feature in Family Health Assessments.

Variances express clinical judgment that a concern or problem exists, or that treatment or care is needed. For each Variance Question where the user-entered response (Observed, Refer, etc.) identifies a variance, the user may have the option of recording a comment. The Comment field is enabled after the response has been selected. For these Variances, Panorama automatically creates a **Focus Area** related to the variance. A summary of all Focus Areas that will be created based on the Variance Question responses is displayed at the bottom of each assessment form for the user to review prior to finalizing the form answers.

The table below contains the list of the pre-defined Variance Question Responses and their definitions:

Response (Code)	Definition	Express a Variance
Not Assessed (NA)	Assessment or evaluation is not performed for this item at this Encounter.	No
No Apparent Problem (NAP)	Assessment is performed and no apparent concern or problem exists at this time.	No
Refer (REF)	Concern or problem is noticed and the client needs to be referred to an internal or external health	Yes (Requires a comment)
Observe (OBS)	Concern or problem is evident and active observation or monitoring needs to be performed	Yes (Requires a comment)
Under Continuing Care (UCC)	Concern or problem was acknowledged, but it is currently being handled by health professionals	Yes (Requires a comment)
Closed		

If a Variance Question **is not associated** with any existing Focus Area for the Client, the eligible Responses for this Variance Question are: *Not Assessed, No Apparent Problem (NAP), Refer, Observe* and *Under Continuing Care.*

If a Variance Question **is associated** to an existing Focus Area for the Client, the eligible Responses for this Variance Question are: *Not Assessed, Refer, Observe, Under Continuing Care, and Closed.* Note that *No Apparent Problem (NAP)* is an eligible response when a variance question is not associated with any existing Focus Area for the Client, or when a variance generating that is associated to an existing Focus Area has been set to Closed.

NOTES:

- The **Apply NAP to All** check-box is not available when there are no variance-generating questions on a particular section of an Assessment.
- If you have a previous variance associated to an existing **Focus Area** for the client from another UDF in the same category (e.g., growth), **NAP** is not available for selection unless the previous variance has been set to Closed.

Focus Areas

Focus Areas define any concerns or problems that need to be addressed for the client by Public Health. Examples include behavioral issues (e.g., Drug usage), environmental circumstances (e.g., Presence of tobacco smoke where an infant sleeps), or treatable medical conditions (e.g., Poor eyesight).

A Variance Question is associated to a **Focus Area** through the **Care Category** and **Sub-Category**. Each Care Category and Care sub-category combination defines a **Focus Area** for a client. When a user identifies a Variance on an Assessment, the system may create or update a Focus Area that is associated to the same Care Category and Care Subcategory. Users are not able to manually create a Focus Area; these are always triggered as an outcome of answering a variance-generating question.

Menu Access

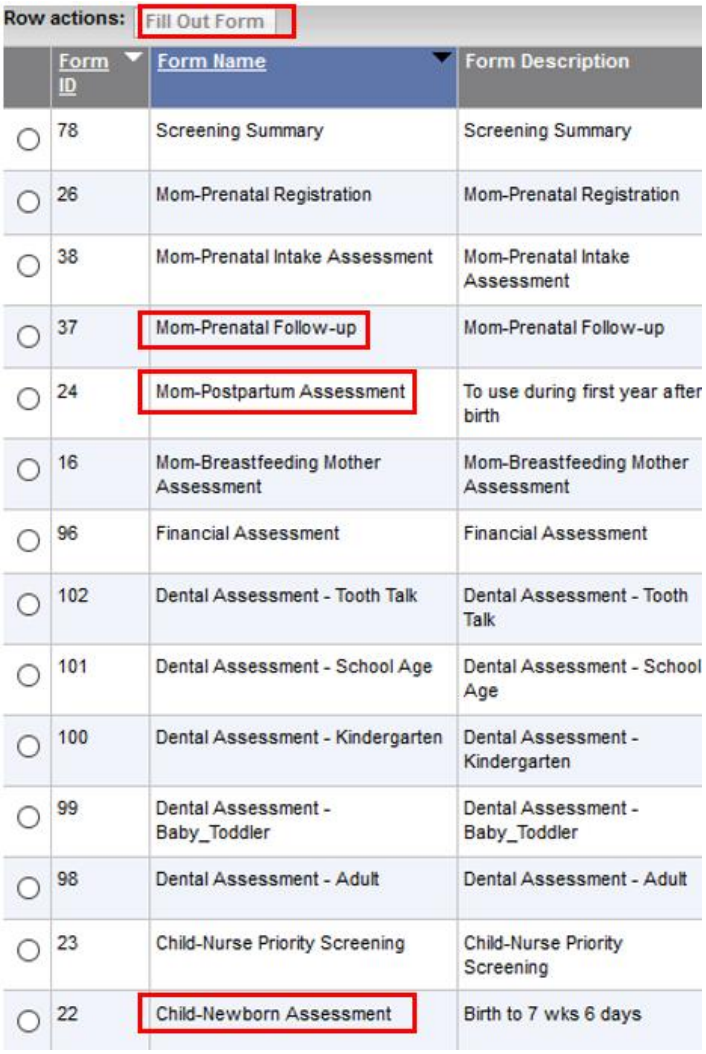
From the left-hand navigation, select Family Health Client Summary. In the *Family Health Client Summary* screen, select the **Date hyperlink** next to the encounter of interest to display the *Encounter Details* screen. In the *Encounter Details* screen, select **Encounter UDF hyperlink.** The *Encounter UDF* screen displays with a list of Available Forms and Filled-Out Forms. If an encounter has a completed UDF assessment attached to it, a hyperlink to the assessment detail will be displayed in the Assessments (Summary) table column.

