First Nations Health Authority
Health through wellness

Panorama User Guide #2

TB Screening Data Entry
TB Screening with Skin Test

Version 3.2

Contact us at: panorama@fnha.ca

Find our Guides at: **http://www.fnha.ca/what-we-do/communicable-disease-control/panorama**

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Please Note:

It is required for CHNs working in FN communities with Panorama access to have training with the FNHA Panorama team prior to use of the Panorama system. Panorama guides are to be used in conjunction with formal FNHA Panorama training. To arrange a training session, please contact **panorama@fnha.ca**

This guide is appropriate for TB screens where you will enter a client's **TB skin test, Risk Factors and Signs and Symptoms.**

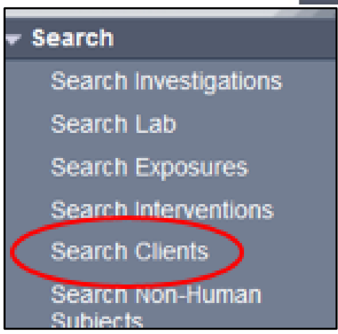
Use the tool "***Which Panorama TB Guide Should I Use?***" To help you to determine how to enter your screens.

This detailed guide will show you through the steps in entering your client's TB screening information:

- **Search and update client information** (Last/First Name, DOB; Jurisdictional Registry)
  - Review/Edit Client Demographics
  - Add/Update Indigenous Information
  - Add Immigration Information
  - Add Allergies
- **Create TB Investigation**
  - Add External Sources
- **Add Risk Factors**
- **Add Signs and Symptoms**
- **Enter Consent**
- **Enter TB History Summary**
- **Enter TB Skin Test**
- **Close Investigation (if applicable)**

This guide accompanies *Panorama TB Screening Data Entry – QuickGuide (for Guide #2 and Guide #3)*

Search for Client Chart



For more information about searching and opening client charts please see our **[Core Guide]()**

In the INVESTIGATIONS Module:

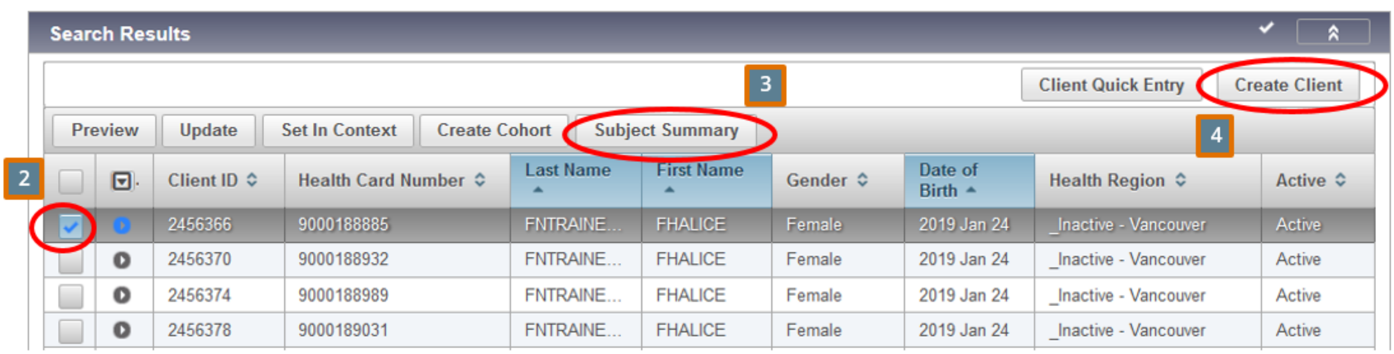
<u>Search/Create Client</u>

LHN > Search > **Search Clients**

Ensure you have done a thorough search for the correct client and that all demographic information are correct and up-to-date.

1. Search client following your choice of search options (See **Panorama Core Guide**).
2. Using the search results table, choose a single client by selecting the checkbox next to the *Client ID column*
3. Under *Row actions*, you will have several choices depending upon which module you are in. Select **SUBJECT SUMMARY**.
4. Alternately, you can select **CREATE CLIENT** if you have done a thorough search and the client does not have a chart in Panorama. You can then create the client's chart.

Ensure you have done a thorough search for the correct client and that all demographic information are correct and up-to-date.



Subject Summary

A client's subject summary page is a great way to get a quick overview of client encounters and investigations

Tip: To "hide" and show" components of the screen, click the *hide* or *show* hyperlinks along the encounter headers to view/hide more details

Note: When the User does not have data access to a module or an Investigation, the Investigation and all associated Encounters are not displayed

The Subject Summary screen lists all *Encounters* and *Investigations* that have been recorded for a client under the various *Encounter Groups* (Communicable Disease, Sexually Transmitted Investigations, and Tuberculosis Disease Investigation, Immunization). Depending on which Module you are in, the subject summary page may vary slightly.

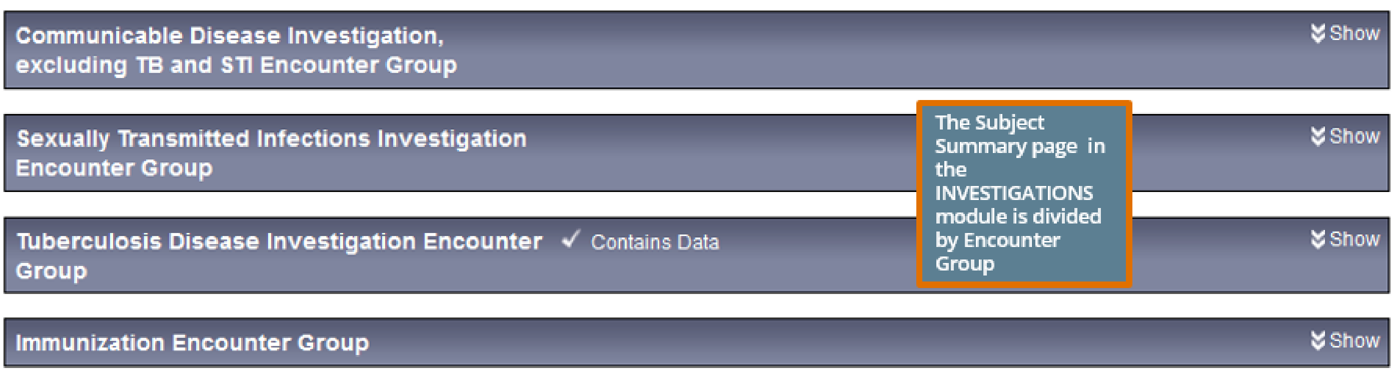
Viewing Subject Summary
With your client in context:

LHN > Investigation > **Subject Summary**

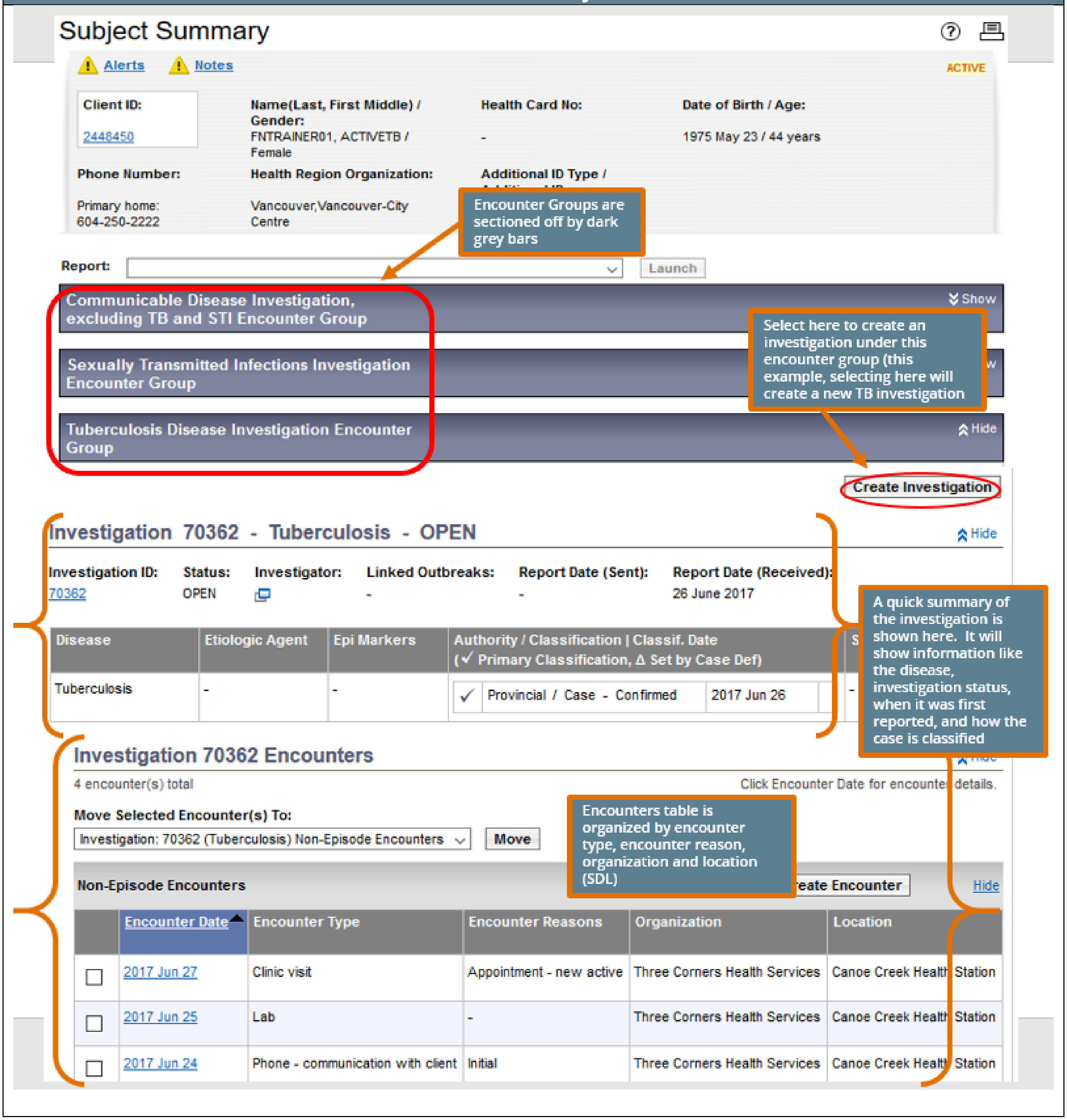
Investigation Encounter Groups are sectioned off by:

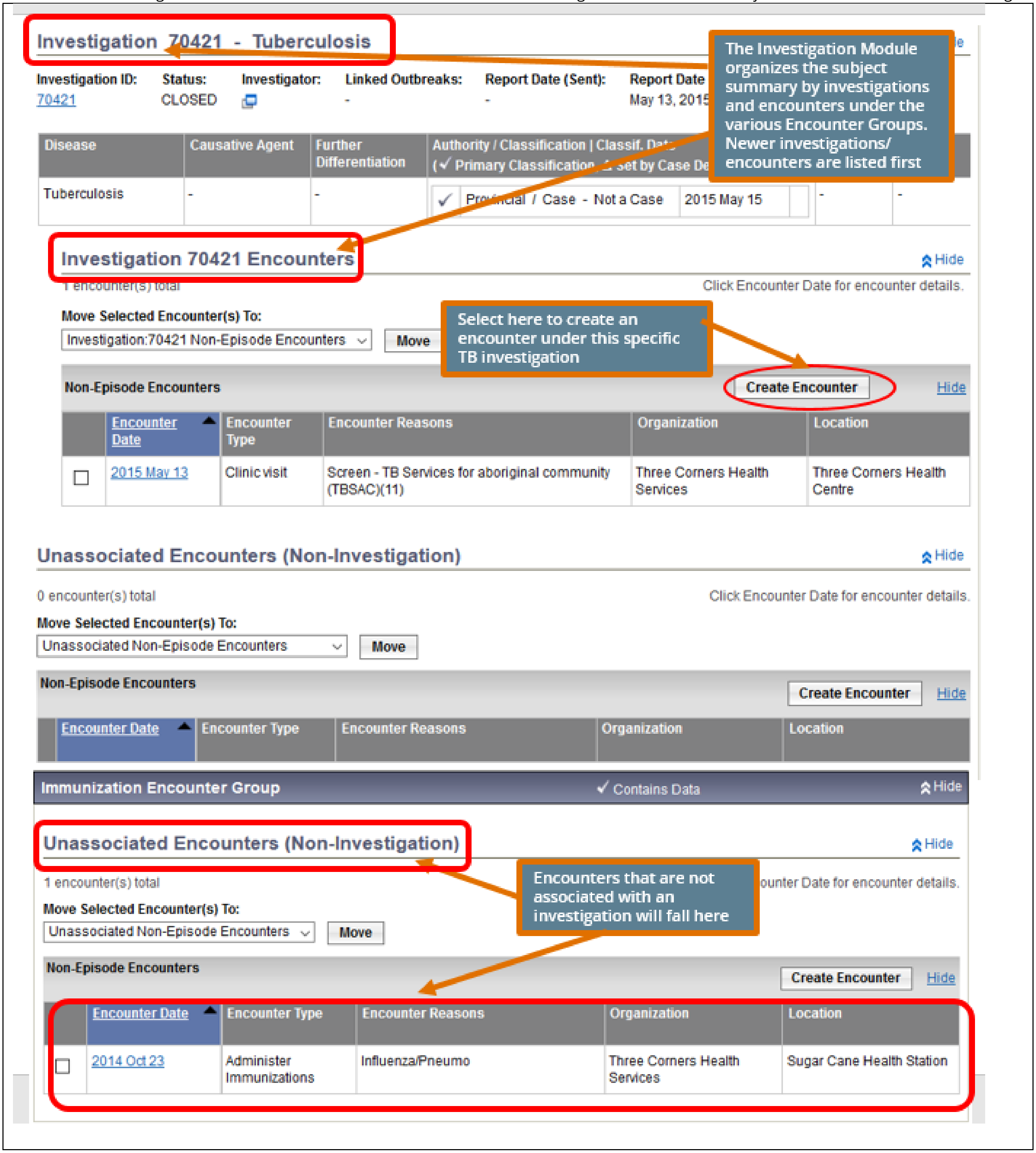
- **CD** Investigations (excluding TB and STIs)
- **STI** and **HIV** Investigations
- **TB** Investigations
- and **Immunizations**.

You can navigate to any investigation or encounter that are listed on the screen by clicking the appropriate hyperlink: Investigation ID, Encounter Date. This also sets the Investigation or Encounter in context.

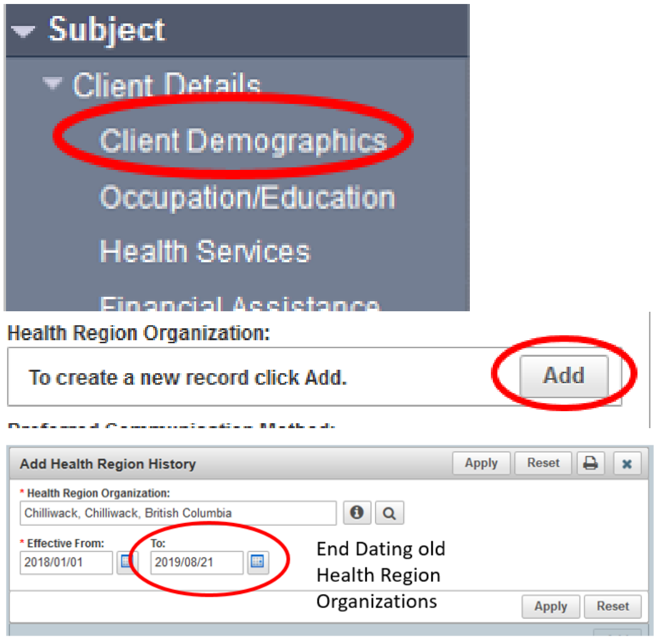


INVESTIGATIONS MODULE SUBJECT SUMMARY PAGE




Investigation 70421 - Tuberculosis
The Investigation Module organizes the subject summary by investigations and encounters under the various Encounter Groups. Newer investigations/ encounters are listed first
Investigation ID: 70421
Status: CLOSED
Investigator:
Linked Outbreaks: -
Report Date (Sent): -
Report Date May 13, 2015
Disease
Causative Agent
Further Differentiation
Authority / Classification | Classif. Date
(✓ Primary Classification
Tuberculosis
Provincial / Case - Not a Case
2015 May 15
Investigation 70421 Encounters
Hide
Click Encounter Date for encounter details.
Move Selected Encounter(s) To:
Investigation:70421 Non-Episode Encounters
Move
Select here to create an encounter under this specific TB investigation
Non-Episode Encounters
Create Encounter
Hide
Encounter Date
Encounter Type
Encounter Reasons
Organization
Location
2015 May 13
Clinic visit
Screen - TB Services for aboriginal community (TBSAC)(11)
Three Corners Health Services
Three Corners Health Centre
Unassociated Encounters (Non-Investigation)
Hide
0 encounter(s) total
Click Encounter Date for encounter details.
Move Selected Encounter(s) To:
Unassociated Non-Episode Encounters
Move
Non-Episode Encounters
Create Encounter
Hide
Encounter Date
Encounter Type
Encounter Reasons
Organization
Location
Immunization Encounter Group
✓ Contains Data
Hide
Unassociated Encounters (Non-Investigation)
Hide
1 encounter(s) total
Encounters that are not associated with an investigation will fall here
Move Selected Encounter(s) To:
Unassociated Non-Episode Encounters
Move
Non-Episode Encounters
Create Encounter
Hide
Encounter Date
Encounter Type
Encounter Reasons
Organization
Location
2014 Oct 23
Administer Immunizations
Influenza/Pneumo
Three Corners Health Services
Sugar Cane Health Station

Edit/Update Client Demographics



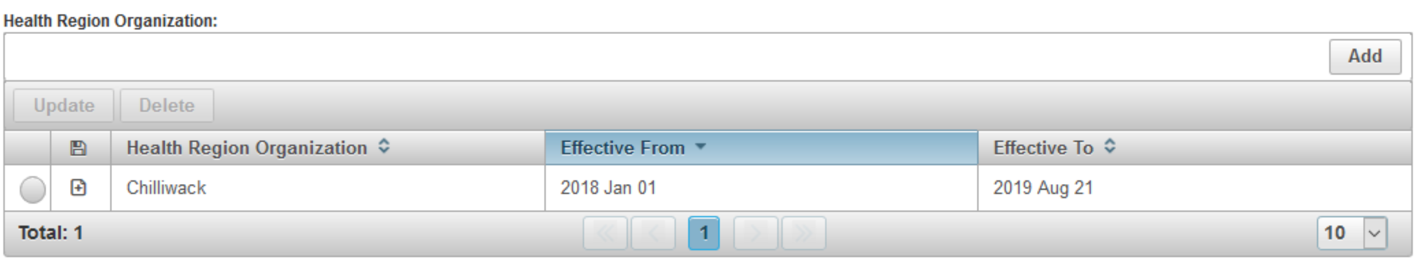
For more information on updating client information and Indigenous Information and Allergies please refer to the **Core Guide**

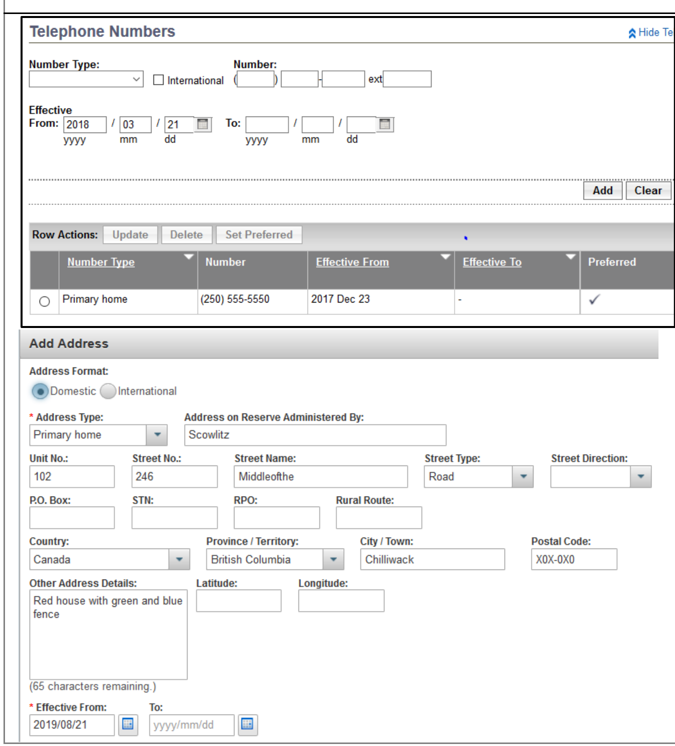
Client Demographics

LHN > Subject > Client Details **> Client Demographics**

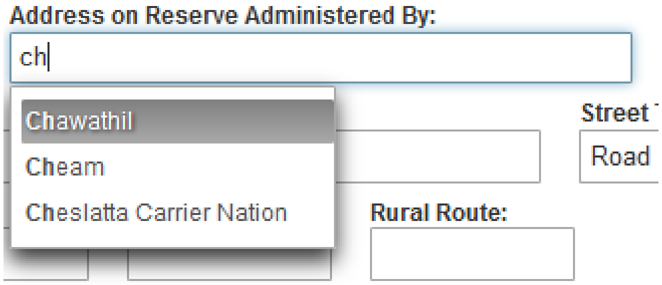
1. Ensure Client skeleton information is correct (First Name, Last Name, DOB, PHN)
2. Ensure *Health Region Organization* is correct. Use the **ADD** button to add the most recent location of residence (ie. The associated Public Health Unit for their Health Centre/Nursing Station). End Date old Health Regions. Select **APPLY** and **SAVE** your changes

Eg. For Stolo Nation, their closest Regional Health Authority branch is Chilliwack





3. Ensure *Phone Numbers* and *Addresses* are correct including *Address Located On Reserve* information if appropriate. **ADD** and **SAVE** your changes to the table below each section. End date any old phone numbers and addresses. DO NOT DELETE old numbers or addresses
4. Ensure all other fields in the *Client Demographics* page are up-to-date (if information is known)
5. **SAVE** your work



Indigenous Information

LHN > Subject > Client Details > **Indigenous Information**

1. Complete the *Indigenous Information* questions and add your client's current *Aboriginal Organization* (use **(I)** location). **SAVE** your work

For more detailed information on how to update Indigenous Information, please see the **Panorama Core Guide** or **Completing Indigenous Information Guide**

Immigration Information

LHN > Subject > Client Details > **Immigration Information**

1. For TB screens, the *Immigration Information* section must be entered.
2. Indicate if *Canadian citizen* (yes/no)
3. *Country Born In*:
   - If born in ***Canada***, indicate Province (if known)
4. Complete the other fields if known/applicable
5. **SAVE** your work

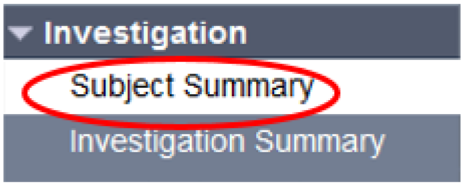
Add Client Allergies

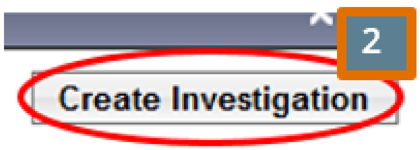
LHN > Subject > **Allergies**

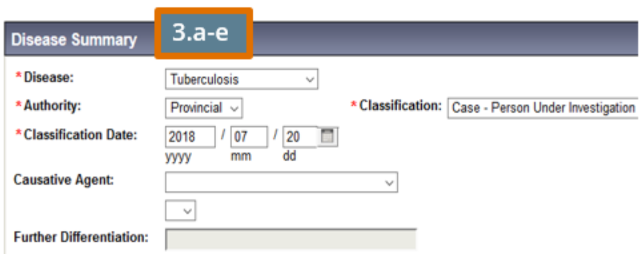
1. If client has no allergies, select **SET NKA** or **CONFIRM NKA** or
2. Select **ADD** and enter client's allergies.