Alternatively, you can select Encounter Details from the left navigation bar for a client and encounter in context and select **Encounter UDF hyperlink** to display Available Forms and Filled-Out Forms.

Create Assessment (UDF)

TIPS:

- Drop-down lists on UDFs have **Hint Text** attached. When users ***hover over the data fields in UDFs,*** hint text pops up, providing users with information on that particular data field. It is recommended that users view the hint text prior to viewing the drop down list as the drop-down list obscures **Hint Text** information.

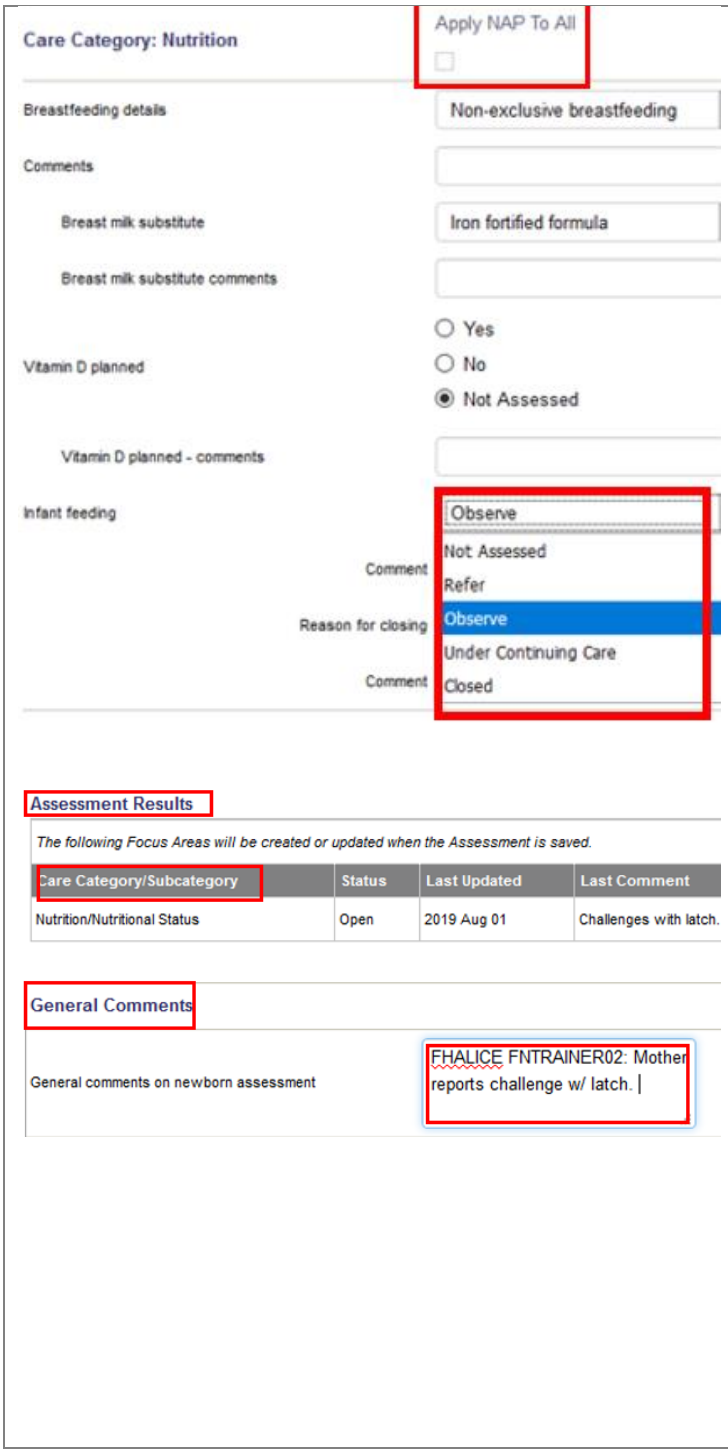


Form ID	Form Name	Form Description
78	Screening Summary	Screening Summary
26	Mom-Prenatal Registration	Mom-Prenatal Registration
38	Mom-Prenatal Intake Assessment	Mom-Prenatal Intake Assessment
37	Mom-Prenatal Follow-up	Mom-Prenatal Follow-up
24	Mom-Postpartum Assessment	To use during first year after birth
16	Mom-Breastfeeding Mother Assessment	Mom-Breastfeeding Mother Assessment
96	Financial Assessment	Financial Assessment
102	Dental Assessment - Tooth Talk	Dental Assessment - Tooth Talk
101	Dental Assessment - School Age	Dental Assessment - School Age
100	Dental Assessment - Kindergarten	Dental Assessment - Kindergarten
99	Dental Assessment - Baby_Toddler	Dental Assessment - Baby_Toddler
98	Dental Assessment - Adult	Dental Assessment - Adult
23	Child-Nurse Priority Screening	Child-Nurse Priority Screening
22	Child-Newborn Assessment	Birth to 7 wks 6 days

You can only create an assessment if the encounter has been created.