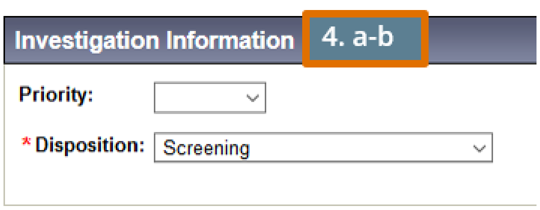
For more detailed information on how to update client allergies, please see the **Panorama Core Guide**

Create a TB Investigation







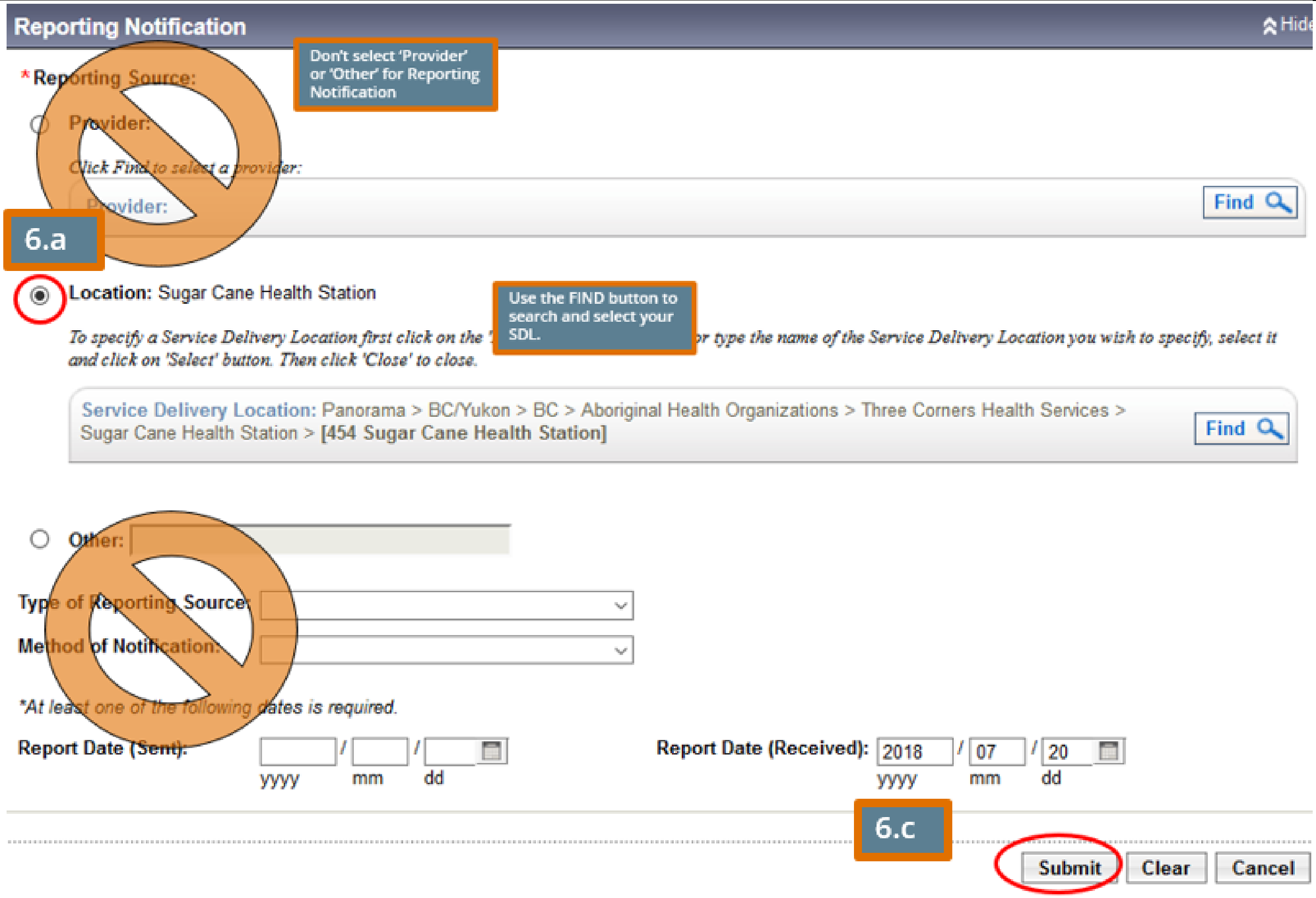


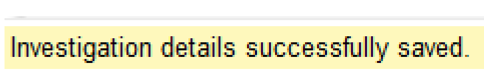
With your client in context, you need to go to their ***Subject Summary*** screen where all the client investigations and encounters are listed. For more information about Subject Summary, please see the **Subject Summary** section in this guide.

LHN > Investigation > **Subject Summary**

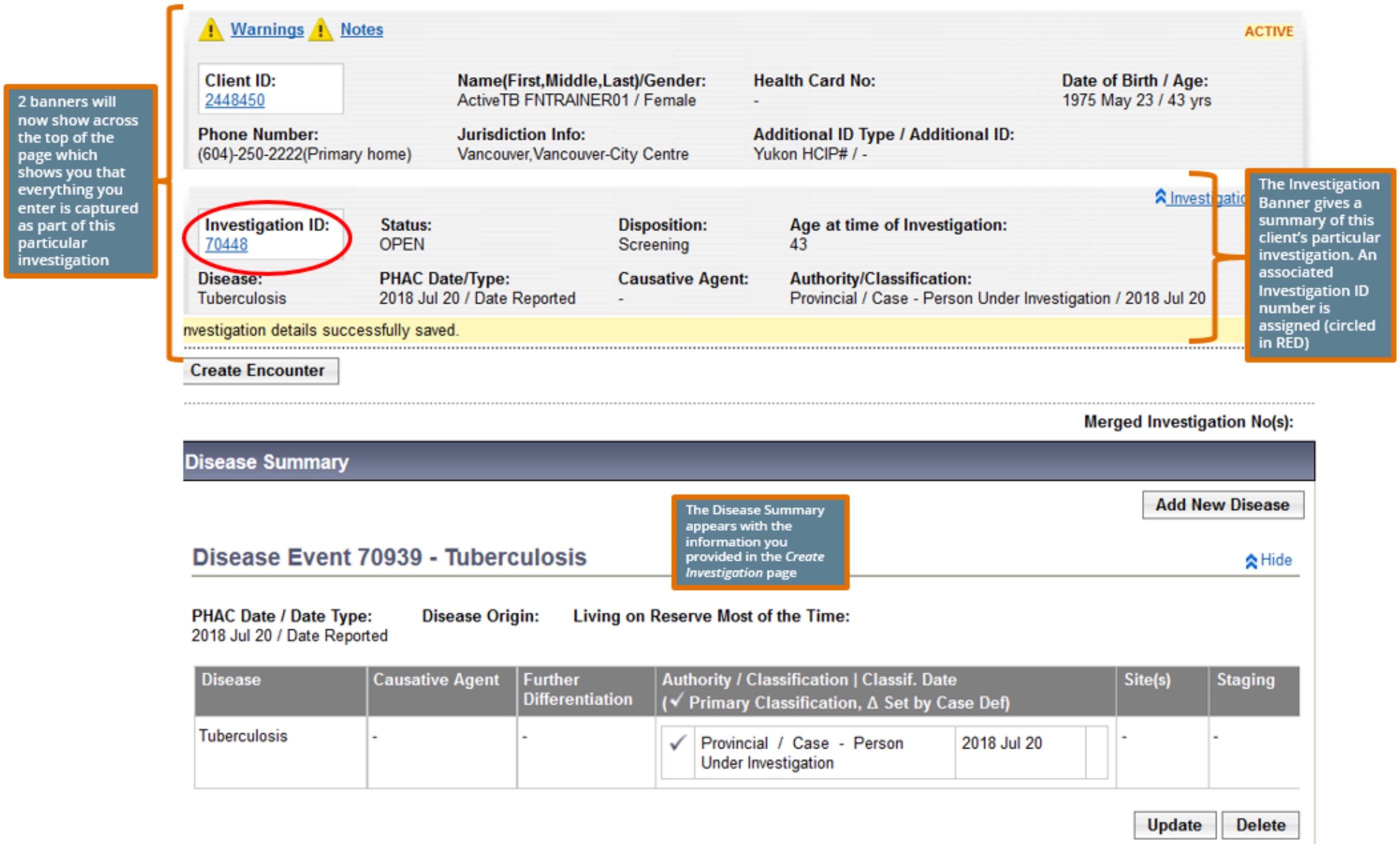
1. Client Investigations are separated by Encounter Group (dark grey bars). Scroll down to the *Tuberculosis Disease Investigation Encounter Group* section of the page
2. Just under the dark grey header, select **CREATE INVESTIGATION**. You will be brought to the *Create Investigation* page
3. In the *Disease Summary* section:
   a. *Disease:* select ***Tuberculosis*** from the drop down menu
   b. *Authority:* select ***Provincial***
   c. *Classification:* select ***Case – Person Under Investigation***
   d. *Classification Date:* populates to today's date. Can be backdated to the TB screen visit date
   e. *Causative Agent:* can be left blank
4. In the *Investigation Information* section:
   a. *Priority:* can be left blank
   b. *Disposition:* select ***Screening***
5. In the *Responsible Organization/Investigator* section:
   a. *Responsible Organization:* Your organization should be pre-populated. If not, use the **FIND** type-ahead to search and select your organization
   b. *Responsible Organization Workgroup:* select your organization's TB workgroup
   c. *Responsible Organization Date:* will populate to today's date. This can be back dated
   d. *Investigator Workgroup:* select your organization's TB workgroup
   e. *Investigator Name:* leave this field blank (not required)
   f. *Assigned Date:* will populate to today's date. Can be back dated
6. In the *Reporting Notification* section:
   a. *Reporting Source:* select the radio button (❍) next to *Location*. Your location should automatically populate. If not, use the **FIND** and **SELECT** function to search for your SDL.
   b. Ignore *Type of Reporting Source, Method of Notification, and Report Date (Sent).*

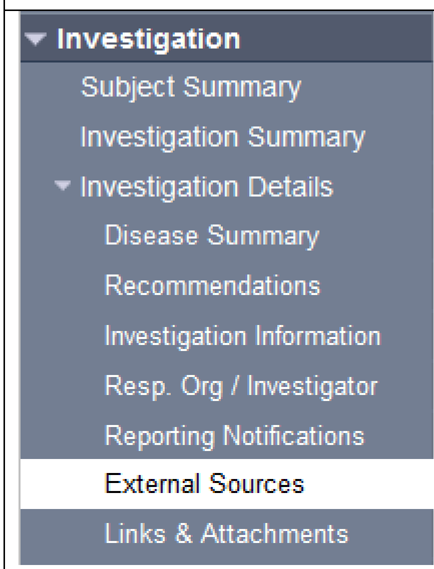
c. *Report Date (Received):* will populate to today's date. Date can be changed to date of client visit. Press **SUBMIT**





You will now see 2 banners along the top of the page, the *Client banner* and an *Investigation banner*. A confirmation will appear below the banners showing that your Investigation has been successfully created.





Note: The *External Source* section in Panorama needs to be completed for the screen to be followed up. If your client does not have a health care provider, please contact **FNHATB@fnha.ca**

Adding External Sources

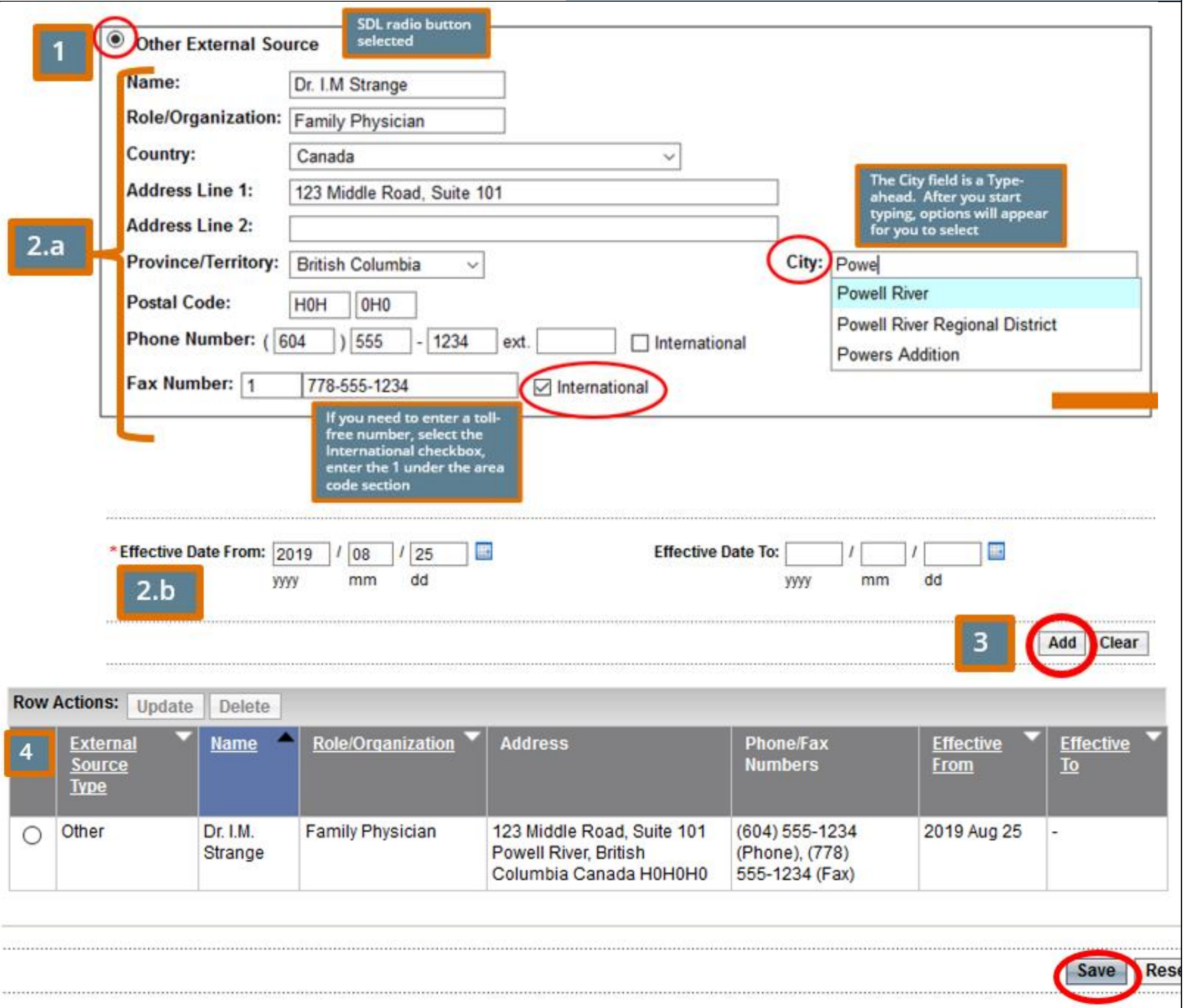
This is where you will add the client's health care provider(s) involved in the client's care in relation to the TB screen (ie. Client's General Practitioner or Nurse Practitioner, Physician Specialist requesting the TB screen).

With your **Client** and **Investigation** in context:

LHN > Investigation > Investigation Details > ***External Sources***

1. Select the radio button **(❍)** next to the *Other External Source*
2. Using the free text fields, enter the P*rovider's Name, Role/Organization, Country, Address, Province, City, Postal Code, Phone Number and Fax Number*.
   a. At minimum, enter either the provider's Address or Phone Number.
   b. *Effective Date From* populates to today's date. Can be changed as needed.
3. Select **ADD**
4. The provider contact information will appear in the table at the bottom of the page.

Repeat steps **1-4** to add additional providers involved with the TB screening. When you are done, **SAVE** the page.



Risk Factors

The pre-populated table of risk factors in the TB module reflect the risk factors listed in the BCCDC TB screening (939) form

When you create a TB investigation for a client, a table of present risk factors recommended for the Investigation appears. Unlike the ***Immunization*** and ***Family Health*** modules, the ***Investigation*** *(TB)* module has a pre-populated list of Risk Factors for you to enter a response.

There are 3 types of Risk Factors (RF) that you may see in a client chart:

1. **Blank Risk Factors** – These Risk factors have been recommended for the Investigation and a response has not yet been entered.
2. **Risk Factors pertinent to a past Investigation** – These are Risk Factors that have been carried over from a previous Investigation.
3. ***iPHIS DC* – [RISK FACTOR]** – These are old risk factors from the previous public health charting system. These risk factors are no longer used

As of December 1, 2018, FNHSO users will enter Risk Factors by exception. This change in process is to avoid redundancy and eliminate charting errors. This change will also simplify the data entry process.

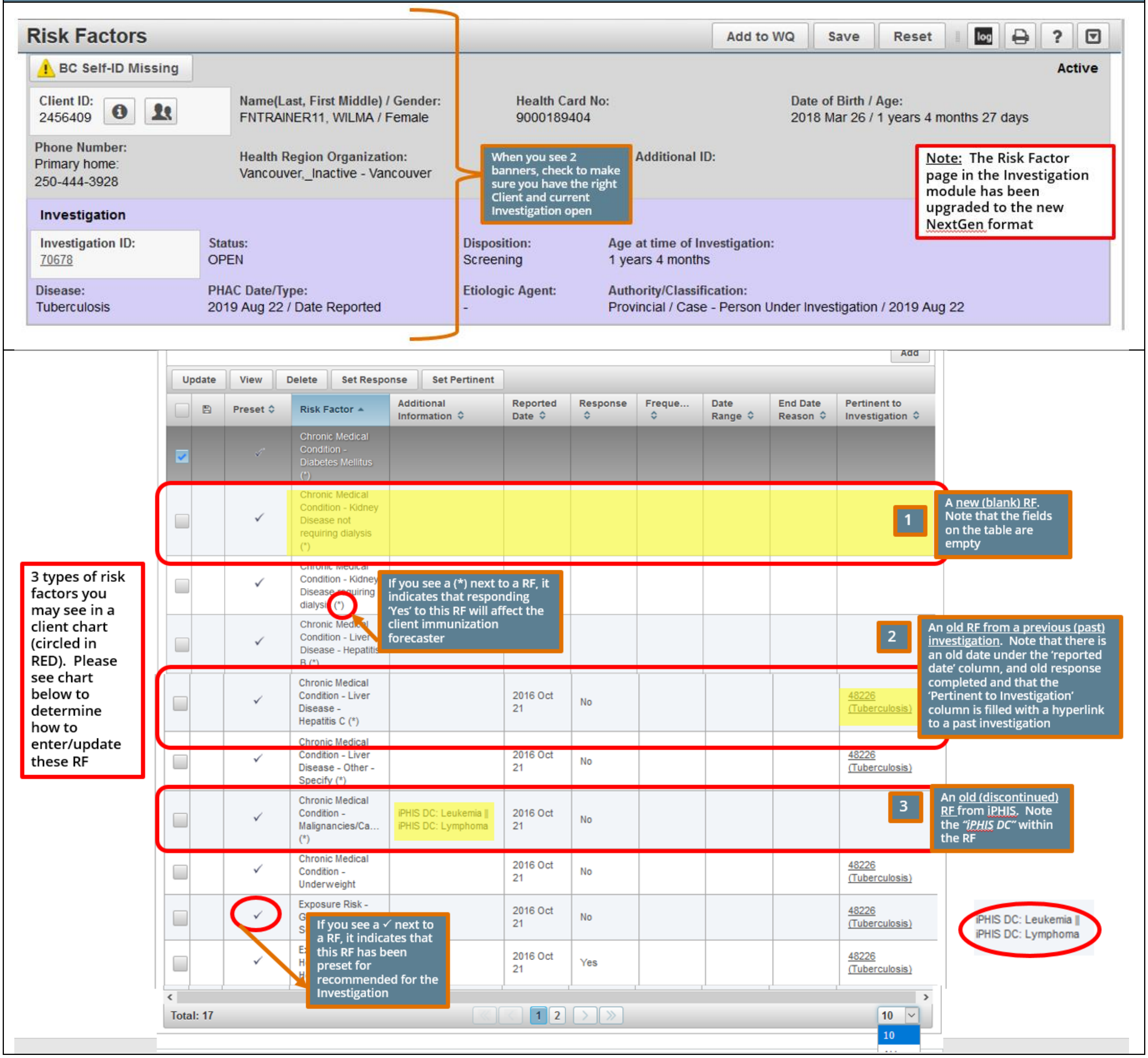
FNHA enters their Risk Factors in Panorama **by exception**. This means that unless you are changing a specific Risk Factor response to a 'yes', or making a risk factor pertinent to an investigation, there is no need to enter a response.