1. From the **Encounter Details** screen with an encounter displayed and in context, select the **Encounter UDF hyperlink**.

   The **Encounter UDF** screen displays In the Available Forms section; select a form to use by clicking the radio button next to it.
2. Click the **Fill-Out Form button**. The selected UDF form is displayed, including the current Focus Areas and Care Category sections.



3. Enter data for **Required Fields** and complete appropriate **Care Category** sections. Select appropriate item from drop down menu:
   - **Not Assessed**
   - **No Apparent Problem**
   - **Observe**
   - **Refer**
   - **Under Continuing Care**

   The user can also check the tick box for 'Apply NAP to All' if '*No Apparent Problem*' applies to all the variance questions within a section.

   The system displays details of any **Focus Areas** (variances) that are created or updated as a result of the Assessment in the **Assessment Results** section visible at the bottom of the UDF screen.
4. If necessary, provide general comments in the **General Comments** section. Please note that comments entered under General Comments section should be specific to the assessment/UDF you are completing.
   a. The general comments field has a 2000 character limit with the short comment field has a 100 character limit

When assessment UDF is completed, click Submit. The system saves the Assessment, creates or updates any related Focus Areas and displays a message indicating the Assessment was saved.

See additional notes provided on the next page.

NOTES:

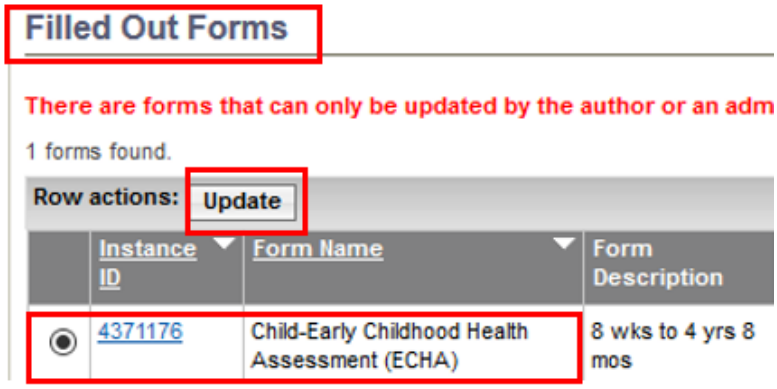
- When filling out a UDF, users must tab or click out of each data entry/checkbox and ***allow the UDF to finish "loading" before continuing***. This is especially important after selecting a Provider in the Provider field, or at any step that requires data entry.
- If the NAP to All checkbox becomes disabled, the *Care Category* section can be completed by selecting **No Apparent Problem** from the drop-down list(s) within the section.
- **The Provider** (Administrator/SDL Provider) drop-down list on the UDF form is filtered by the user such that each user has access to only those Providers and SDLs that have been configured for their access The provider drop-down list is filtered based on **the Encounter Responsible JOrg and SDL** selected.
- Provider drop lists are sorted alphabetically and indicate whether the provider is Active or Inactive. When filling out a UDF, ensure you select the correct Provider from the 'Provider' drop list.
- All required fields on a UDF are denoted by a red exclamation mark: Users are not able to activate the Submit button without completing all required fields.
- Clicking 'Apply NAP to All' for a particular section of a UDF will change all '**Not Assessed**' values on that section to '**No Apparent Problem**.' Selecting NAP indicates that an assessment was performed and no apparent concern or problem was identified at the time.
- The Apply NAP to All check-box is not displayed when there are no variance-generating questions on a particular section of an Assessment.

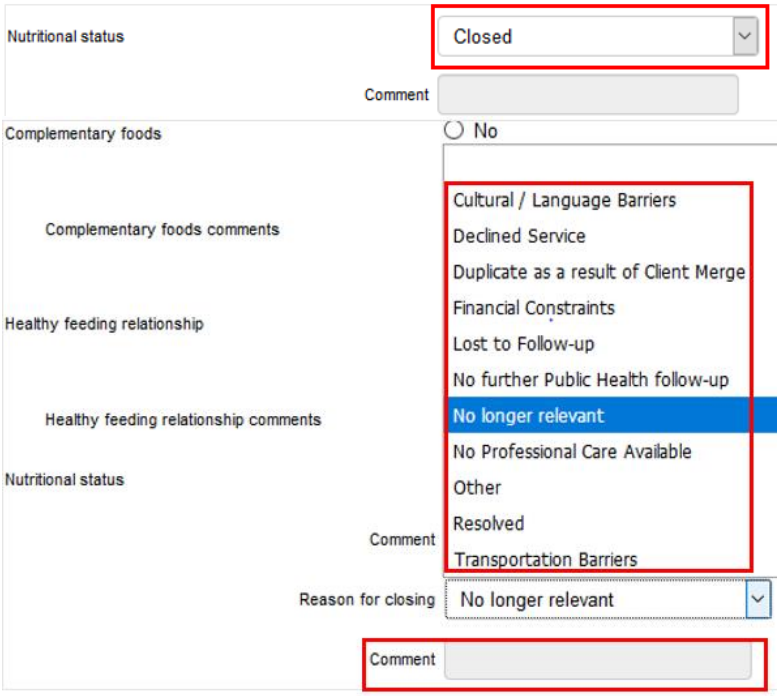
NOTES:

- Remember to note down on paper the Focus Area care category (generated from your assessment) if you are creating a Care Plan for it. On the **Care Plan Details** screen, select the care category you noted and click the Open Category button. The **Care Plan Details** screen redisplays and the **Focus Areas** section displays any Focus Areas related to the active Care Categories for the Care Plan.
- The **Assessment Results** section is visible on the UDF forms at all times. Focus Areas that are created or updated as a result of the assessment appear in this section.

View Assessment

1. In the Family Health tab, have the client in context.
2. From the left-hand navigation, select **Client Summary**. The *Family Health Client Summary* screen displays.
3. Scroll to the *Encounters* section and select the **Assessment/UDF hyperlink** in the Assessments (Summary) column. The Assessment Form/UDF opens in a new window for viewing.

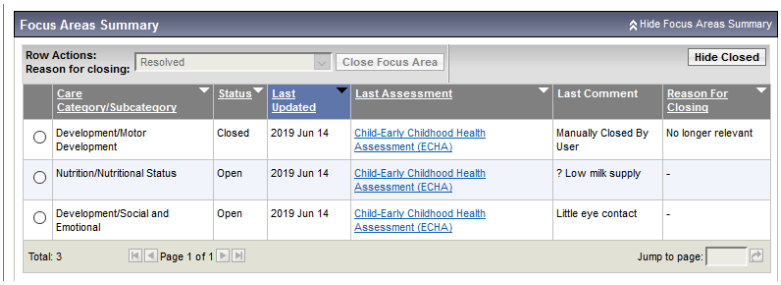


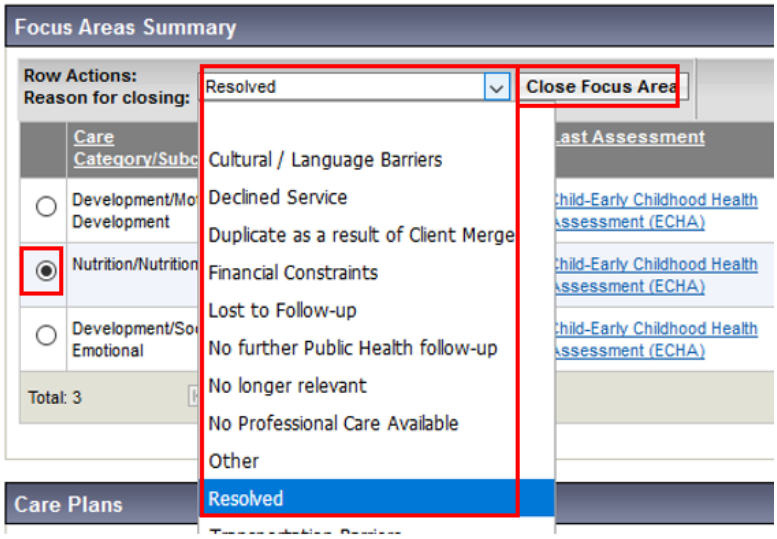


Update Assessment (UDF)

1. In the Family Health tab, have the client in context.
2. From the left-hand navigation, select **Client Summary**. The *Family Health Client Summary* screen displays.
3. From the *Family Health Client Summary Encounter* section, select the **Encounter Date hyperlink** that contains the Assessment Form/UDF requiring updating.
4. From the ***Encounter Details*** screen with an encounter displayed, click on the **Encounter UDF**. The *Encounter UDF* screen displays.
5. Scroll to the bottom of the screen and select the Assessment/UDF you wish to update from the **Filled-Out Forms section.**
6. Click on **Update**. The Assessment/UDF form selected is displayed.
7. Update information on the Assessment/UDF form.
8. When an assessment has open Variance Questions, the user has the option to set these to **Closed** (or no longer relevant and does not require follow-up). This can be only be completed by creating a new encounter and a new UDF of the same assessment type.
    - Ex: If during a follow up telephone assessment, the mother is no longer having issues with milk supply, the nurse will open another newborn UDF and close that variance/focus area open.
9. The Reason for closing drop-down menu will offer selections, and an optional Comment field is enabled for the user to document the reason for closing.

	10. Click **Submit** to save the changes to the Assessment/UDF form. The system saves the Assessment, creates or updates any related Focus Areas and displays a message indicating the Assessment was saved**.**





View and Close Focus Areas

View Focus Areas

A summary of all Focus Areas that will be created based on the Variance Question responses is displayed at the bottom of each assessment form. Focus Areas are also displayed in the **Client Summary** screen.

Close Focus Area

1. From the **Family Health Client Summary** screen, users can select the radio button beside the assessment they wish to close.
2. This will enable the **Reason for Closing** button. Users can select the **Reason for Closing** from the drop-down list and select **Close Focus Area**.
3. Users can view **Closed Focus Areas** in the **Client Summary** screen by selecting **Show Closed** button. A Closed Focus Area will display information on Reason for Closing along with the **Comments** entered by the user.
4. When a Focus Area has its Outcome set to **Closed**, the system records the date. If a subsequent Variance Question in a new Assessment identifies a Variance with the same Focus Area, it is considered a new episode; the old one is not reactivated.