To view client's risk factors, have your **Subject/Client** and **Investigation** in context:

LHN > Subject > **Risk Factors**

VIEWING THE CLIENT RISK FACTOR PAGE

Once opening your client Investigation and are in their Risk Factor page:



Types of Risk Factors

Once you have determined the Type(s) of Risk Factors that you client currently has listed, this will determine how you will enter/update into Panorama

Type of Risk Factor:		If:	What to do:
1	**A new (blank) risk factor**	You wish to add a **'YES'** response	Freely enter the response to **'YES'** for this risk factor
		You wish to add a **'NO'** response	**Ignore** this RF and do not alter/change
2	**A risk factor that is pertinent to an old investigation**	The old response is **'NO'**, and will stay as a **'NO'**	**Ignore** this RF and do not alter/change
		The old response is **'YES'** and will stay as a **'YES'**	Make this risk factor pertinent to your current investigation
		The old response is switching from a '**NO**' to a 'YES'	End-date the **'NO'** risk factor; Add the same risk factor with the new **'YES'** response
		The old response is switching from a **'YES'** to a **'NO'**	End-date the **'YES'** risk factor
3	**'*iPHIS DC*' – [RISK FACTOR]**	You see this listed for a client RF	**Ignore** this RF and do not alter/change
4	**Risk Factor is not listed in the table**	If you need to add a Risk Factor that is not currently in the table	Add the Risk Factor with a **'YES'** response

Used if you have a blank Risk Factor and you wish to change the response to **'YES'**:

When you respond ***"YES"*** to a Risk factor, this means that "**YES**, this client has this particular risk factor"

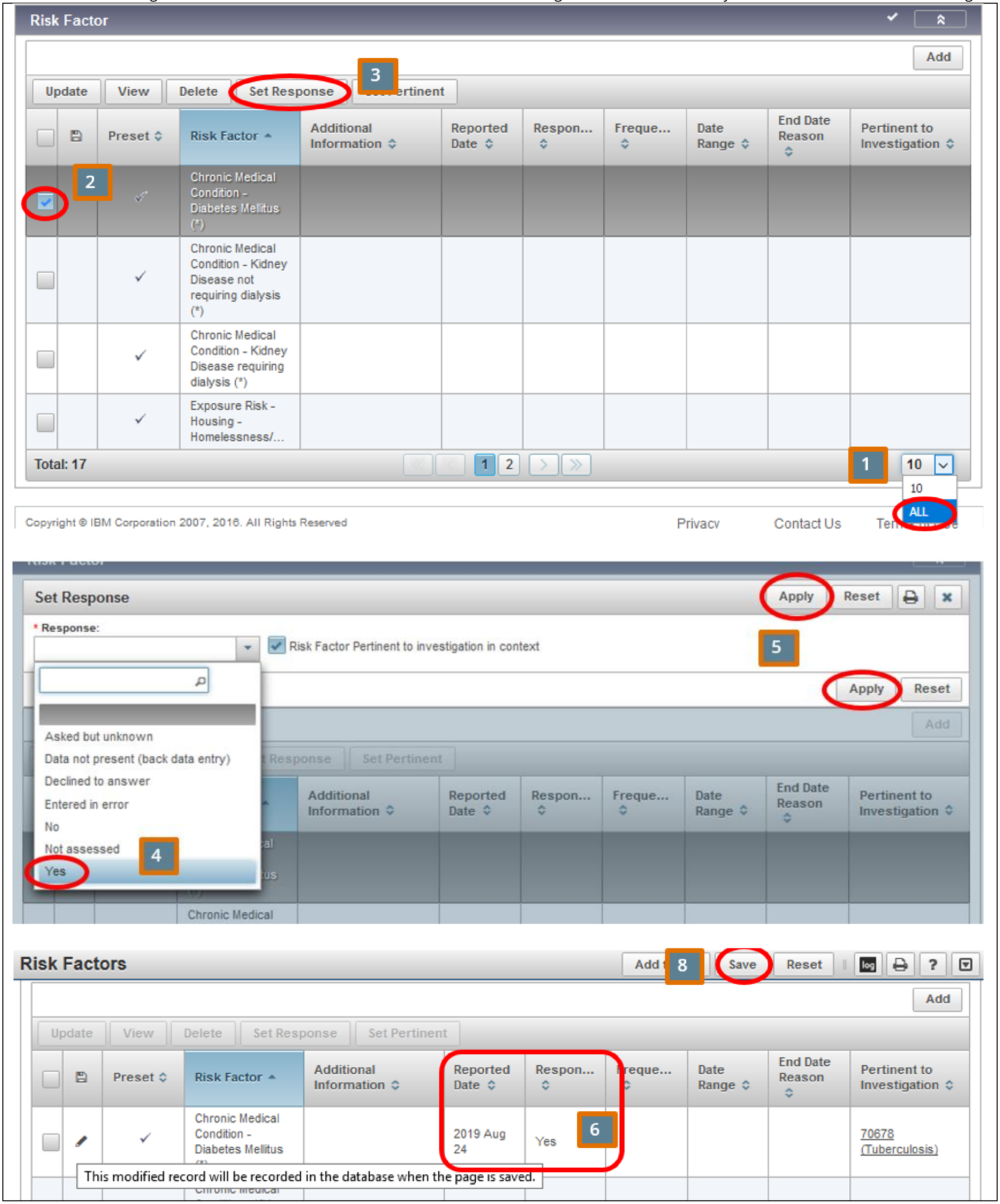
Entering "YES" responses into the Risk Factor Table

With your **Subject/Client** and **Investigation** in context:

LHN > Subject > **Risk Factors**

1. Scroll down to the bottom right corner of the RF table. Using the dropdown, select **ALL,** so all available RF are visible on the table.
2. Select the blank Risk Factor you wish to enter a *'YES'* response to using the check box ☑.
3. At the top of the table, select the **SET RESPONSE** row action button**.**
4. The *Set Response* field will populate in a separate modal. Set the Response field to **Yes**. Reported date will automatically set to today's date.
5. Select **APPLY** (found at the top or bottom of the modal window).
6. The information for your RF will update in the table.
7. Repeat steps 2-7 for additional blank RF you wish to update.
8. **SAVE** your work prior to exiting the RF page.

***Please note**: You can only update one risk factor at a time


Risk Factor
Add
Update
View
Delete
Set Response
3
Set Pertinent
Preset
Risk Factor
Additional Information
Reported Date
Respon...
Freque...
Date Range
End Date Reason
Pertinent to Investigation
2
Chronic Medical Condition - Diabetes Mellitus (*)
Chronic Medical Condition - Kidney Disease not requiring dialysis (*)
Chronic Medical Condition - Kidney Disease requiring dialysis (*)
Exposure Risk - Housing - Homelessness/...
Total: 17
1
2
1
10
10
ALL
Copyright © IBM Corporation 2007, 2016. All Rights Reserved
Privacy
Contact Us
Set Response
Apply
Reset
* Response:
Risk Factor Pertinent to investigation in context
5
Apply
Reset
Asked but unknown
Data not present (back data entry)
Declined to answer
Entered in error
No
Not assessed
4
Yes
Chronic Medical
Risk Factors
8
Save
Reset
Add
Update
View
Delete
Set Response
Set Pertinent
Preset
Risk Factor
Additional Information
Reported Date
Respon...
Freque...
Date Range
End Date Reason
Pertinent to Investigation
Chronic Medical Condition - Diabetes Mellitus
2019 Aug 24
Yes
6
70678 (Tuberculosis)
This modified record will be recorded in the database when the page is saved.

***This is an advanced function in Panorama. For additional support with entering and updating client Risk Factors in the TB module, please contact panorama@fnha.ca**

Using this carry over method will prevent changes to the client's old/previous TB investigations.

Note: You can only do this function for one RF at a time. There are some Risk Factors that require you add '*Additional Information'* in order to save it in the table

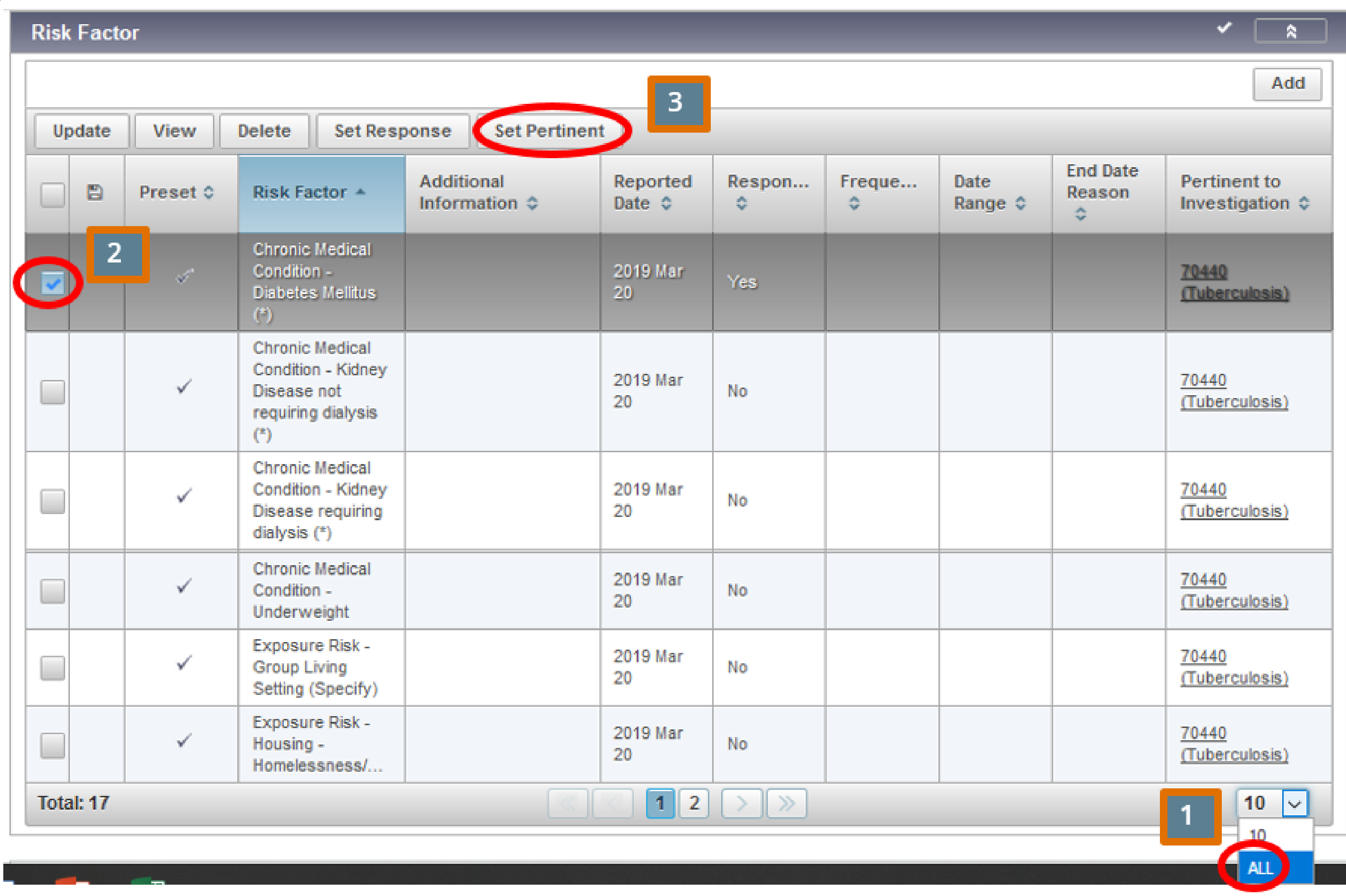
Note: Risk Factors can be pertinent to more than 1 investigation

Making an old Risk Factor Pertinent to the Current Investigation

Ensure your **Subject/Client** and **Investigation** is in context:

If the risk factor is still 'YES' and is pertinent to the current TB investigation then follow steps below.

1. Scroll down to the bottom right corner of the RF table. Using the dropdown, select **ALL,** so all available RF are visible on the table.
2. Select the checkbox ☑ with the old RF you wish to make pertinent to your current investigation
3. At the top of the table select the **SET PERTINENT** row action button. Your information will update in the table.
4. You will now see 2 Investigation ID numbers in the *Pertinent to Investigation* column (the old Investigation and current Investigation)
5. Repeat steps 1-3 for all other RF you wish to make pertinent to your current investigation
6. **SAVE** your work before exiting this page.



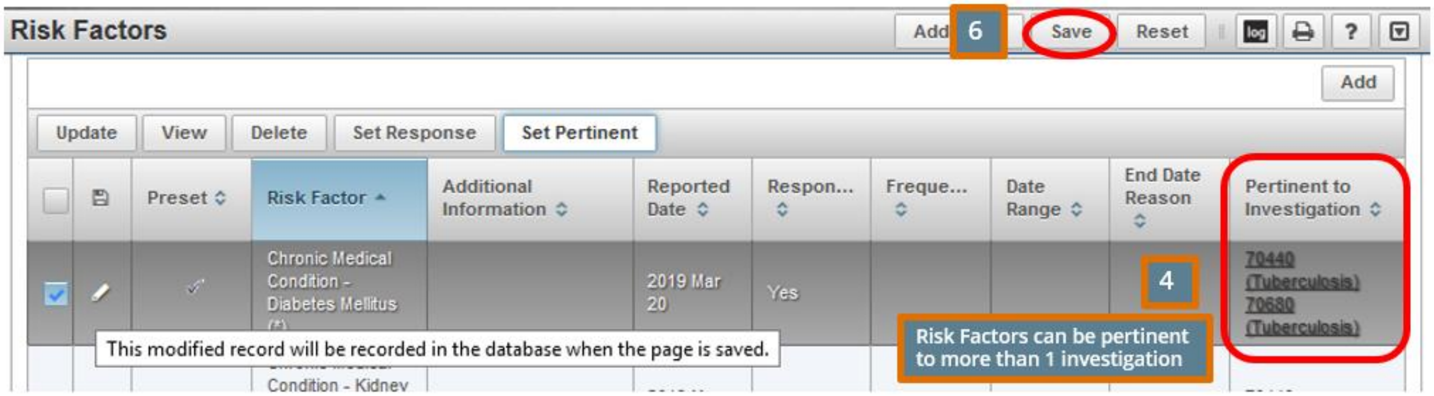
Risk Factor

Add

Update | View | Delete | Set Response | Set Pertinent

		Preset	Risk Factor	Additional Information	Reported Date	Respon...	Freque...	Date Range	End Date Reason	Pertinent to Investigation
☑		✓	Chronic Medical Condition - Diabetes Mellitus (*)		2019 Mar 20	Yes				70440 (Tuberculosis)
☐		✓	Chronic Medical Condition - Kidney Disease not requiring dialysis (*)		2019 Mar 20	No				70440 (Tuberculosis)
☐		✓	Chronic Medical Condition - Kidney Disease requiring dialysis (*)		2019 Mar 20	No				70440 (Tuberculosis)
☐		✓	Chronic Medical Condition - Underweight		2019 Mar 20	No				70440 (Tuberculosis)
☐		✓	Exposure Risk - Group Living Setting (Specify)		2019 Mar 20	No				70440 (Tuberculosis)
☐		✓	Exposure Risk - Housing - Homelessness/...		2019 Mar 20	No				70440 (Tuberculosis)

Total: 17 1 2 10 | 10 | ALL



Note: You can only end date or add details for one RF at a time. There are some Risk Factors that require you add '*Additional Information'* in order to save it in the table

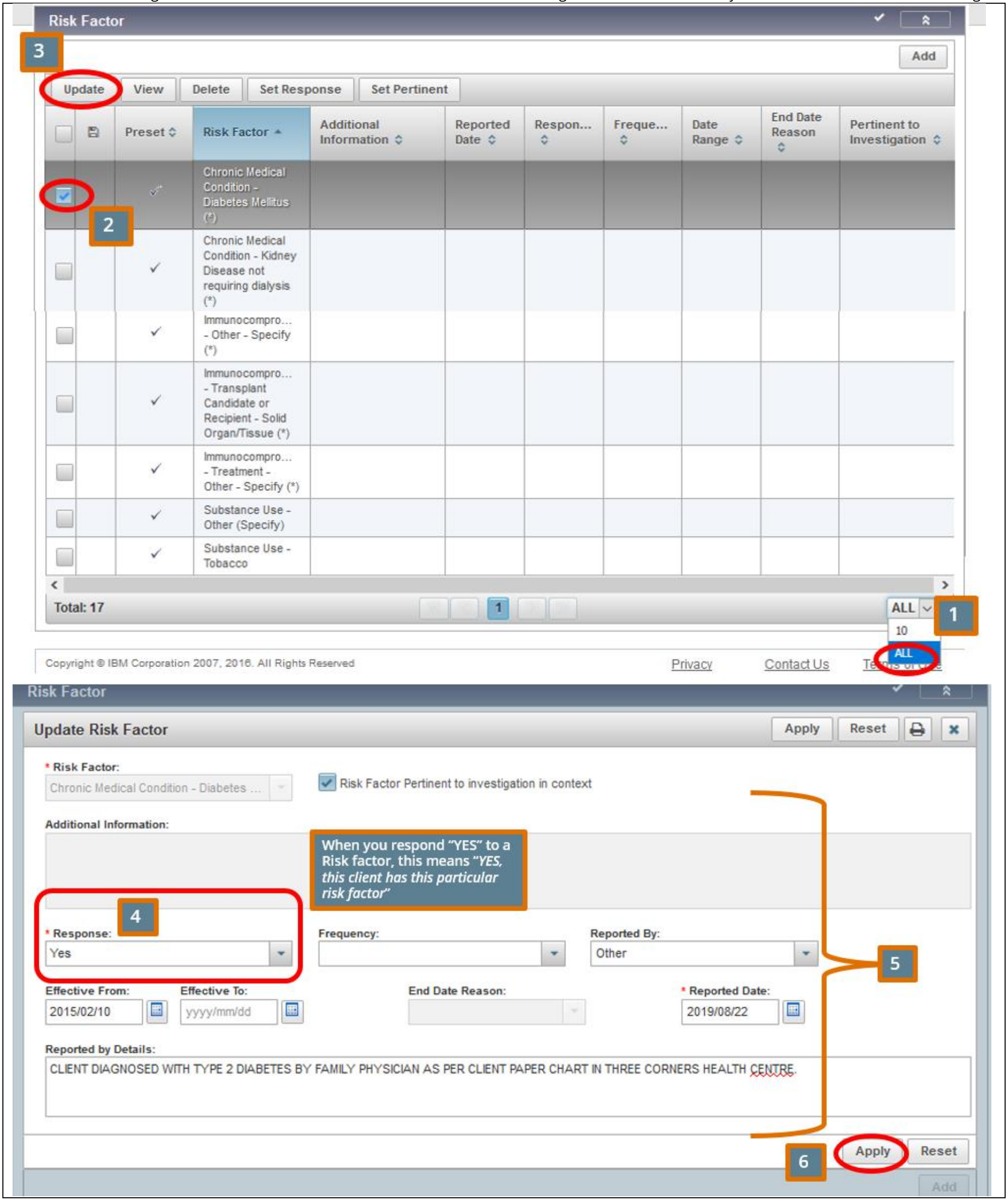
<u>End-Dating Risk Factors and Adding Risk Factor Details:</u>
You can add details to a client RF such *as Start/End Date*, *End Date, Reason* and *Frequency*.

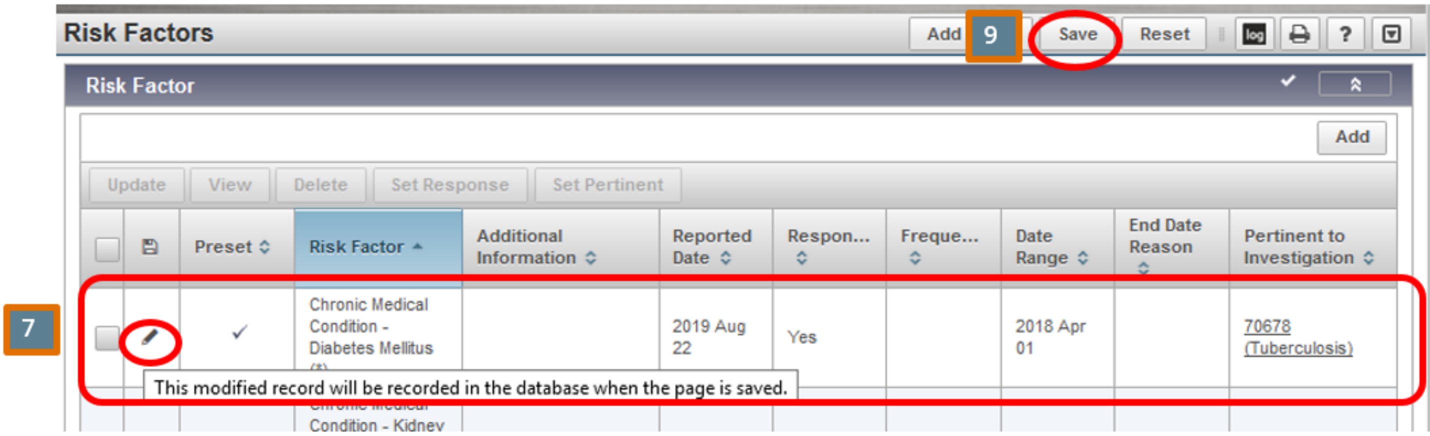
Ensure your **Subject/Client** and **Investigation** is in context:

LHN > Subject > **Risk Factors**

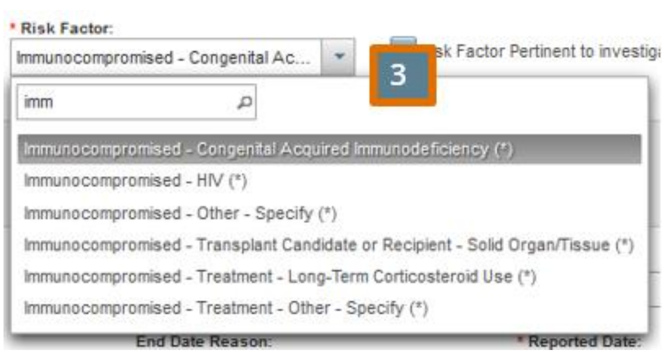
1. Scroll down to the bottom right corner of the RF table. Using the dropdown, select **ALL,** so all available RF are visible on the table.
2. Select the Risk Factor you wish to enter additional details to using the check box ☑.
3. At the top of the table, select the **UPDATE** row action button**.**
4. The RF information will populate in a separate modal. Set the *Response field* to **Yes**. Reported date will automatically set to today's date (can be changed to date of screening)
5. Update RF information such as entering *additional information, reported by*, *effective from, effective to, end date reason, reported by details* (if required).
6. When your entry is complete, select **APPLY** (found at the top or bottom of the modal window).
7. The information for your RF will update in the table.
8. Repeat steps 2-7 for additional blank RF you wish to update.
9. **SAVE** your work prior to exiting the RF page.

***Please note**: You can only update one risk factor at a time


Risk Factor
3
Add
Update
View
Delete
Set Response
Set Pertinent
Preset
Risk Factor
Additional Information
Reported Date
Respon...
Freque...
Date Range
End Date Reason
Pertinent to Investigation
Chronic Medical Condition - Diabetes Mellitus (*)
2
Chronic Medical Condition - Kidney Disease not requiring dialysis (*)
Immunocompro... - Other - Specify (*)
Immunocompro... - Transplant Candidate or Recipient - Solid Organ/Tissue (*)
Immunocompro... - Treatment - Other - Specify (*)
Substance Use - Other (Specify)
Substance Use - Tobacco
Total: 17
1
ALL
1
10
ALL
Copyright © IBM Corporation 2007, 2016. All Rights Reserved
Privacy
Contact Us
Risk Factor
Update Risk Factor
Apply
Reset
* Risk Factor:
Chronic Medical Condition - Diabetes ...
Risk Factor Pertinent to investigation in context
Additional Information:
When you respond "YES" to a Risk factor, this means "YES, this client has this particular risk factor"
4
* Response:
Yes
Frequency:
Reported By:
Other
5
Effective From:
2015/02/10
Effective To:
yyyy/mm/dd
End Date Reason:
* Reported Date:
2019/08/22
Reported by Details:
CLIENT DIAGNOSED WITH TYPE 2 DIABETES BY FAMILY PHYSICIAN AS PER CLIENT PAPER CHART IN THREE CORNERS HEALTH CENTRE.
6
Apply
Reset
Add



Can be used for RF that you end-dated from previous investigations, you can use these instructions to add in the 'YES' response.



<u>Adding a new Risk Factor to the Table</u>

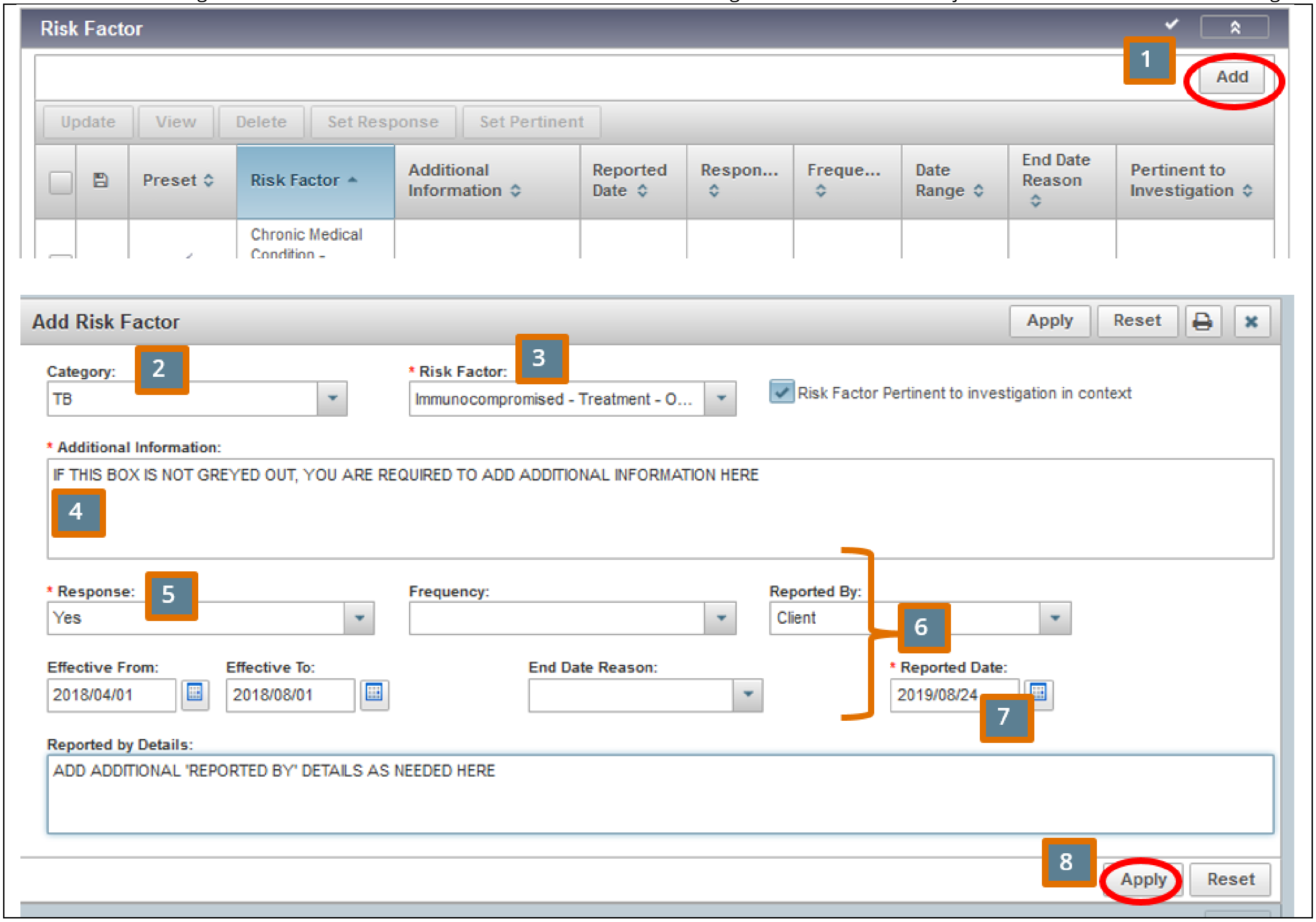
To add a Risk Factor not already included on the table or has previously been end dated:
With your **Subject/Client** and **Investigation** in context:

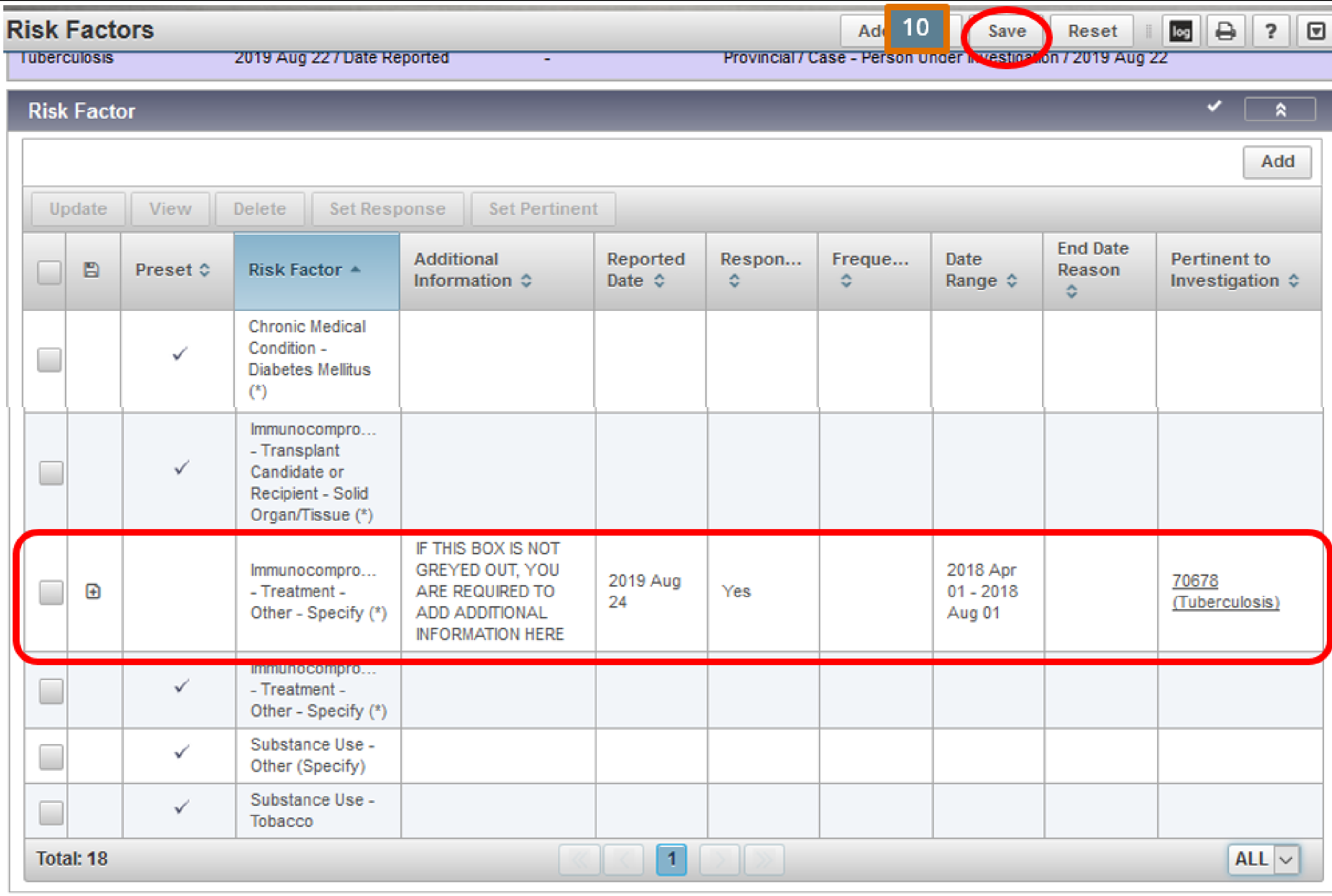
LHN > Subject > **Risk Factors**

Scroll down to the bottom right corner of the RF table. Using the dropdown, select **ALL,** so all available RF are visible on the table.

1. On the top right corner of the *Risk Factor* table, select the **ADD** button. An *Add Risk Factor* modal will appear.
2. If you want to narrow the number of risk factors listed, select the *Category* field related to your Risk Factor (***CD, Immunization, STI/HIV, TB***).
3. Under the *Risk Factor* field, search and select the Risk Factor you wish to add to the table
4. The *Additional Information* field may be required depending on the RF selected
5. For *Response*, select ***Yes***
6. *Frequency, Reported By, Effective From, Effective To, End date Reason,* are not required fields. Complete if known/applicable.
7. *Reported Date* populates to today's date. Can be changed to the date client was screened.
8. Select **APPLY** to add the risk factor to the table.
9. Repeat steps 1-7 to add additional Risk Factors
10. Select **SAVE** to save the entered risk factors. The risk factor table will update with your entry(ies).

If there are many RF, you may need to scroll down the table to see your updates.


Risk Factor
1
Add
Update
View
Delete
Set Response
Set Pertinent
Preset
Risk Factor
Additional Information
Reported Date
Respon...
Freque...
Date Range
End Date Reason
Pertinent to Investigation
Chronic Medical Condition -
Add Risk Factor
Apply
Reset
Category:
2
TB
* Risk Factor:
3
Immunocompromised - Treatment - O...
Risk Factor Pertinent to investigation in context
* Additional Information:
IF THIS BOX IS NOT GREYED OUT, YOU ARE REQUIRED TO ADD ADDITIONAL INFORMATION HERE
4
* Response:
5
Yes
Frequency:
Reported By:
Client
6
Effective From:
2018/04/01
Effective To:
2018/08/01
End Date Reason:
* Reported Date:
2019/08/24
7
Reported by Details:
ADD ADDITIONAL 'REPORTED BY' DETAILS AS NEEDED HERE
8
Apply
Reset



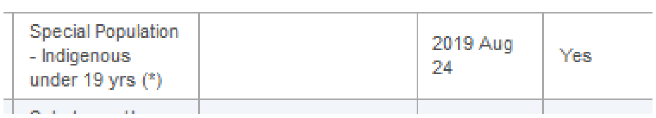
Risk Factors

Tuberculosis 2019 Aug 22 / Date Reported - Provincial / Case - Person Under Investigation / 2019 Aug 22

Risk Factor

		Preset	Risk Factor	Additional Information	Reported Date	Respon...	Freque...	Date Range	End Date Reason	Pertinent to Investigation
		✓	Chronic Medical Condition - Diabetes Mellitus (*)							
		✓	Immunocompro... - Transplant Candidate or Recipient - Solid Organ/Tissue (*)							
			Immunocompro... - Treatment - Other - Specify (*)	IF THIS BOX IS NOT GREYED OUT, YOU ARE REQUIRED TO ADD ADDITIONAL INFORMATION HERE	2019 Aug 24	Yes		2018 Apr 01 - 2018 Aug 01		70678 (Tuberculosis)
		✓	Immunocompro... - Treatment - Other - Specify (*)							
		✓	Substance Use - Other (Specify)							
		✓	Substance Use - Tobacco							

Total: 18



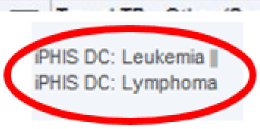
Special Population - Indigenous under 19 yrs (*)		2019 Aug 24	Yes

For Children under the age of 19

Similar to adding the '*Special Population: Indigenous under 19 years'* Risk Factor for children in the **Immunization** module, please ensure that children who qualify for the hepatitis A vaccine have the risk factor '*Special Population: Aboriginal under 19 years'* added to the TB risk factor table as well.

For more information, please see the **[Immunization Data Entry Guide]**

When *iPHIS* (the Province's previous Public Health charting system) charts were converted over to Panorama, some old Risk Factors that are no longer used, were pulled over to the client's Panorama chart.



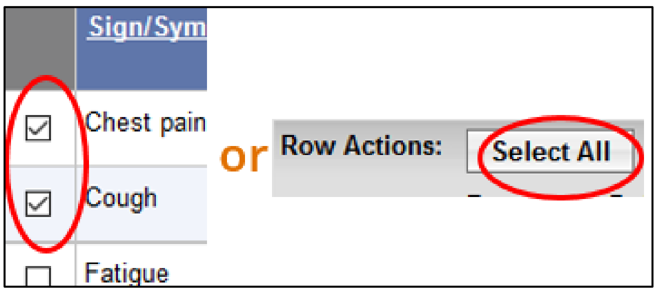
Risk Factors from iPHIS Transfer:

Some client charts may have old iPHIS risk factors on the table when you open their risk factor page. These risk factors were brought over from iPHIS and are no longer used.

*Please see examples of old iPHIS RF on the left hand column.

If you encounter any of these risk factors, please ignore. If you see **'iPHIS DC'** within the client RF, DO NOT CHANGE the response

Signs & Symptoms



The Signs and Symptoms page in Panorama is displayed as the old 'Classic' version of Panorama

*All S&Sx in the table needs to have a documented response. ie. Do not leave blank. When you create a TB investigation for a client, a table of S&Sx recommended for the investigation appears.

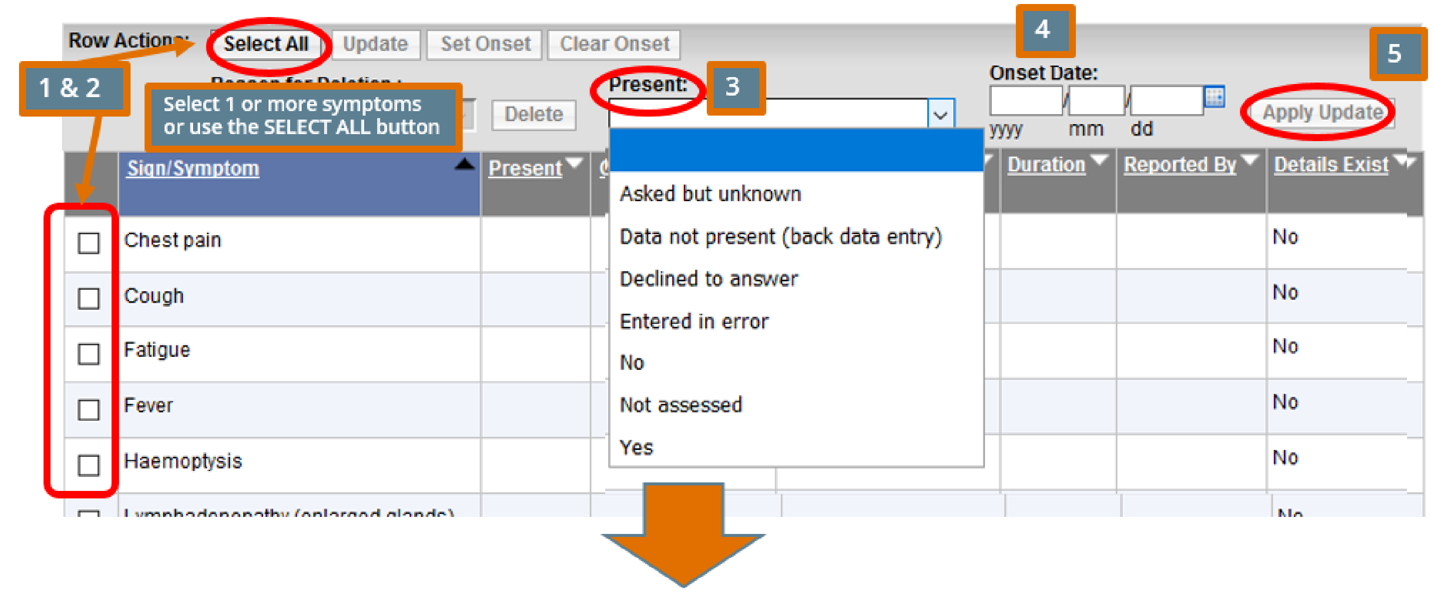
Updating the Sign and Symptoms Table

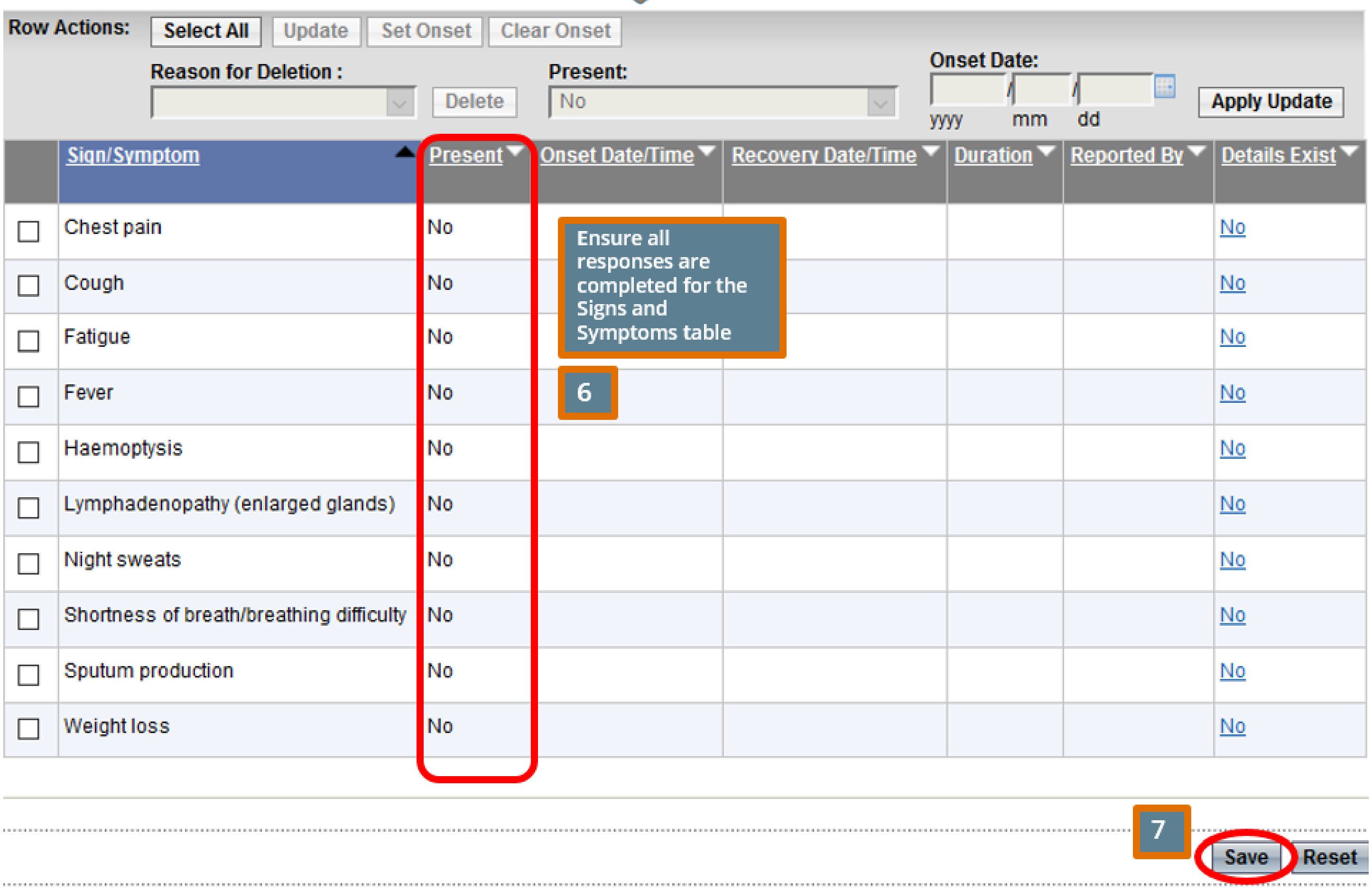
With your **Client** and **Investigation** in context:

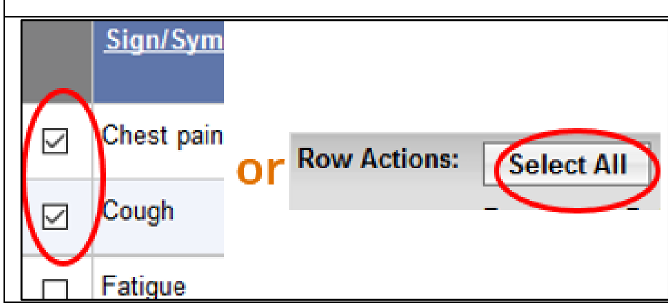
LHN > Investigation > **Signs & Symptoms**

Scroll down to the table containing the pre-populated list of signs and symptoms (S&Sx).