NOTE: Closing variances from Family Health Client Summary Page should only be used to close variances that have been open for some time. All other variances are to be closed once an assessment via an encounter UDF has been completed.

Delete a UDF/ Assessment

If a UDF has been entered in error or on a wrong client, please contact the Panorama team to have the UDF deleted.

Care Plans

A **Care Plan** is a person-specific narrative record that documents client services and/or issues requiring ongoing public health support and follow up.

The Care Plan functionally is launched from the **Family Health Client Summary**. Only Family Health and Family Sexual Health are eligible for Care Plans.

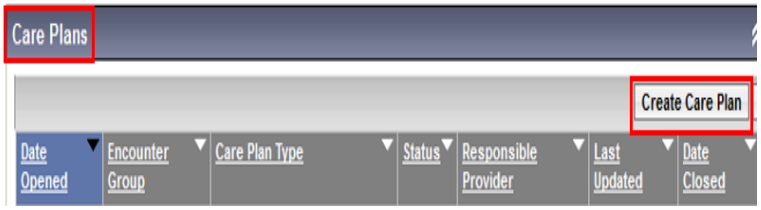
Care Type	Description
Infant & Early Childhood	Infant or child to age 4 years 8 months receiving ongoing public health services and follow up related to issues of growth, development, nutrition, physical, behavioral, general health, lifestyle support, safety or issues affecting infant or child health and wellbeing.
Child	Child aged 4 years 9 months to 12 years receiving ongoing public health services and follow up related to issues of growth, development, nutrition, physical, behavioral, general health, lifestyle support, safety or issues affecting child health and wellbeing.
Youth	Youth aged 13 years to under 19 years receiving ongoing public health services and follow up related to issues of growth, development, nutrition, physical, behavioral, general health, lifestyle support, safety or issues affecting youth health and wellbeing.
Adult	Adults 19 years or older receiving ongoing public health services and follow up related to issues of growth, development, nutrition, physical, behavioral, general health, lifestyle support, safety or issues affecting adult health and wellbeing.

Care Categories

Care Category	Definition
Growth	Documentation of care and follow-up related to issues affecting growth and/or weight gain.
Development	Documentation of care and follow-up related to issues affecting development or reaching developmental milestones (fine/gross motor).
Nutrition	Documentation of care and follow-up related to support or concerns about breastfeeding or issues affecting nutritional status such as food security.
Physiological	Documentation of care and follow-up related to issues affecting physiological status including chronic health issues, congenital or acquired health issues.
General Health	Documentation of care and follow-up related to issues affecting general health and wellbeing.
Behaviour	Documentation of care and follow-up related to issues affecting behavior, attachment and emotional security.
Psychosocial	Documentation of care and follow-up related to issues affecting behavior, attachment and emotional security.
Support	Documentation of care and follow-up related to issues affecting support or supportive relationships
Care Category	Definition
Lifestyle	Documentation of care and follow-up related to issues related to lifestyle factors including substance and tobacco use, education and socio-economic.
Safety/Injury Prevention	Documentation of care and follow-up related to issues affecting safety or injury prevention including violence, abuse and neglect.
Vision	Documentation of care and follow-up related to issues for visual health.
Dental	Documentation of care and follow-up related to issues related to oral health
Sexual Health	Documentation of care and follow-up related to issues affecting sexual health
Communication	Documentation of care and follow-up related to issues related to speech and language, development or hearing.
Prenatal	Clients receiving ongoing public health prenatal follow up related to physical, emotional, general health, or psychosocial issues affecting prenatal health and wellbeing.
Postnatal	Women in first year after pregnancy receiving ongoing public health prenatal follow up related to physical, emotional, general health, or psychosocial issues affecting postnatal health and wellbeing.

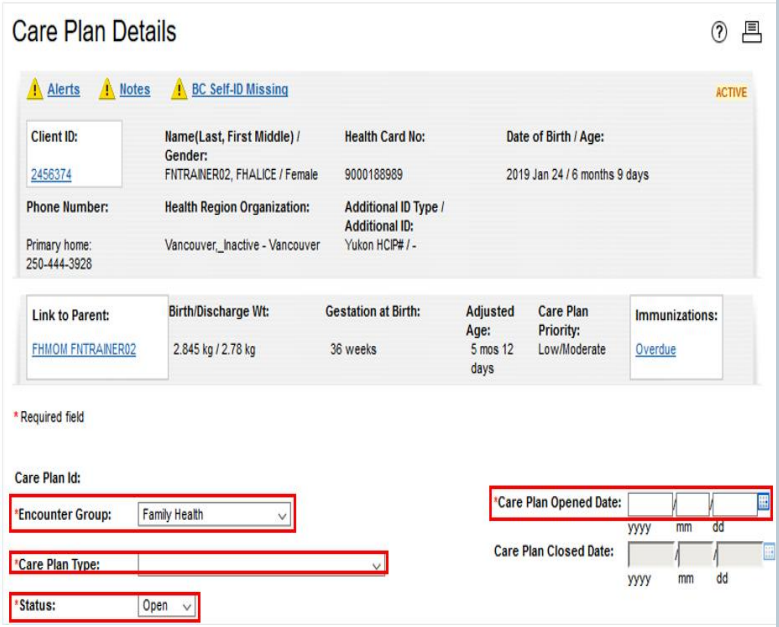
How to Create a Care Plan

A care plan indicates to a provider that there are potential or identified issues for this client that require more than episodic follow up and that a care plan (series of goals and outcomes) has been created to assist in and follow up and resolution of these issues.