1. Select one or more S&Sx using the checkbox ❒ on the left hand column of the table
2. Alternately, you can press the **SELECT ALL** button above the table, under *Row Actions* to select all S&Sx listed in the table.
3. The *Present* field on the top right portion of the table, can be selected to the following options:
   a. *Asked but unknown*
   b. *Data not present (back data entry)*
   c. *Declined to answer*
   d. *Entered in error*
   e. *No*
   f. *Not Assessed*
   g. *Yes*
4. Enter an **Onset Date** if applicable (*see **Adding Additional Information to Signs and Symptoms**)
5. Select **APPLY UPDATE**
6. The response(s) will populate in the table below, under the *Present* column
7. Once all S&Sx have been entered, **SAVE** your work



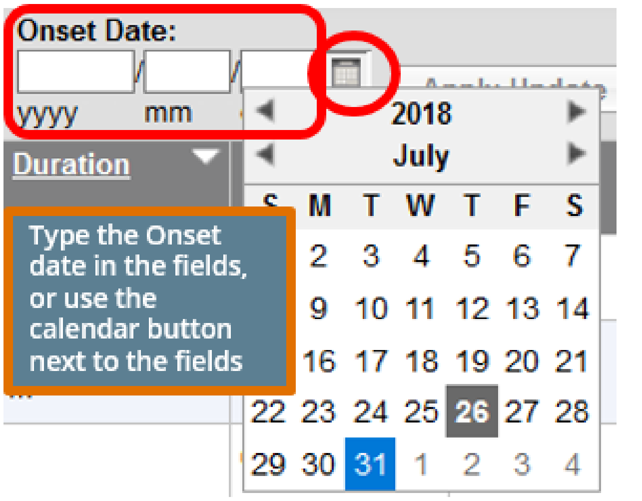




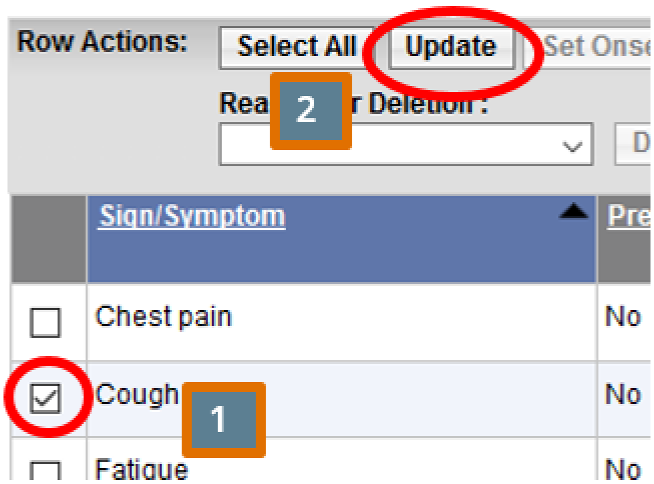
Adding Additional Information to Signs and Symptoms

To add an onset date to S&Sx:

1. Select the S&Sx you wish to add an onset date to using the checkboxes ❐ on the left hand column of the table

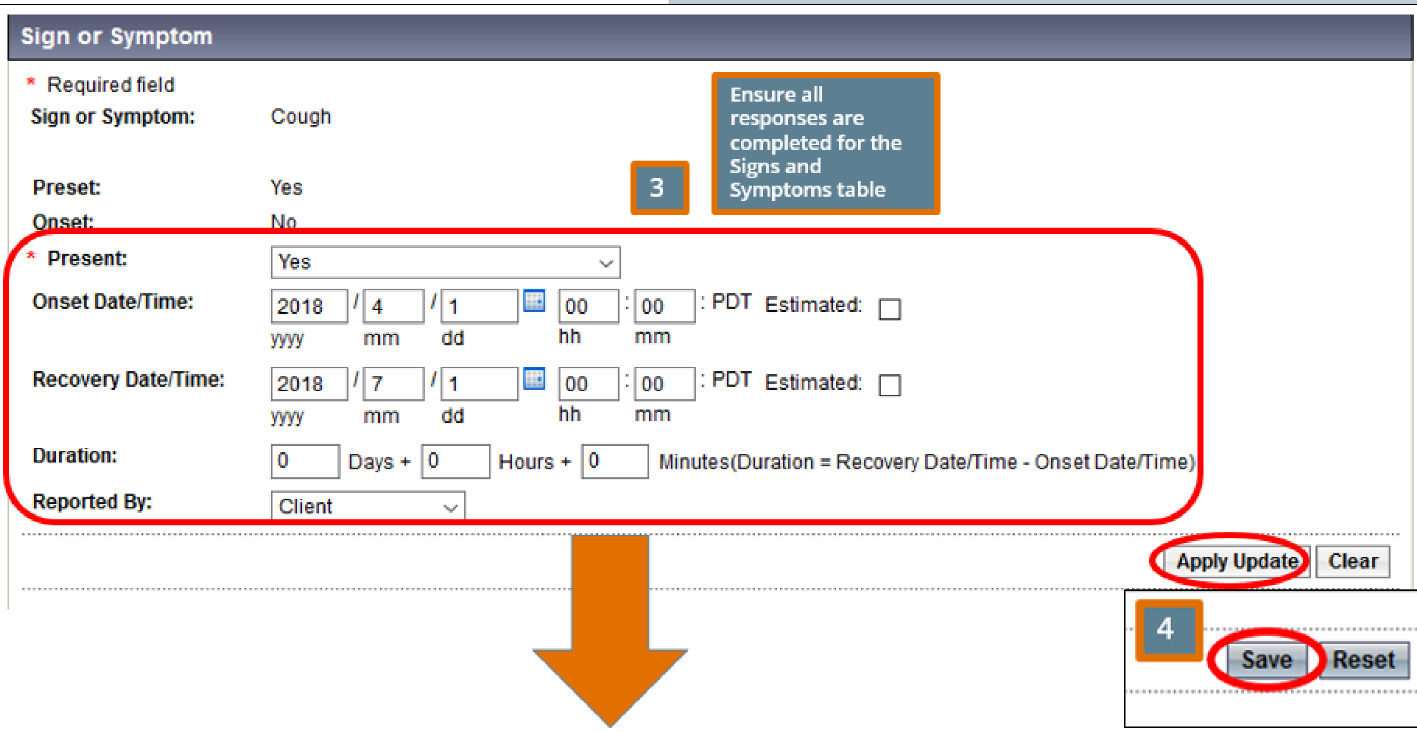


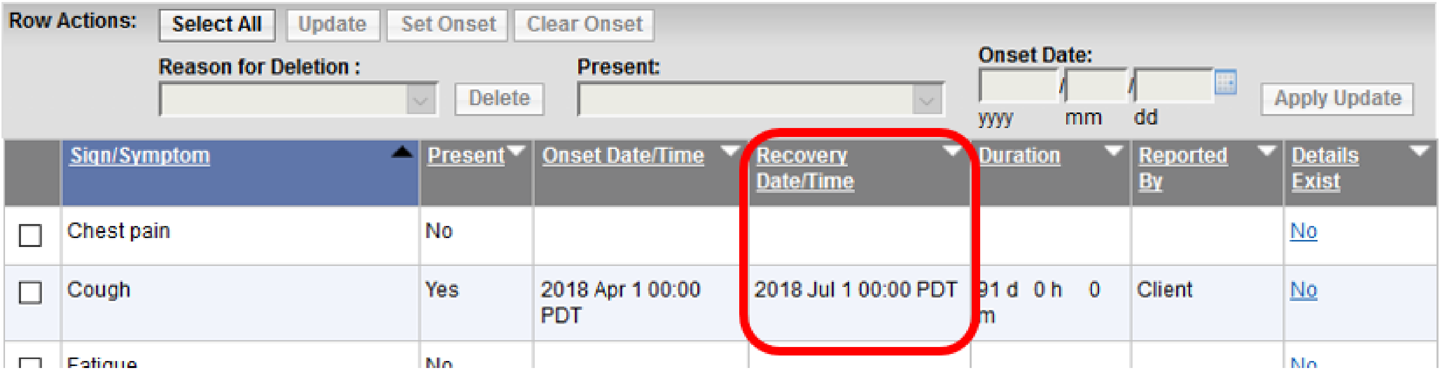
2. Along to top of the table, enter the *Onset Date* by either typing in the fields or using the calendar button next to the fields.
3. Select **APPLY UPDATE**. The onset date will populate to the corresponding S&Sx in the table below.
4. **SAVE** your updates

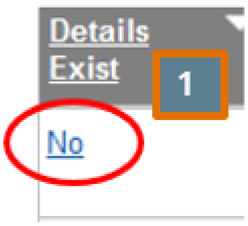


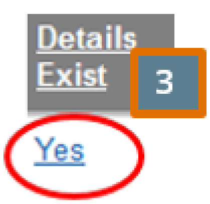
To add a recovery date to S&Sx:

1. Select the S&Sx you wish to add an end date to using the checkboxes ☑. You can only enter a recovery date one S&Sx at a time.
2. At the top of the table, next to Row Actions, select **UPDATE**
3. The S&Sx information will populate to the top of the page, above the table where you can update and enter the recovery date.
4. When your entry is complete, select **APPLY UPDATE**. The information for your S&Sx will update in the S&Sx table below. **SAVE** you work





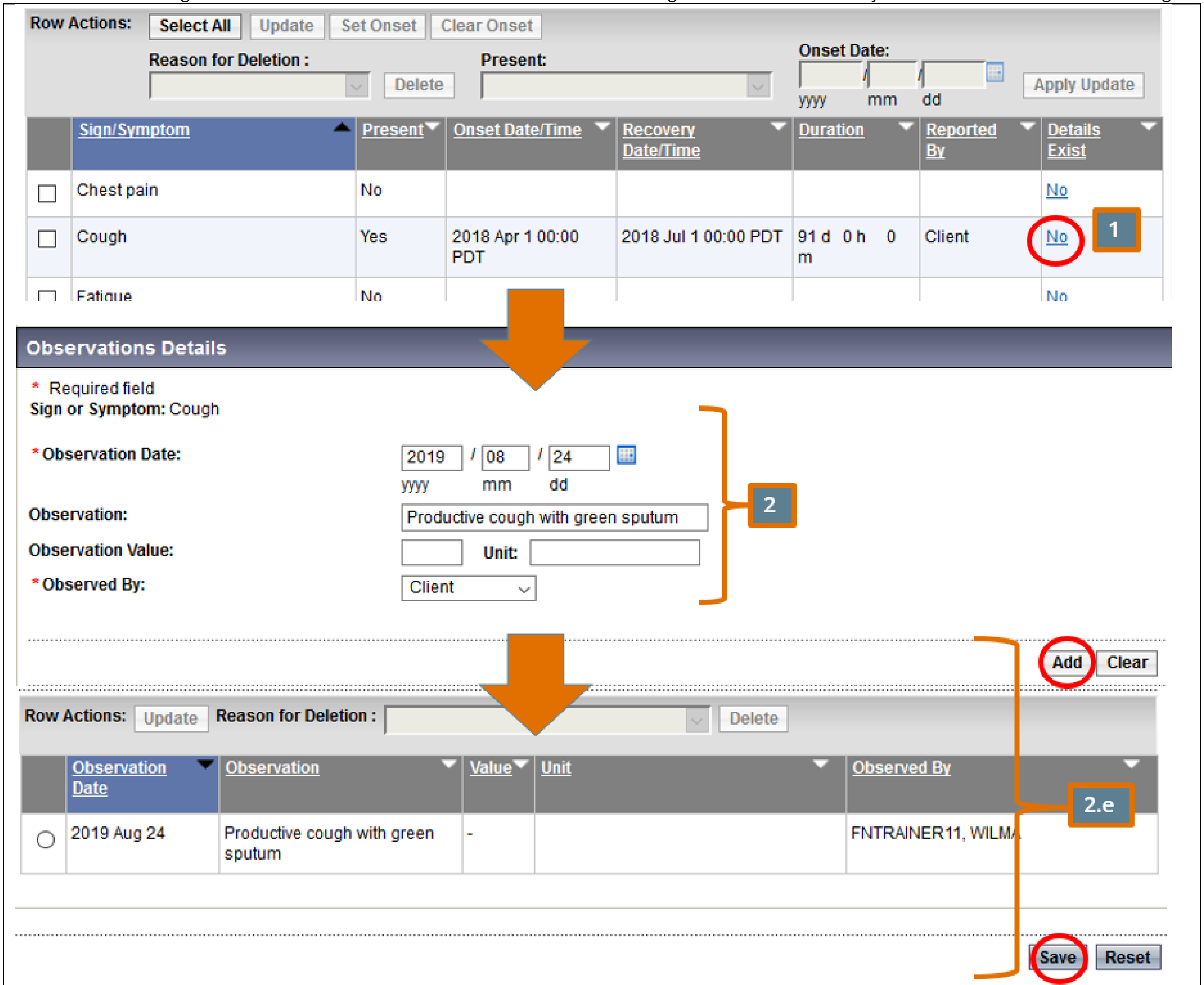


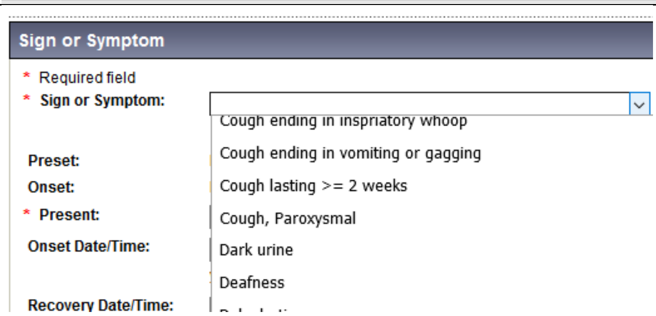


Adding Symptom Details:

Once you entered a response for a S&Sx, you can add description details.

1. In the S&Sx table, under the *Details Exist* column, select the **No** hyperlink corresponding to the S&Sx you wish to add details to
2. The *Observation Details* section will appear below the table. Complete the pertinent fields related to the symptom you selected.
   a. *Observation Date:* Populates to today's date; can be backdated.
   b. *Observation:* A free-text field where you can enter details/description of the symptom.
   c. *Observation Value* and *Unit* can be completed if needed
   d. *Observed By*: can select *Client, Current User* (ie. You), or *Other*. If Other is selected, another field will populate prompting you to type in who observed this S&Sx.
   e. Select **ADD**. Your data will be populated in a table below. **SAVE**
3. When you return to the symptom table, the *Details Exist* hyperlink will change from No to Yes. Selecting the Yes hyperlink will take you back to the observation details.
4. You can return to the S&Sx details section to add further details by repeating steps 1-3. The most recent entries will appear at the top of the table.





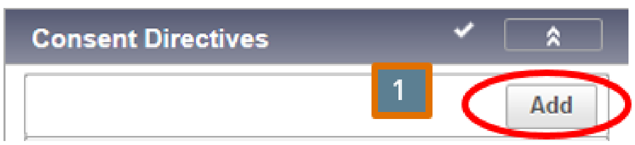
Adding Additional Signs and Symptoms

You can add S&Sx that are not already listed in the table. Only add additional S&Sx to the table that may be pertinent to the client's TB screen.

1. Scroll to the top of the S&Sx page (above the S&Sx table)
2. In the Sign or Symptom field, select the S&Sx from the drop down list.
3. Complete the other fields (*Present, Onset/Recovery Date, Reported By*) as needed.
4. **ADD** and the table will be update with the new symptom information.

You can **add details** as instructed above. **SAVE** your work.

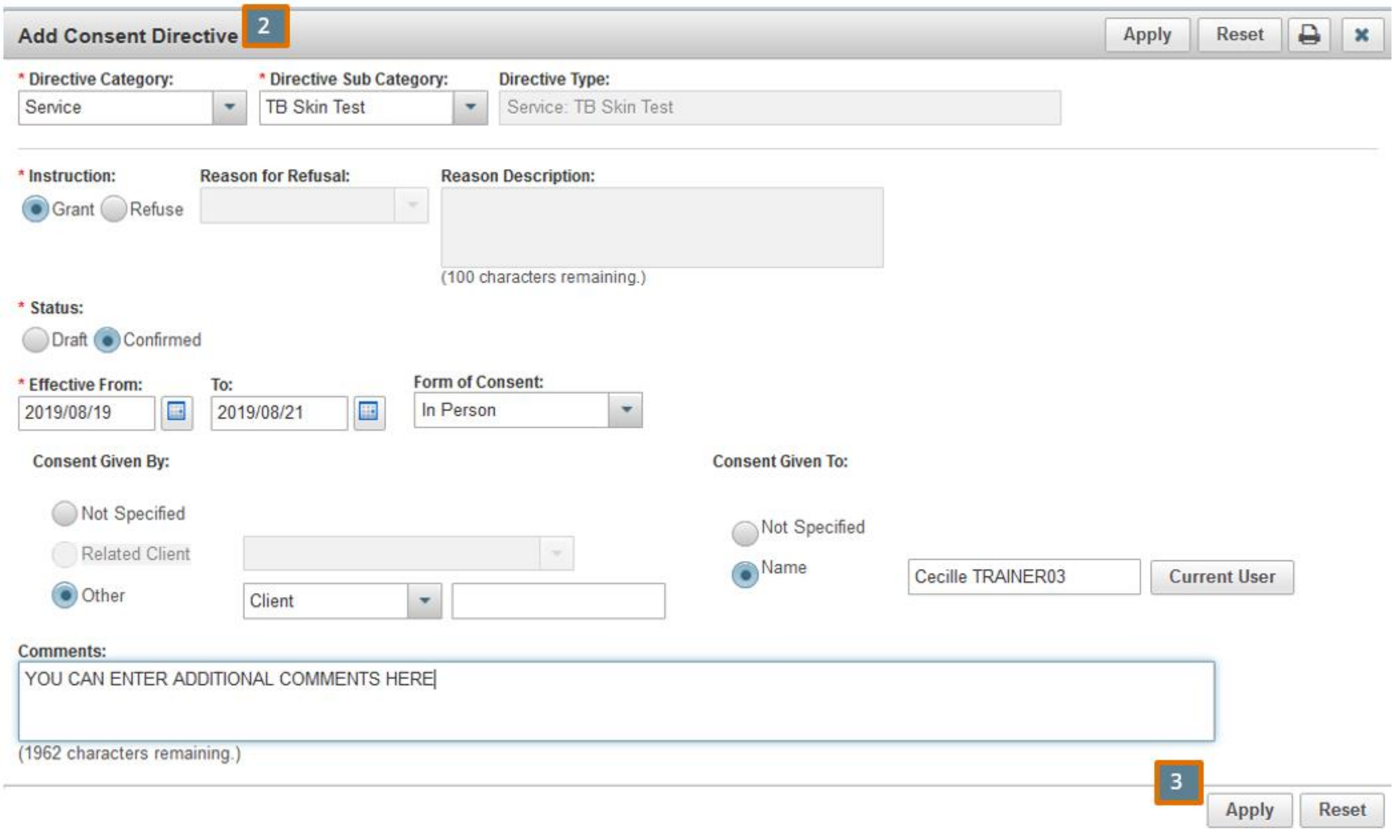
Create Consent

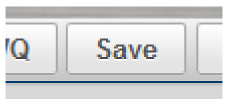


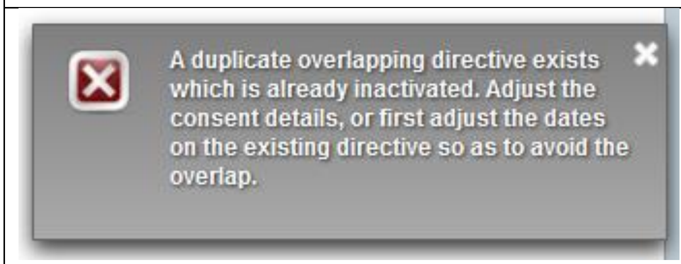
If a previous consent is present, end-date the current consent and enter new one.

LHN >Subject >Consent Directives > **All Services**

1. Select **ADD** to add a new consent directive
2. A Consent Directive modal will appear. Complete fields:
    a. *Directive Category* = ***Service***
    b. *Directive Sub Category* = ***TB Skin Test***
    c. *Instruction:* Select either the **Grant** or **Refuse** Radio Button
    d. *Status = select **Confirmed** radio button*
    e. *Effective From Date* defaults to today's date (can be back dated).
    f. *Effective To Date:* Enter anticipated date of TST read (ie. 48-72 hours post TST give)
    g. Choose the *Form of Consent* from the drop down list
    h. *Consent Given By:* (three choices):
        i. *Not Specified*
        ii. *Related Client* – will appear as an option if the client is linked to a family member
        iii. *Other* – Select the *Relationship Type* and use the free-text field to enter the name of the person giving consent on behalf of the client.
    i. *Consent Given To:* - select the Name radio button. Select **CURRENT USER** button and your name will populate in the field. You can also enter the name of the provider that obtained the consent.
    j. *Comments* can be entered if needed in the free text box.
3. Select **APPLY** and **SAVE** your consent.







End Dating old TST consents

In Panorama, you cannot have 2 consents for a TST with overlapping dates. If you run into this issue, you will need to end date one of the consents.

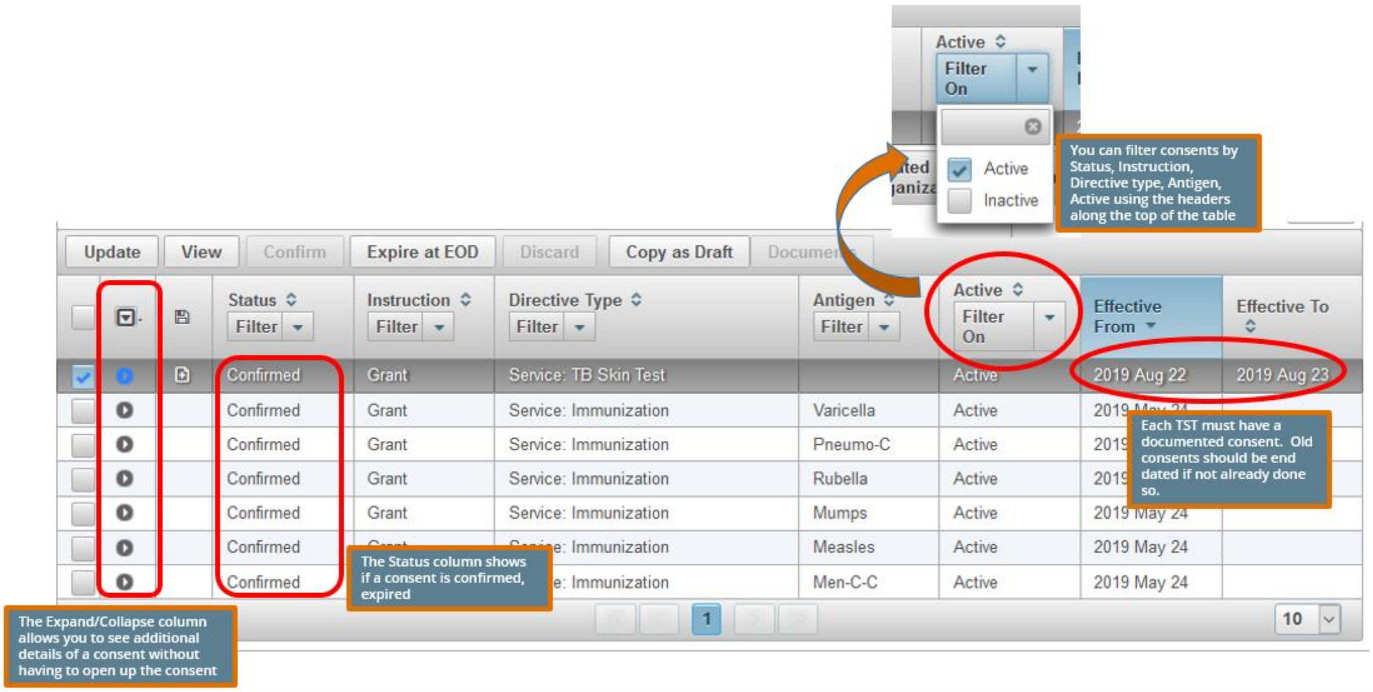
LHN > Subject > Consent Directives > **All Services**

1. From the *Consent Directives* page, in the table, select the checkbox ☑ next to the consent you wish to end date.
2. The Row Action buttons will become available at the top of the table. Select **UPDATE**
3. Once the consent is opened, you can add in the *Effective To Date* (ie end date)
4. **SUBMIT** and the consent will update into the table with the end date

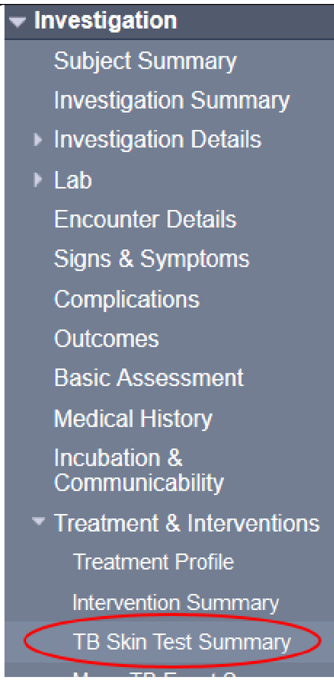
Viewing Consents

You can review all of your client consents on the table, and filter them as needed. You can use the

	expand/collapse column (2nd column) on the table to see additional consent details. Alternately, you can select any individual consent using the checkbox ☑ and select **VIEW**. The consent details will appear in a modal.



Update TB History Summary



*Please note the TB History Summary Page is displayed as the old 'Classic' version of Panorama

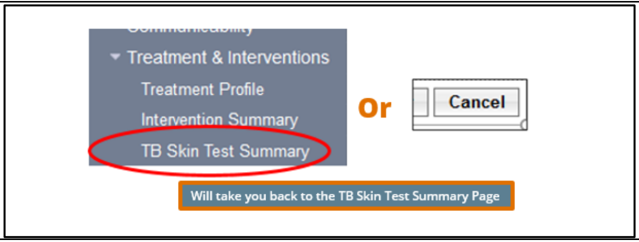
Before entering the client TST, first review and update your client's TB history summary.

LHN > Investigation > Treatment & Interventions > **TB Skin Test Summary**

1. Scroll down to the *TB History Summary* section of the page. Select **UPDATE**
2. The *TB History Details* page opens where you can review and update client information:
   a. *Previous TB Test:* Can select ***Negative, None, Positive, or Unknown*** from the drop down menu
   b. *Source:* Source where you received the previous TB test information from. Choose ***Client*** or ***Other***
   c. *Previous Test Date:* Enter date the last TST was given. If Full Date is not known, you can use the radio **(❍)** button to enter a *Partial Date* (year/month)
   d. *Previous Test Country*: Use the drop down to select the Country where client received her last TST
   e. *Previous Diagnosis:* Select ***Active TB, Latent TB, None,*** or ***Unknown.*** Enter the *Previous Diagnosis Date* (Full or Partial Date)
   f. *Previous Treatment:* Select ***Active TB, None, Prophylaxis Complete, Prophylaxis Incomplete, Prophylaxis Unknown, Unknown Treatment,*** or ***Untreated.*** Enter the *Previous Treatment Date* (Full or Partial)
   g. *Previous BCG Vaccine:* Select ***No, Unknown,*** or ***Yes***. Enter the *BCG Vaccine Date* (Full or Partial Date).
   h. *BCG Vaccine Country:* Enter the country where client received BCG vaccine
   i. *BCG scar visible:* Enter your assessment of client's BCG scar. Select ***No, Unknown,*** or ***Yes***
   j. *Client Age at Last BCG:* Enter age of client when they received BCG (in years) if applicable/known.
   k. There is a free text field under *TB History Comments* where you can add additional information such as any changed or updated fields you have updated, or any relevant comments regarding TB History. Select **ADD** after adding additional comments to put into the comment table.
   l. **SAVE** your work.

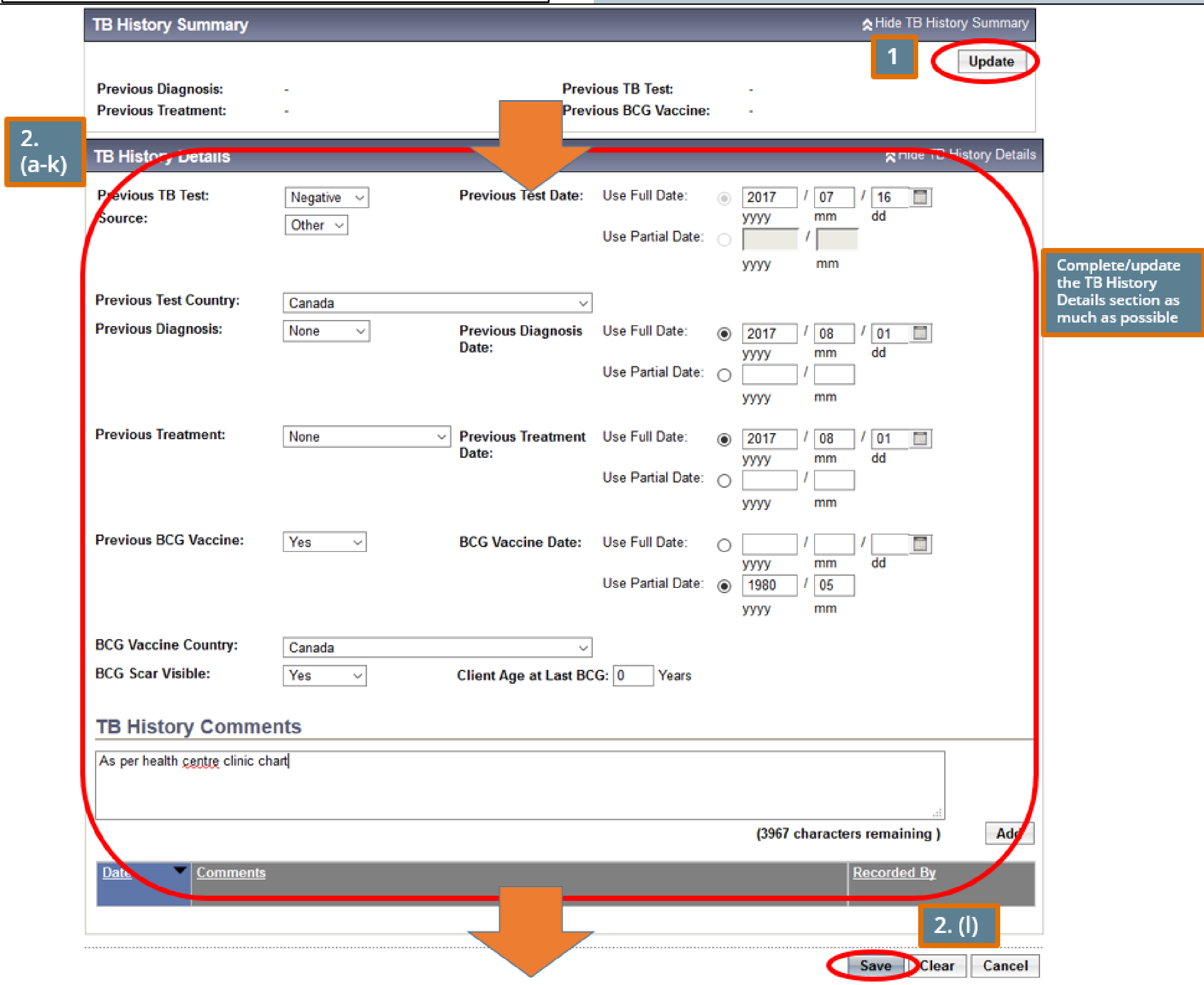
If selecting **None** or **Unknown** for *Previous Diagnosis*, or *Previous Treatment*, enter date of client TB screen. You will not be able to save your entry without a date entered.

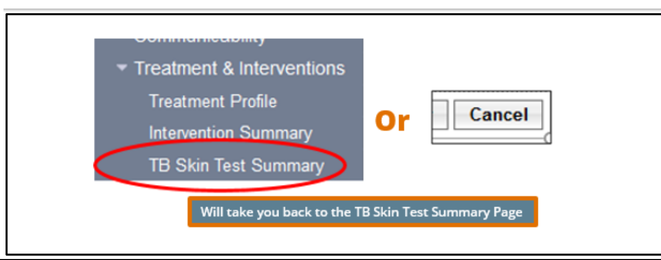
If *Previous BCG Vaccine* is selected ***Yes***, a date must be entered. If only year of BCG known, enter the month the client was born.

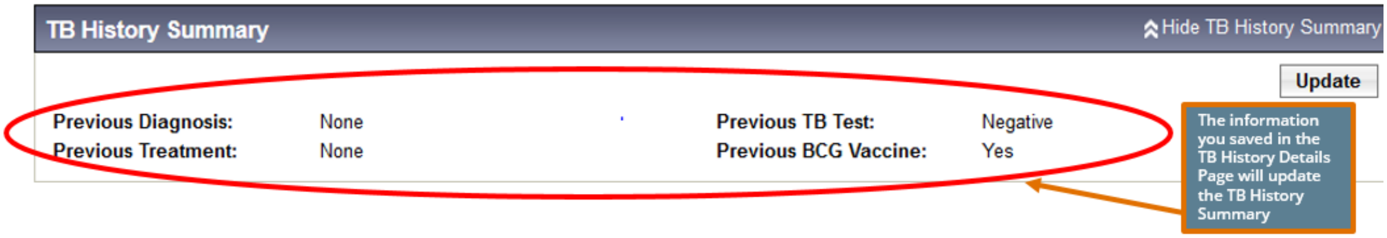


m. Select **CANCEL** to take you back to the *TB History Details* page **OR**

LHN > Investigation > Treatment & Interventions > **TB Skin Test Summary**

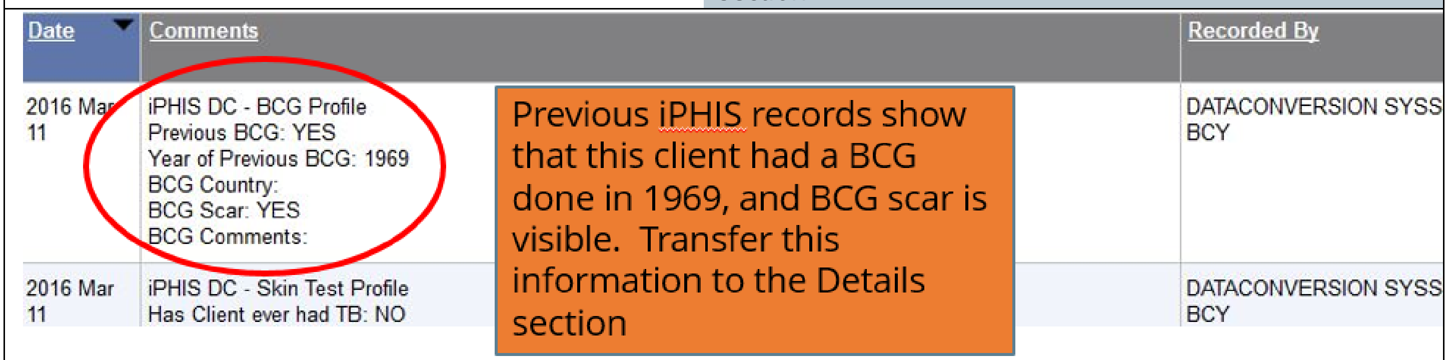


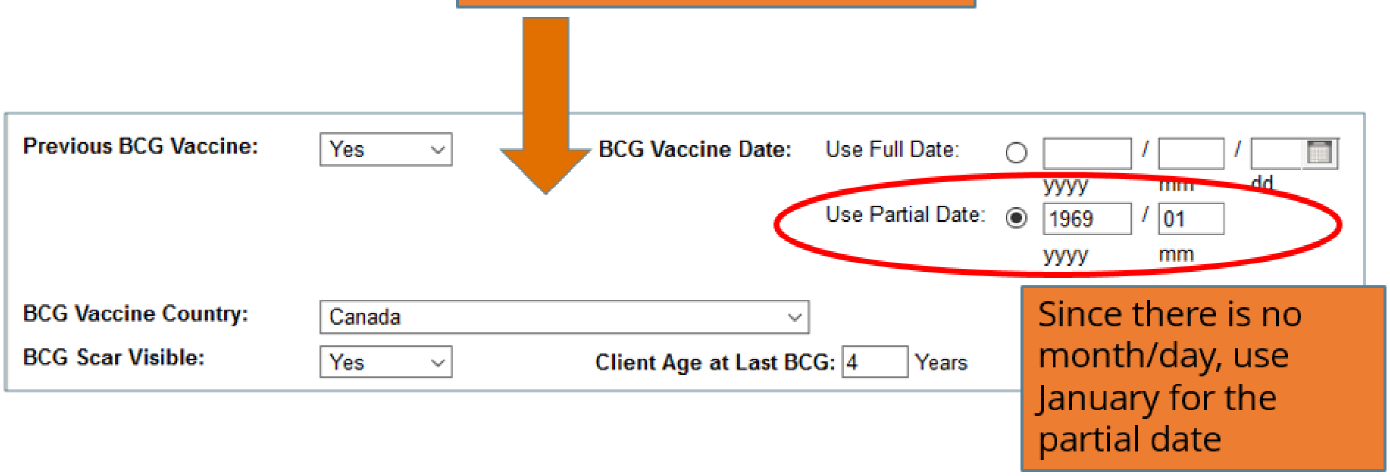




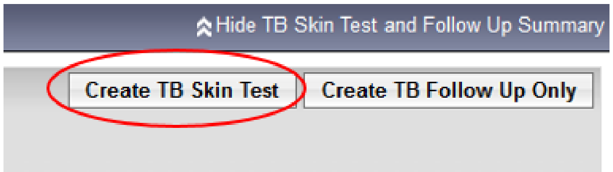
BCG History from iPHIS

In many client charts transferred from iPHIS, their BCG history has been placed in the *TB History Comments* section. If you see this information in the comments section, transfer the information to the *TB History Details* section





Create TB Skin Test

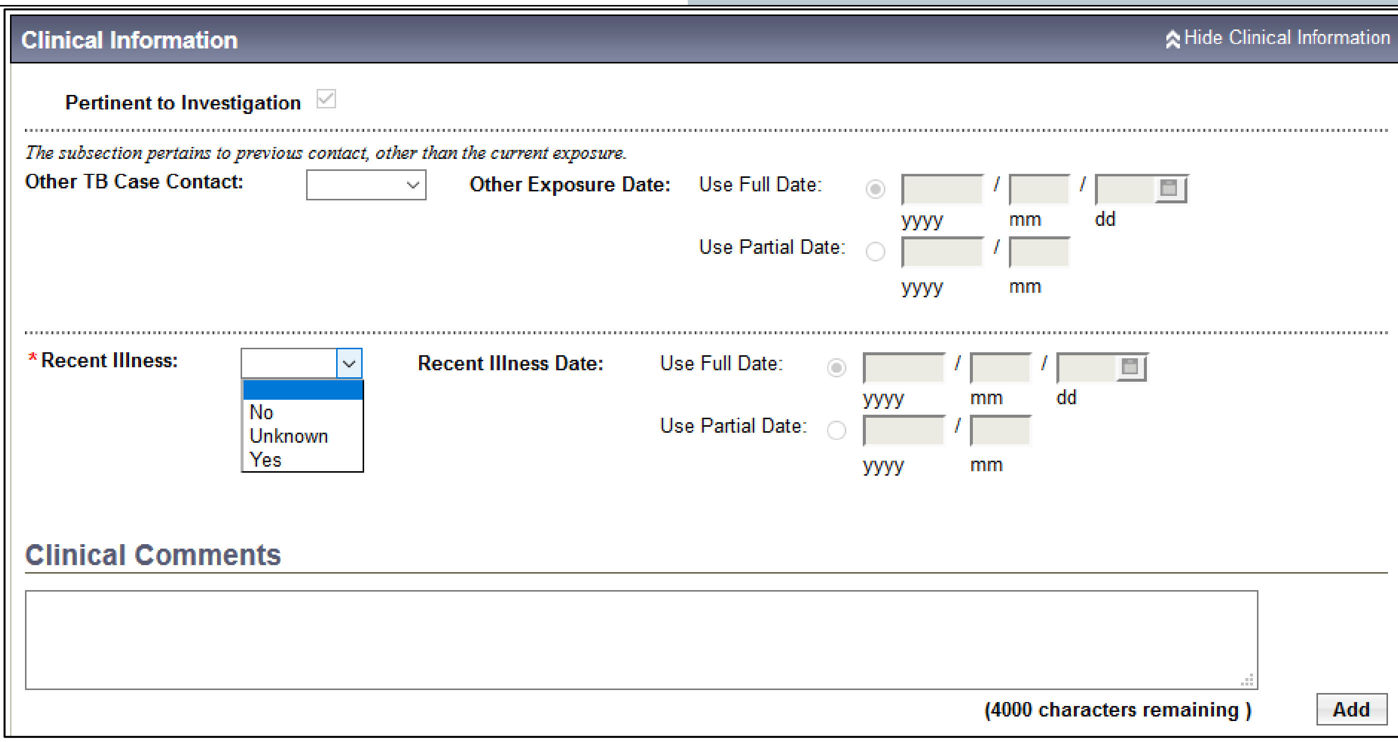


<u>TB Skin Test – GIVE</u>
With your **Client** and **Investigation** in context:

LHN > Investigation > Treatment and interventions > **TB Skin test Summary**

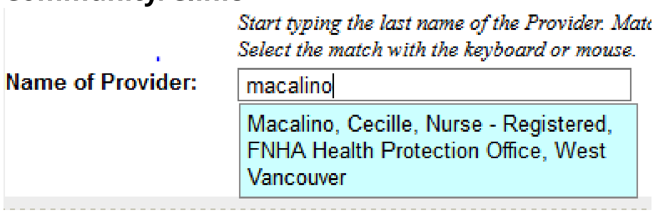
From the *TB History Details* page, select **CREATE TB SKIN TEST** from the *TB Skin Test and Follow Up Summary* section. For *Encounter Group*, select **Tuberculosis Disease Investigation** from the dropdown menu

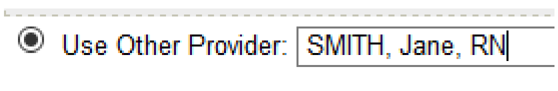
1. In the *Clinical Information* section:
   a. *Other TB Case Contact* – select from dropdown menu **No, Unknown, or Yes**.
   b. *Recent Illness* – choose from ***No, Unknown, Yes***. Enter date if ***Yes*** is selected.
   c. Enter *Clinical Comments* in the free text field if applicable. Select **ADD** if comments are entered.



2. *Test Given Details* section:
   a. Select the *Historical* checkbox ☑ if entering a TST give done by another agency/clinic (See ***Entering a Historical TST entry*** section)

When searching for provider, providers are listed by **Lastname, Firstname, Designation – Community/Clinic**





b. Select *Reason for Testing* from the drop-down list (codes as per BCCDC TB screening form)

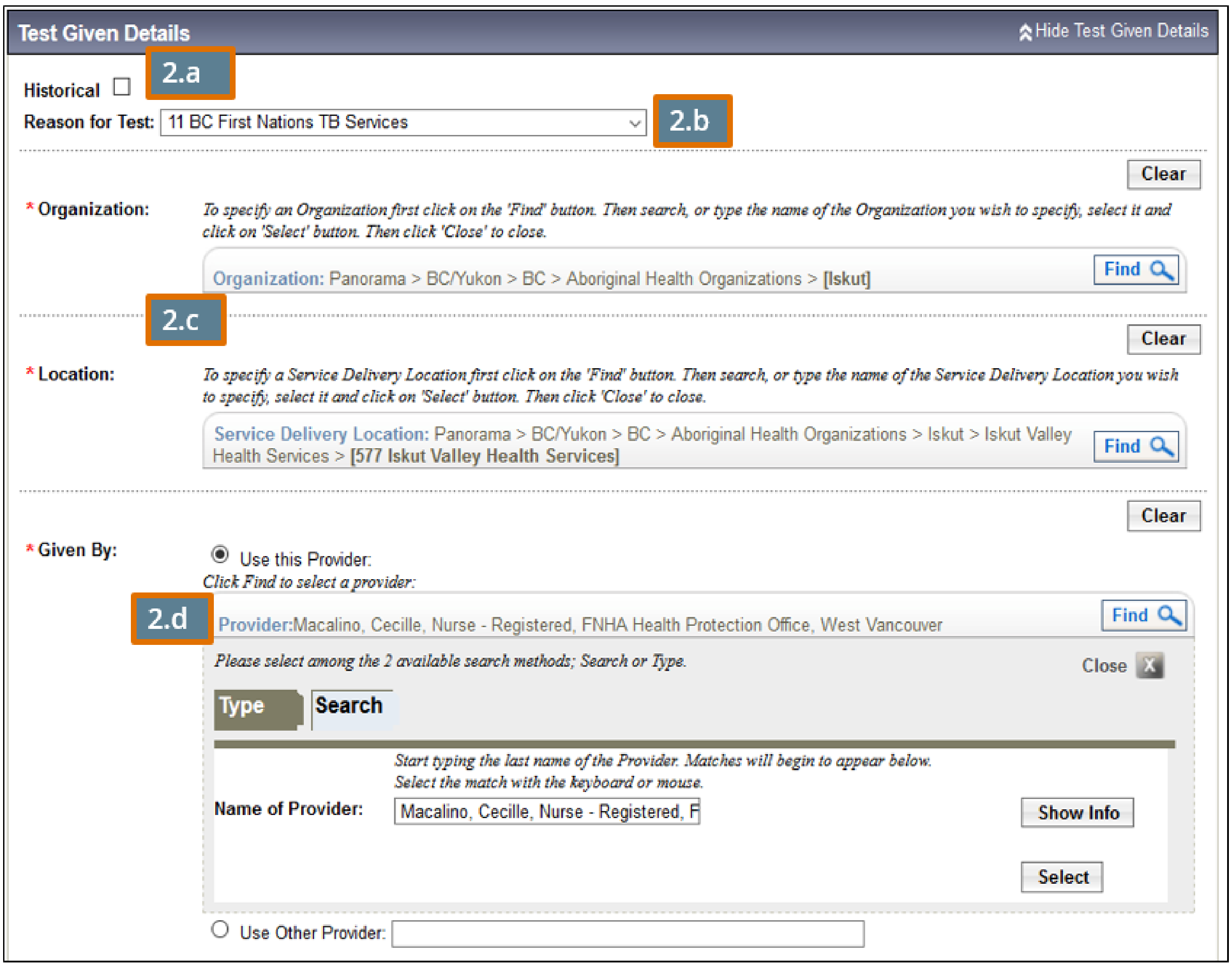
c. *Organization* and *Location/SDL* will default to your Organization (can be changed using **FIND** and **SELECT**)

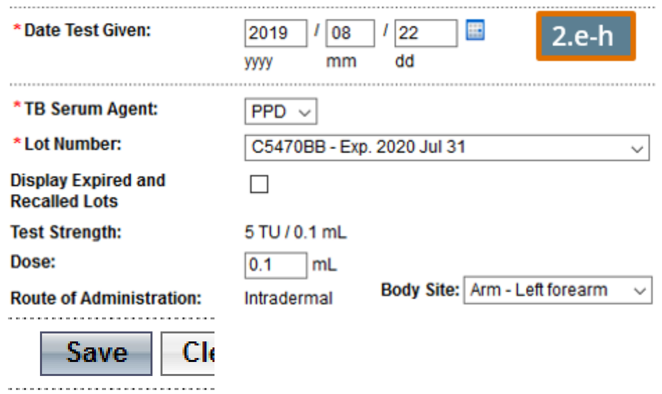
d. *Given by* – either **FIND** and **SELECT** yourself or another provider as the *Provider*. Providers are listed last name, first name, designation. If the name is not listed in the provider list, use the radio button **(❍)** in the *Other Provider* area and enter the provider name in the free text field.