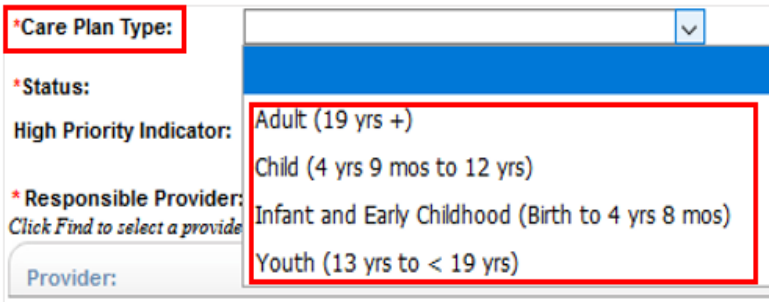


1. Log onto **Family Health** and have client in context
2. LHN > **Client Summary.** The Family Health Client Summary screen displays.
3. Scroll down to the Care Plan section and click the **Create Care Plan**

On the Care Plan Details screen, ensure that you select the appropriate care category you wrote down and click on the "open category" button.

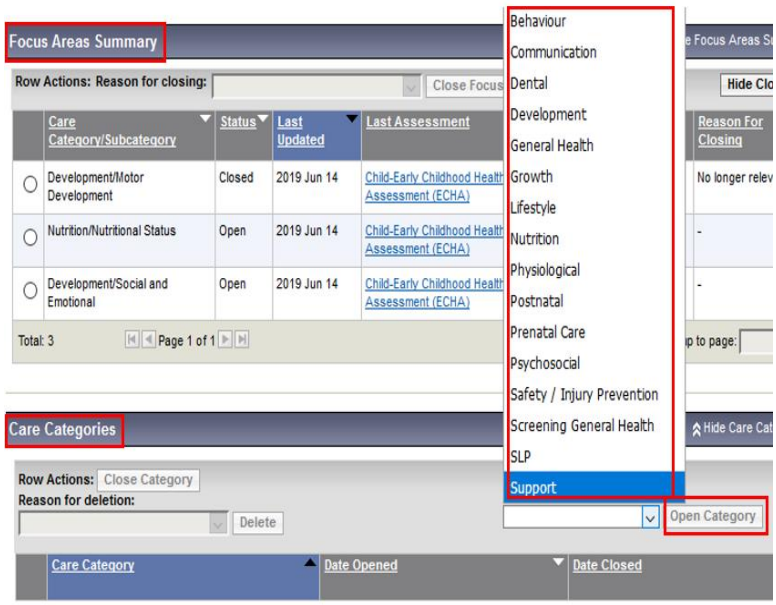


4. The Care Plan details screen displays
5. Select the **Encounter Group** from the drop down list > Choose **Family Health**
6. Select the **Care Plan Type** from the drop down list and make selection
7. Select the **Status** from the drop down list > Select **open**
8. Enter a **Care Plan Open Date** Optionally select the **High Priority** Indicator box. If you choose this option it will appear in yellow as high priority on the client's summary page.
9. Select a **Reasonable provider** using the Provider Find function. When you have your name choose **select**



10. Scroll down to **Care Category** section.
11. Click on **Core Category,** select from the drop down list based on focus areas.

Care Plan categories are used to indicate and track which health concerns and outcomes are relevant to the Care Plan. You may create more than one Care Category.



A user may wish to maintain the Care Categories so that multiple, related Focus Areas are monitored through a single Care Plan, e.g. having a Care Plan for Lifestyles and Support care categories.

The **Care Plan Details screen** displays with a care plan ID and a confirmation message that the data was saved successfully. If you selected the "High Priority" this will show up in the yellow header.

The **Client Narrative History** section now displays at the bottom of the screen. This section allows you to

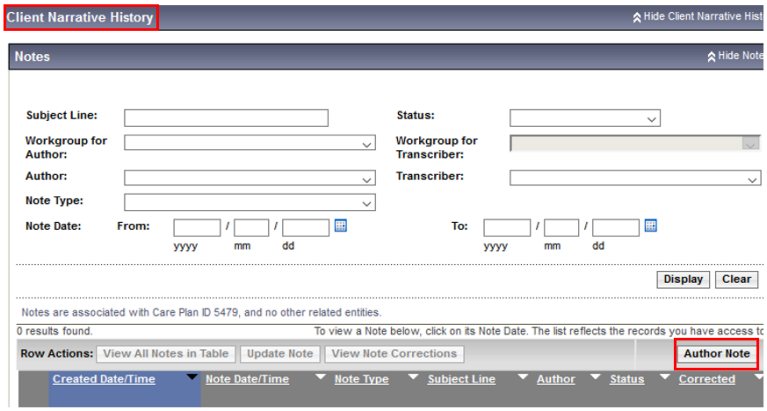
You can view focus areas in section above **Focus Areas Summary**.

- The focus areas section of the Care Plan now displays any **Focus Areas** related to the active Care Categories for the Care Plan.

12. Click on **Open Category** button.
13. Click **SAVE.** The core category will now display under **Core Categories.** The Care Plan will now have an associated Care Plan ID number.

14. Scroll to **Client Narrative History** section at bottom of the screen. Add a note about your Care Plan. click **Author Note**. This note will be automatically

record client notes and narratives relating to the care plan.
A Care Plan must be saved before a new Client Narrative Record can be created



lined to the **Care Plan ID.** Click **note complete**.

How to structure your notes

- Note Subject Line
- Enter the note subject line in the following standard:

Panorama Module	Available Encounter Groups	Subject Line's Required Prefix
IMMUNIZATION	Immunization	IMM
FAMILY HEALTH	Family Health	FH
INVESTIGATIONS	Tuberculosis Disease Investigation	TB
	Communicable Disease Investigation, excluding TB and STI	CD

[Encounter Group Prefix] – [Note Description]

- Eg. FH – Breastfeeding visit with mom and baby
- Eg. IMM – 6-Month Immunization
- Eg. TB- school screening

Uploading a document into client notes

** Please see Advanced Checklist-*Uploading a document into Panorama*

The **Care Category** section displays the clients active Care Categories, which are associated to the Care Plan in context.

The **Focus Areas** section displays the clients active Focus Areas, which are created by identifying possible issues within the corresponding assessment.

The **Assessment hyperlinks** take the user to view the details of that assessment.

- Focus areas that are no longer active can be viewed by clicking the **Show Closed button.**

The **Client Narrative History** section contains client notes and narratives relating to the Care Plan. The **Note Date Hyperlinks** take the user to view the details of that note.

View Care Plan

1. In the Family Health Tab have clients record in context.
2. **LHN > Family Health > Client Summary.** The Family Health Client Summary screen appears.
3. From the **Care Plan** section click the **Date Hyperlink** of the desired Care Plan.
4. The Care Plan Details screen displays. The screen allows the user to view or print the following:
   - **Care Categories**
   - **Focus Areas**
   - **Client Narrative History**

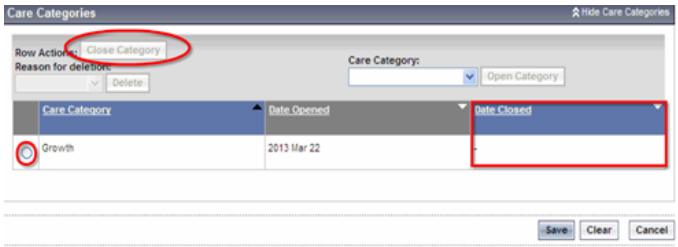
	Close a Care Category 1. Select the radial button of the **Care Category** you wish to close. 2. The **Close Category button** will now be available. Click on the **Close Category** button. • A message will display indicating "Related focus areas will not be set to automatically closed. Please close appropriate Focus Areas manually." The **Care Category** will close and the date of the closing will appear in the Date Closed column.

Maintain Care Category / Focus Area

Care Plan Categories are used to indicate and track which health concerns and outcomes are relevant to the Care Plan. For each Care Category added to the Care Plan, any existing Focus Areas, created via Assessments, will display.

	Close Focus Area 1. Select the **Focus Area** you wish to close. 2. Enter a reason for closing from the drop down selection. 3. Click **Close Focus Area**. The Care Category is closed, and today's date is displayed in the **Date Closed** column.
The Client Narrative History section allows users to record client notes and narratives relating to the Care Plan. Notes: • A Care Plan must be saved before a new Client Narrative Record can be created. • When a Care Plan status is closed, all the Care Categories for this Care Plan are also closed, and the Focus Areas section is no longer displayed.	**Client Narrative History Section** 1. From the **Care Plan** Details screen, expand the **Client Narrative History** section.

Note:
A closed care plan cannot be modified.



A confirmation message displays to let you know that the data has been successfully saved.

Notice the status field is now set to closed. When a care plan is set to closed, all the Care Categories for this Care Plan are also closed and Focus Area section is no longer displayed.

A closed Care Plan cannot be updated.

Close a Care Plan

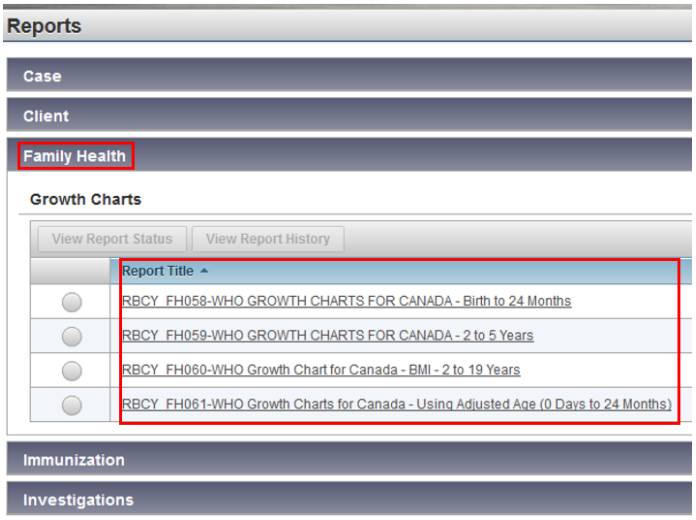
1. **LHN** > **Family Health** > **Client Summary**. The Family Health Client Summary screen displays.
2. Scroll down to the **Care Plan** section and click the **Date Hyperlink** of the Care Plan you wish to close. The Care Plan Details screen displays. Set **Status** to **Closed**.
3. Enter the **Care Plan Closed Date.**
4. Select a **responsible provider** using the Find function.
5. Click **Save.** The Care Plan Details screen refreshes and Status displays **Closed.**

How to Record, View and Print Growth Charts

Panorama will generate growth charts and calculate percentiles based on measurements entered into the client's record through baby birth details, and UDFs (User defined forms). Users can view, print or save a PDF copy of the Growth Chart.