If you select Use *Other Provider*, please type the provider name by:

LASTNAME, Firstname, Designation (See example on left)

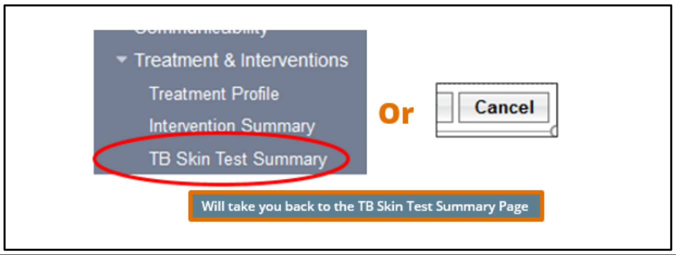
Eg. HARPER, Frank, RN



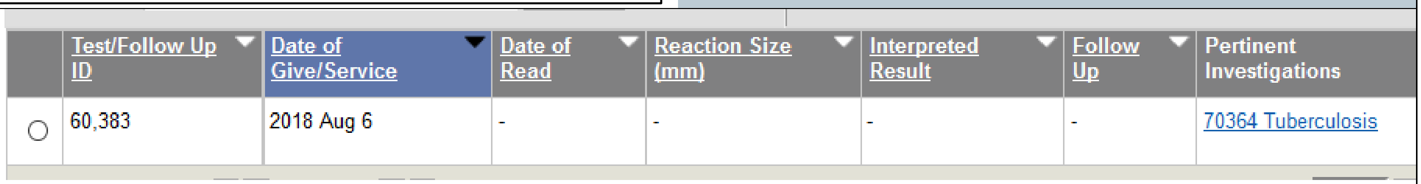


e. *Date Test Given* defaults to today's date – change if needed
f. *TB Serum Agent* - Choose ***PPD***
g. *Choose Lot number* – Lot# details will be populated
h. Choose *Body Site* – ***Left inner forearm, right inner forearm*** or ***other***
i. Select **SAVE.**

3. To get back to the *TB Skin Test Summary* page, you can select **CANCEL** at the top or bottom of the page,
   OR
   LHN > Investigation > Treatment & Interventions > **TB Skin Test Summary**

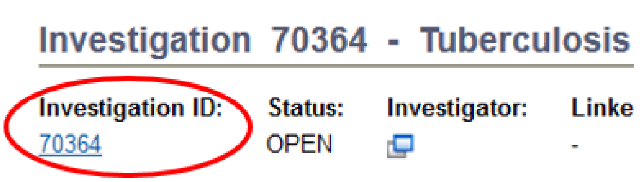


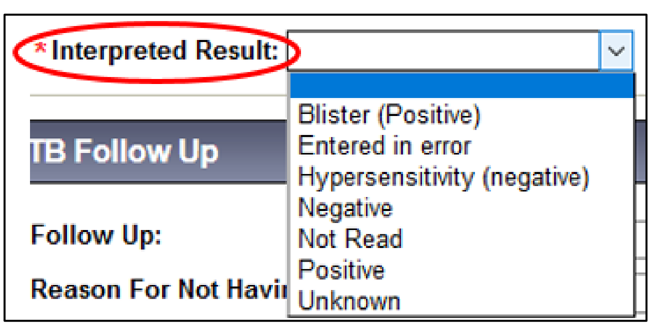
You will see your skin test give in the table. You can continue with the follow up/TB Skin Test **OR** read/follow up in 48-72 hours.



	Test/Follow Up ID	Date of Give/Service	Date of Read	Reaction Size (mm)	Interpreted Result	Follow Up	Pertinent Investigations
○	60,383	2018 Aug 6	-	-	-	-	70364 Tuberculosis

For more information about navigating the Investigation Module Subject Summary page, refer to the **Subject Summary** section of this guide



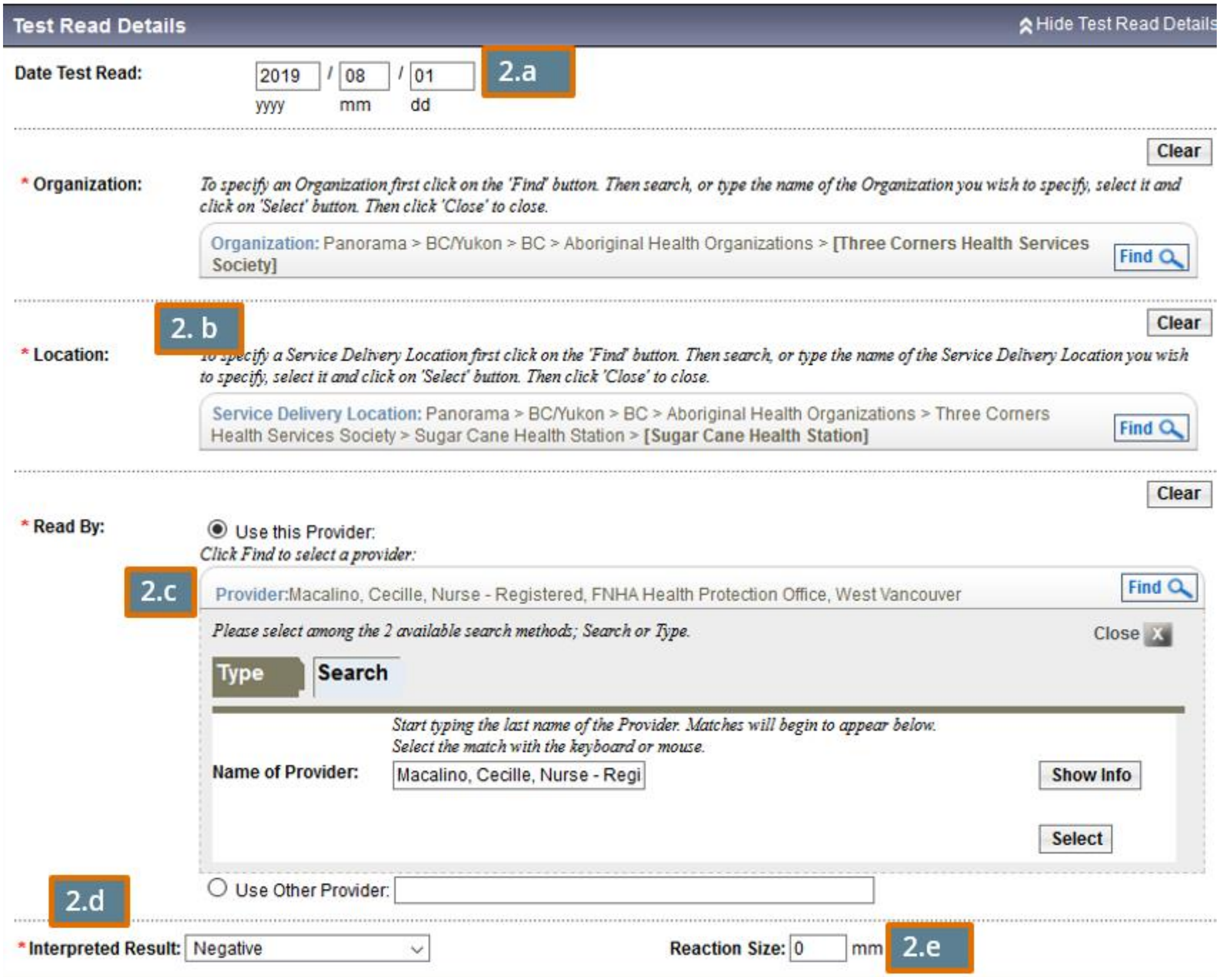


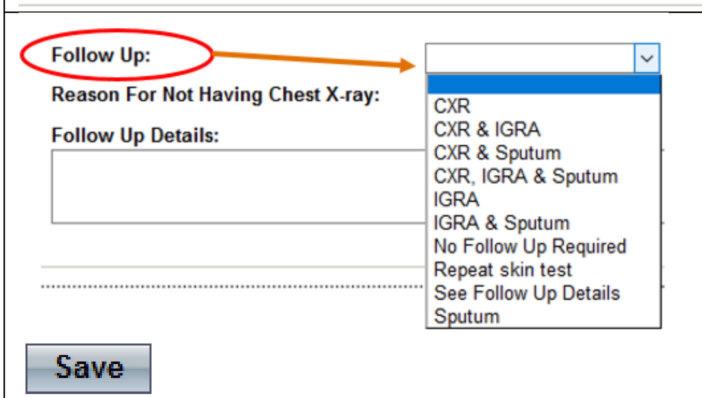
TB Skin Test – READ

To return to your TB Skin Test, have your **Subject/Client** and **Investigation** in context:

LHN > Investigation > Treatments & Interventions > **TB Skin Test Summary**

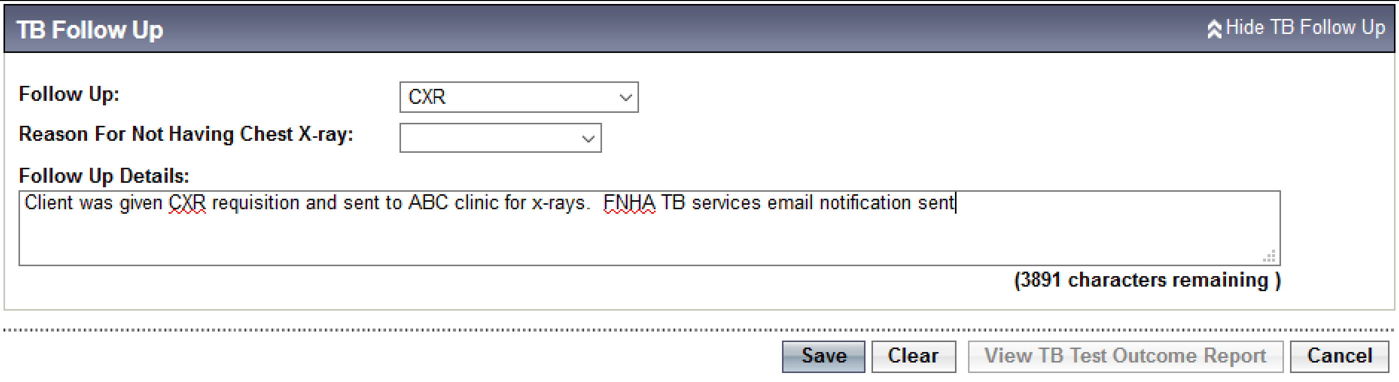
1. In the *TB Skin Test and Follow Up Summary* section, use the radio button **(❍)** to select your TB Skin Test from the table and select **VIEW/UPDATE**.
2. Scroll down to the *Test Read Details* section
   a. Enter *Date Test Read*
   b. *Organization* and *Location/SDL* will default to your Organization (can be changed)
   c. *Read by* – either **FIND** yourself or another provider as the *Provider* or enter information in the *Other Provider* area
   d. Choose *Interpreted Result* from the choices in the drop down list (**see picture on left)*
   e. Enter *Reaction Size* in mm

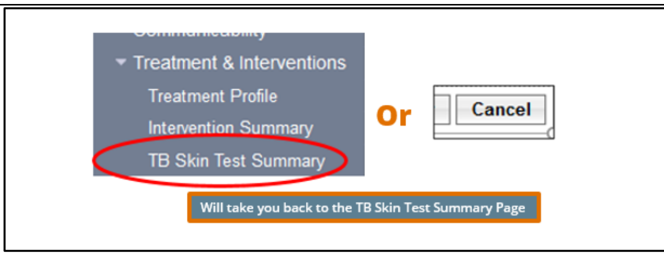




3. *TB Follow Up* section:
   a. *Follow Up*: Select from the drop down list
   b. Under the *Follow Up Details*, there is a free text field where you can add details such as:
      - *Requisition given and client sent to ABC clinic for CXR*
      - *Client given sputum containers and instructions given for collection*
4. Select **SAVE**. Notify the **FNHA TB Services** team FNHATB@fnha.ca if you have:
   a. Sent a client for CXR and/or sputum collection
   b. If they are a contact to a current known TB case

c. If they require medical review (eg. Special medication start, treatment centre requirement).

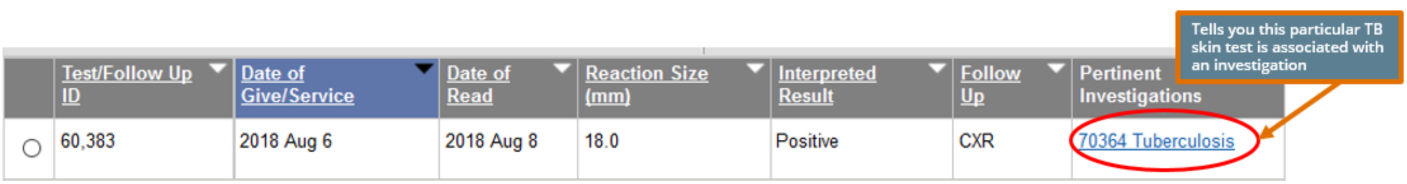




Go back to the *TB Test Summary* page (by selecting **CANCEL OR**

LHN > Investigation > Treatment & Interventions > **TB Skin Test Summary**

You will see your completed TB Skin Test in the table

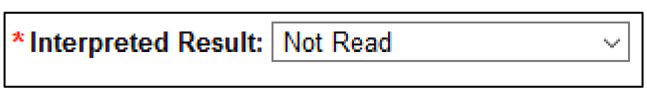


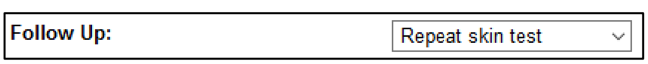
	Test/Follow Up ID	Date of Give/Service	Date of Read	Reaction Size (mm)	Interpreted Result	Follow Up	Pertinent Investigations
○	60,383	2018 Aug 6	2018 Aug 8	18.0	Positive	CXR	70364 Tuberculosis

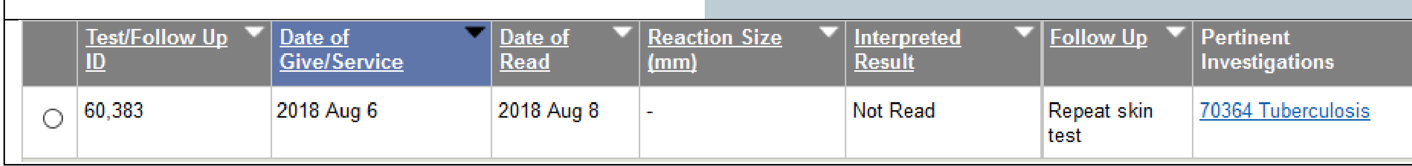
<u>Client No Show for TB Skin Test Read</u>

If your client does not attend the TB skin test read appointment, you can document as follows:

1. Complete steps **1-2c** in the **TB Skin Test Read** section of this guide
2. For *Interpreted Result*, select ***Not Read*** from the drop down menu
3. *TB Follow Up* section: select ***Repeat Skin Test*** in the *Follow Up* field. Enter notes in the *Follow Up Details* field as needed.
4. **SAVE** your work. When you go back to the TB Test Summary page you will see your no show appointment in the table

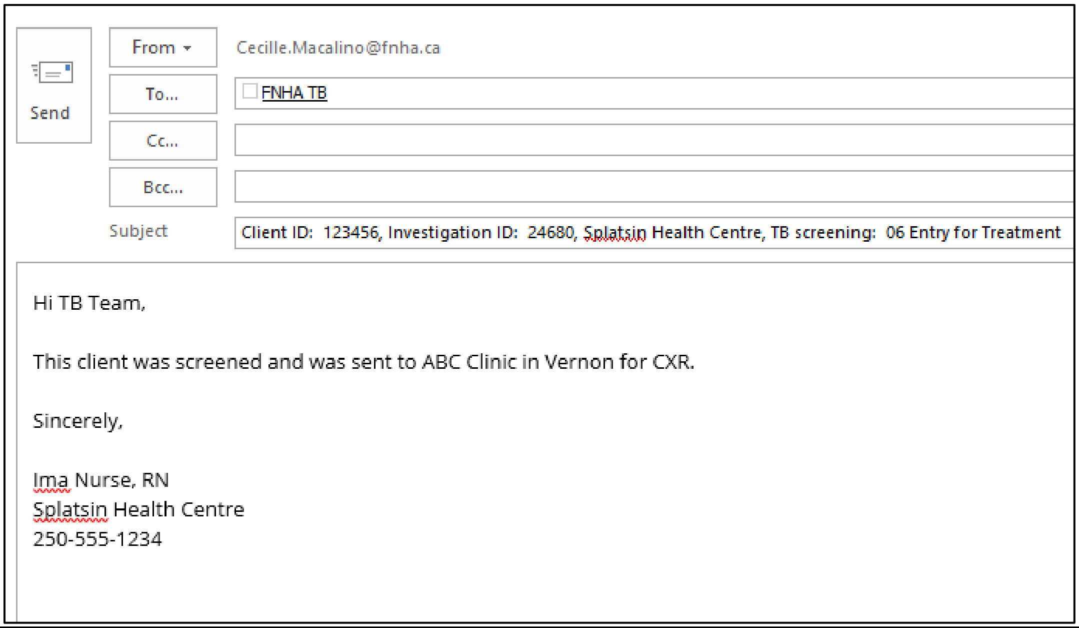






	Test/Follow Up ID	Date of Give/Service	Date of Read	Reaction Size (mm)	Interpreted Result	Follow Up	Pertinent Investigations
○	60,383	2018 Aug 6	2018 Aug 8	-	Not Read	Repeat skin test	70364 Tuberculosis

Notify FNHA TB Services by phone or email FNHATB@fnha.ca if client follow up is needed. AT THIS POINT YOU WILL WAIT TO GET X-ray RESULTS/ RECOMMENDATATIONS. You will be contacted by FNHA TB Services if further information is required or if there are physician recommendations from BCCDC.



Send
From ▾ Cecille.Macalino@fnha.ca
To... FNHA TB
Cc...
Bcc...
Subject Client ID: 123456, Investigation ID: 24680, Splatsin Health Centre, TB screening: 06 Entry for Treatment

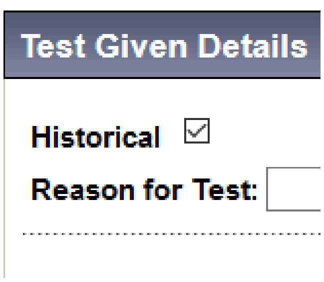
Hi TB Team,

This client was screened and was sent to ABC Clinic in Vernon for CXR.

Sincerely,

Ima Nurse, RN
Splatsin Health Centre
250-555-1234

Please Note: Historical entries are meant to be used for TST entries where information about the client TST is unknown or incomplete. Vaccinations given by Panorama users should not be entered as historic immunizations.



Entering a Historical TST

Historical TST entries are meant to be used when information about a client TST is unknown (ie. Unknown lot number, site, route, provider, organization, SDL). Two examples where a TST may need to be entered as historic:

1. Transfer of a TST entry from a paper chart into Panorama and the provider, lot number, site, or route is not known.
2. Client has record of TST given from outside of the province and the provider, lot number, site, or route is not known.

To enter a historical TST in Panorama you will need to check off the checkbox ☑ next to historical in the ***Test Given Details*** section.

Encounters

Encounters can be automatically, or manually created.

An encounter represents a point of service between a client and healthcare provider for any type of service (eg. Clinic visit, home visit, telephone consult, etc).

Automatic Encounters

Panorama automatically creates an encounter for:

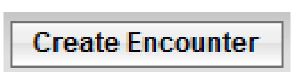
- Administered Immunizations
- AEFI (Adverse Event Following Immunization)
- Special Considerations
- Entry of Lab Results/Diagnostic Imaging Results
- Entry of TST
- Interventions

Eg. You can create a manual encounter to document a phone call or visit regarding immunization that did not include administration of a TB Skin Test.

Manual Encounters

Users can manually create encounters for the following:

- Clinic/ Home/ Outreach/ Street/ Workplace visits
- Telephone assessments with the client/guardian
- Case conferences – Contact between multiple healthcare providers about a specific client
- Counselling/education, provision of care, medication administration/ management, screening, etc.