Growth charts available:

- Length/Height for age (Standard and Premature Infant)
- Weight for Age (Standard and Premature Infant)
- Head Circumference for Age (Standard and Premature Infant)
- Weight for Length (Standard and Premature Infant)
- BMI for Age



1. From the **LHN** click on **Reporting and Analysis** and choose **Reports.**
   LHN>Reporting and Analysis>Reports
2. **Reports** screen will appear with categories of reports listed.
3. Move down the list until **Family Health** and follow line to right hand side and click on arrow to show report folders
4. Select the **Growth Chart** by clicking on the name of the chart e.g., Growth Chart Weight for Age**.**
5. The Report Filters screen will appear. Select the **age range**. Click **Generate Report button Now** on top right of screen.
   Report output will automatically be set to **PDF**.
   A PDF Growth Chart will open in a new screen with each of the growth measurements plotted showing the percentile. The second page will show a table with the birthdate, encounter date, age in weeks, and corresponding measurements.
7. To print the growth charts or save to folder open up the file tab as you would on any document.

**** Note: there are separate charts for weight, length and head circumference**

Report Filters

Report: RBCY_FH058-WHO GROWTH CHARTS FOR CANADA - Birth to 24 Months

* **Report Output:**
PDF

* **Client ID:**
2456374

* **Weight for Age - Birth to 2 Years:**
Yes

* **Length / Height for Age - Birth to 2 Years:**
Yes

* **Head Circumference for Age - Birth to 2 Years:**
Yes

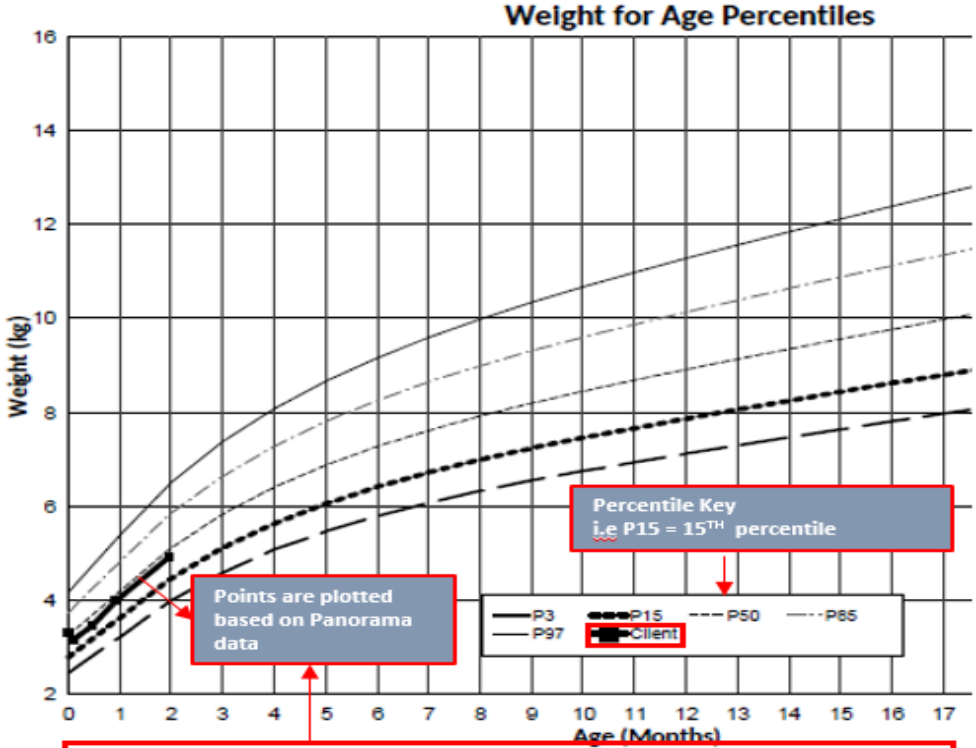
* **Weight for Length - Birth to 2 Years:**
Yes

WHO Growth Charts for Canada - Birth to 24 Months

Name: FNTRAINER05, Alice **DOB:** 2019 Jan 24 **Client I**

Gestational Age at Birth (weeks): 39 **Gender:** Female **PHN/Y**

Weight for Age Percentiles



Measurement Date	Age	Weight (kg)	Percentile
2019 Jan 24	0m 0d	3.299	Not Available
2019 Jan 27	0m 3d	3.15	43
2019 Feb 07	0m 14d	3.45	41
2019 Feb 21	0m 28d	3.99	43
2019 Mar 24	2m 0d	4.92	41