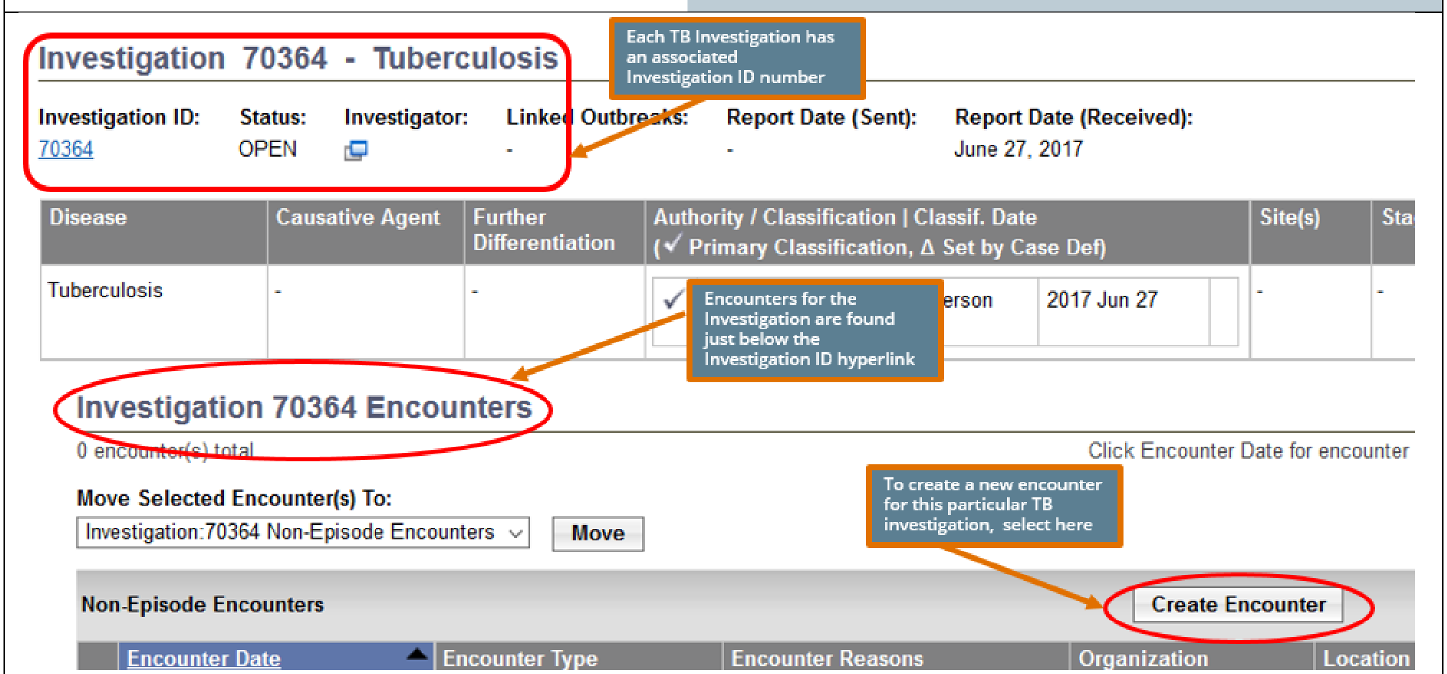


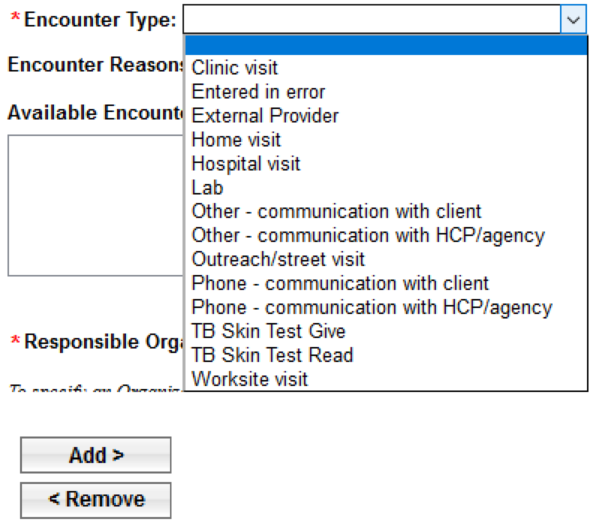
Creating a Manual Encounter

With your **Subject/Client** and **Investigation** in context:

LHN > Investigation > **Subject Summary**

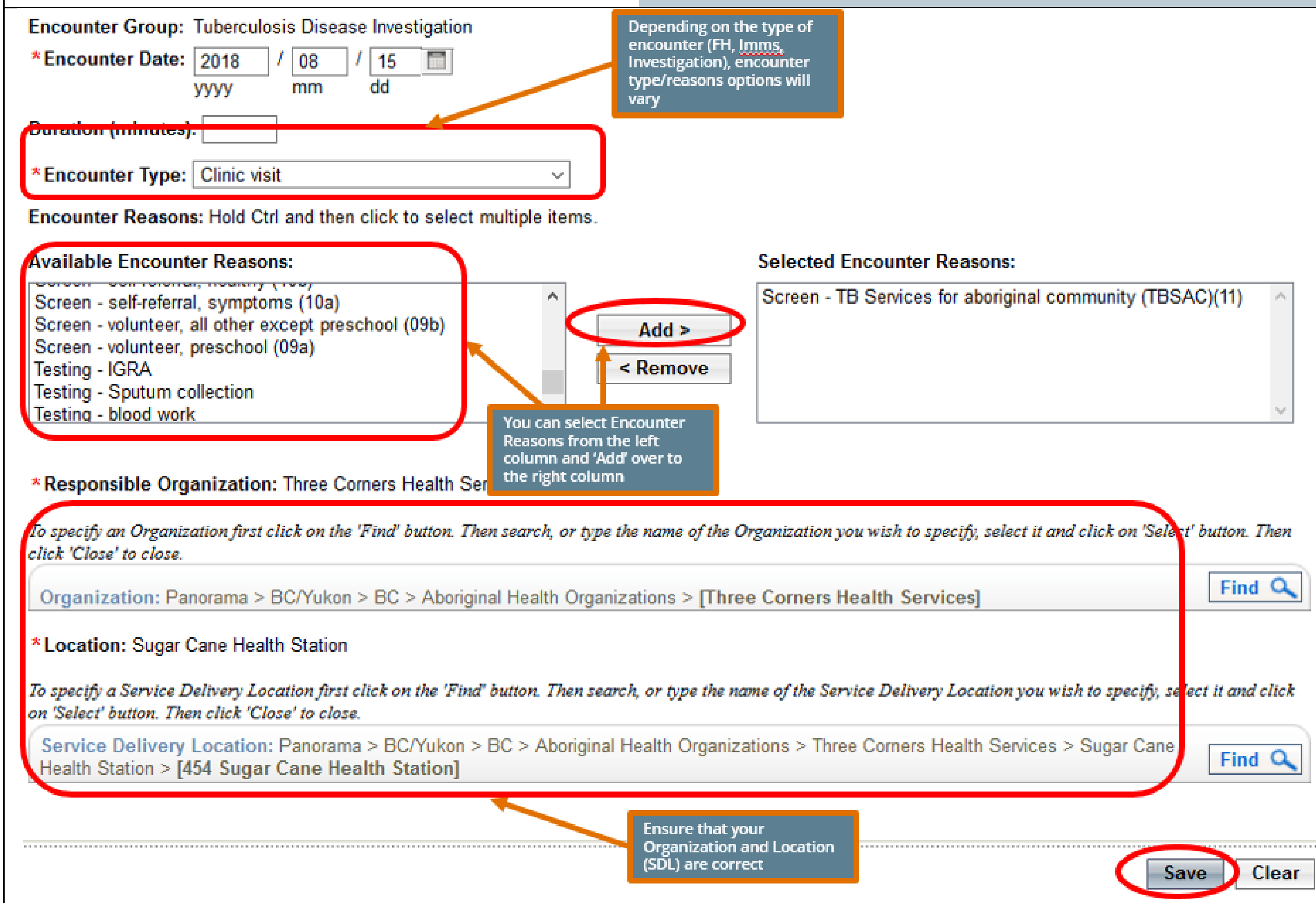
1. You will be taken to the *Subject Summary* page. Choose **CREATE ENCOUNTER** from the associated TB Investigation.



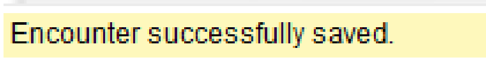


Note: Do not use encounter reasons that are labeled ***(YK Only)***. Those are only to be used by Yukon Panorama users.

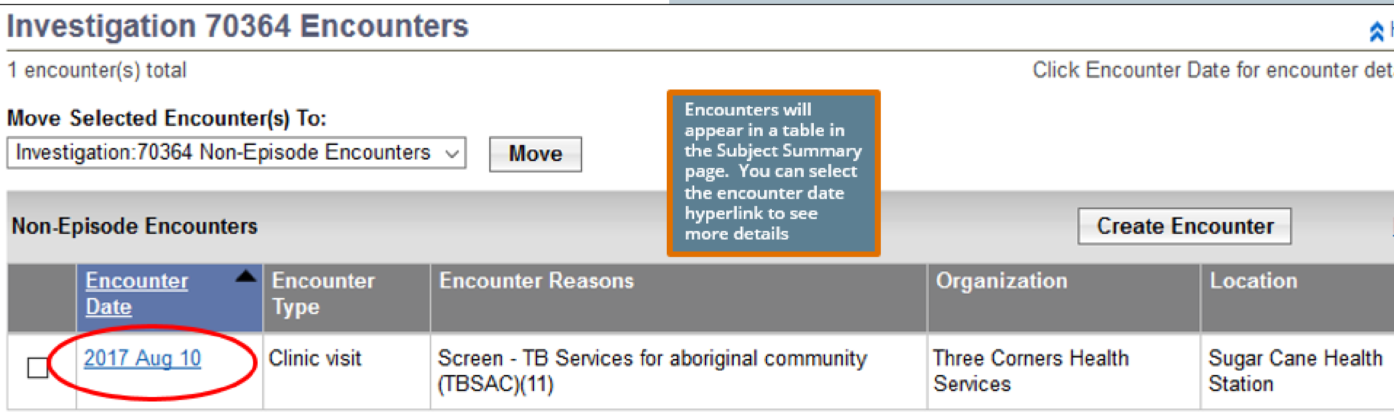
2. The *Create Encounter Details* page appears. Complete the fields:
   a. *Encounter Date:* The date will default to today's date. This can be backdated
   b. Enter the *Duration (minutes):* This field is optional
   c. Choose *Encounter Type* from drop-down menu. See photo on left for options for the Encounter Type
3. *Encounter reasons*: Depending on the encounter type you select, the options for the encounter reasons will vary. You can select and **ADD/REMOVE** encounter reasons as needed.
4. Ensure *Responsible Organization* and *Location* (SDL) are correct.
5. **SAVE** your work

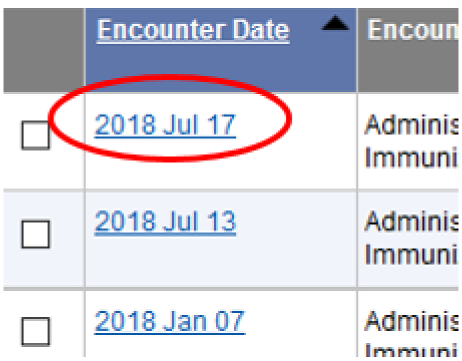


You will receive an *"Encounter successfully saved"* message on the top of the page. The encounter page will refresh and will allow you to add notes (Please see **Notes** section).



When you return to the *Subject Summary* Page, you will now see your created encounter on the table.





Viewing Encounters

The *Subject Summary* screen lists all Investigations and Encounters that have been recorded for a client under the various Encounter Groups.

With your client in context:

LHN > Investigation > **Subject Summary**

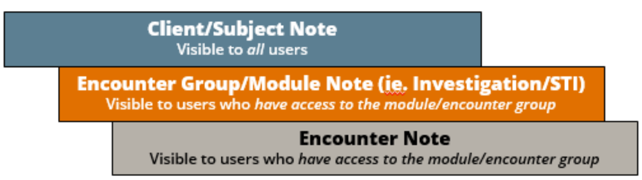
Scroll down to the Investigation and encounter you wish to open. Select the hyperlinked encounter date of the encounter you wish to open

Notes

You can quickly see and access client notes by checking if a *Notes* hyperlink exists on the top left hand corner of the client banner. When selected, this will take you to the *Clinical Notes* screen. For more information, please refer to the **Core Data Entry Guide**

It is very important users are aware which 'level' is in context when a note is created to ensure encounter group protection is maintained. Diligence in attaching Clinical Notes to the appropriate level will help facilitate having the clinical data available to the clinician in a consistent way.

Note Levels



Notes can be created at the **Client/Subject or Investigation** level (eg. A Note needs to be created with both the Client and Investigation in context to associate (ie. Attach) that note with the investigation rather than at the general client level). Notes are visible to users based on their roles and permissions (eg. A user who does not have access to Investigations module will not see any notes associated to Investigations or Outbreaks).

Viewing Clinical Notes

1. If clinical notes exist for your client and with your client in context:

LHN > **Notes**

Or

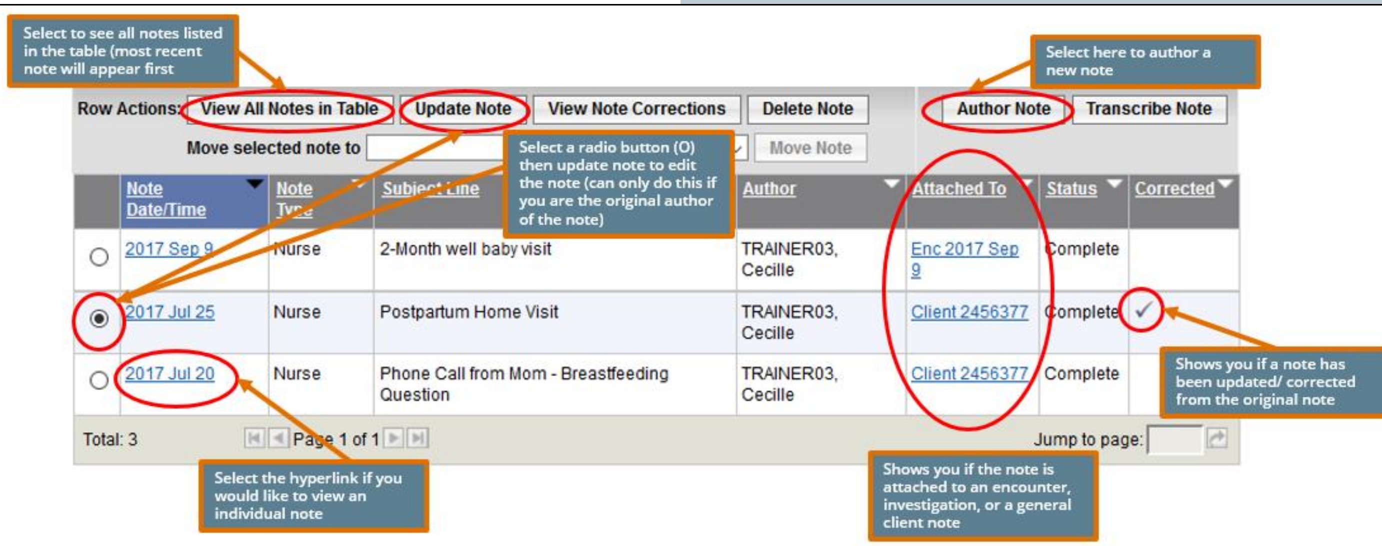
Select the ***Notes*** hyperlink on the top left corner of the client banner

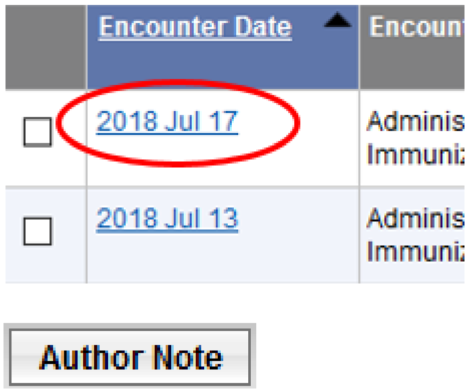
2. The Clinical Notes Page will load and show a table of all clinical notes for the client

You can select the **VIEW ALL NOTES IN TABLE** button in the *Row Actions*. All notes will appear starting with the most recent notes first

Or

To open a specific note, select the hyperlink with the note date/time. The note will appear below the table





Viewing Note Corrections

*Please see the Core Guide for details

Creating a Client Level Note

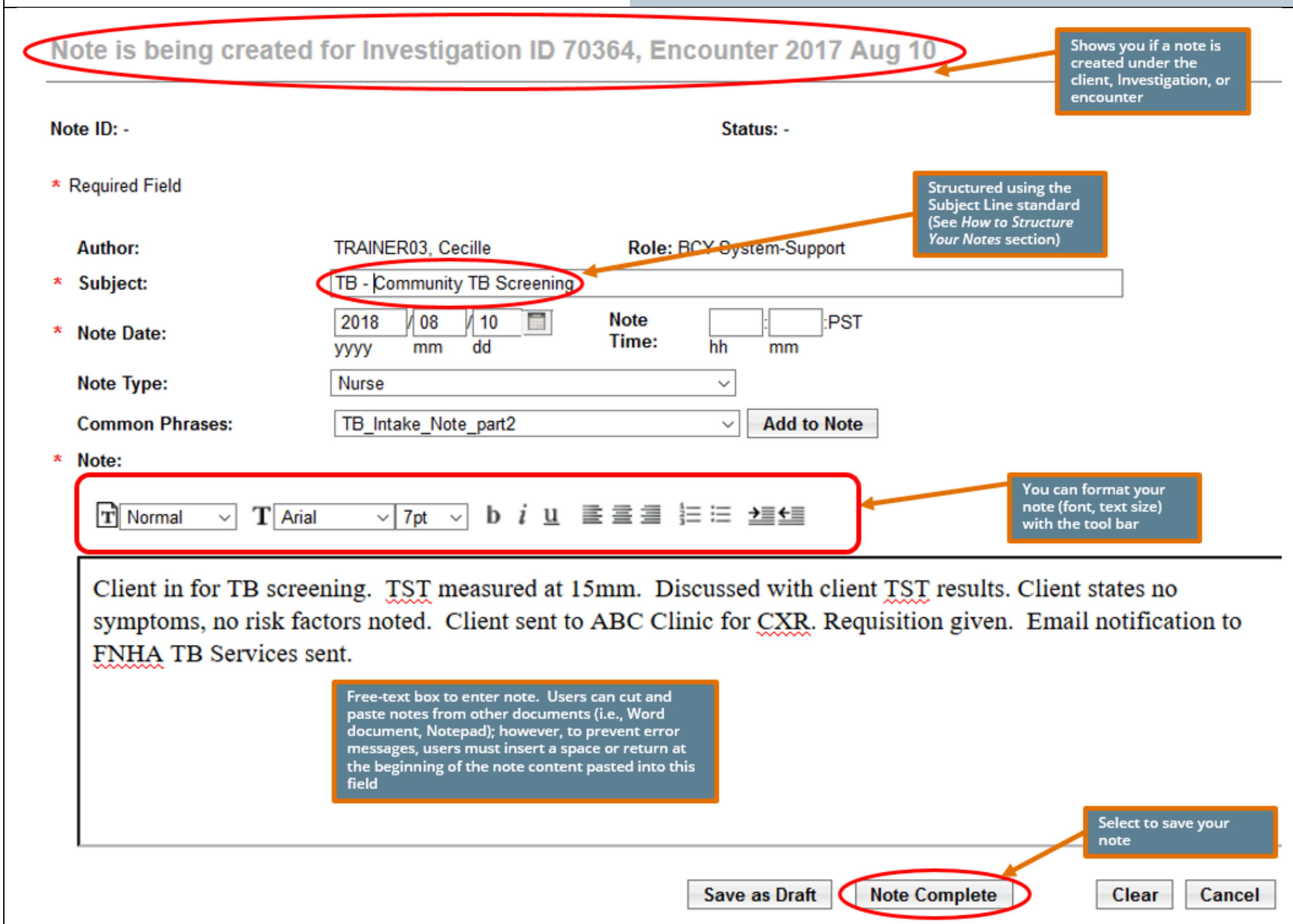
*Please see the Core Guide for details

Adding a Note to an Encounter

You can add a note to an existing encounter. With your client in context:

LHN > Investigation > **Subject Summary**

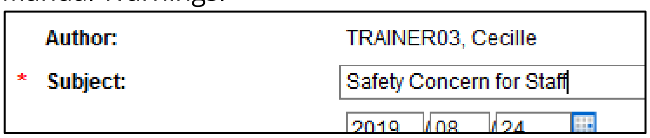
1. Encounters will be listed in a table.
2. Choose the hyperlink date of the encounter you wish to add a note to. You will be taken to *the Encounter Details* page.
3. Scroll down to the Notes section of the page. Select, **AUTHOR NOTE**
4. Enter your note and select **NOTE COMPLETE** to save



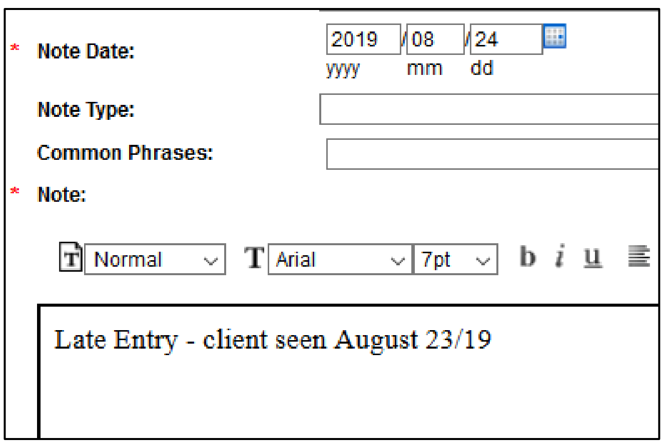
Attaching Clinical Notes to the appropriate level will help facilitate having the clinical data available to the clinician in a consistent way. Standard note structures will also organize notes that will allow clinicians across all authorities to communicate consistently.

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

Manual Warnings:



Late Entries:



Uploading a document into client notes

** Please see the [Advanced Checklist-*Uploading a document into Panorama*]

How to Structure Your Notes:

Note Subject Line

Enter the note subject line in the following standard:

[Encounter Group Prefix] – [Note Description]

Eg. **FH** – Breastfeeding visit with mom and baby

Eg. **IMM** – 6-Month Immunization

Eg. **TB** –Annual Community TB screening

Manual Warnings

If entering a manual warning, the associated note subject line should use the same wording. See **Warnings and Alerts** section in the **Panorama Core Guide**

Eg. *Safety Concern for Staff* as the subject line

Late Entries

Start the body of the note with "Late Entry" and the actual date and time the service/visit was provided

Closing Investigations

If you are unsure if you should be closing a client Investigation, please contact FNHA TB Services fnhaTB@fnha.ca

Negative TB screens with no follow-up required can be closed by the CHN. FNHA TB Services or the BCCDC will be responsible for closing all other TB Investigations.

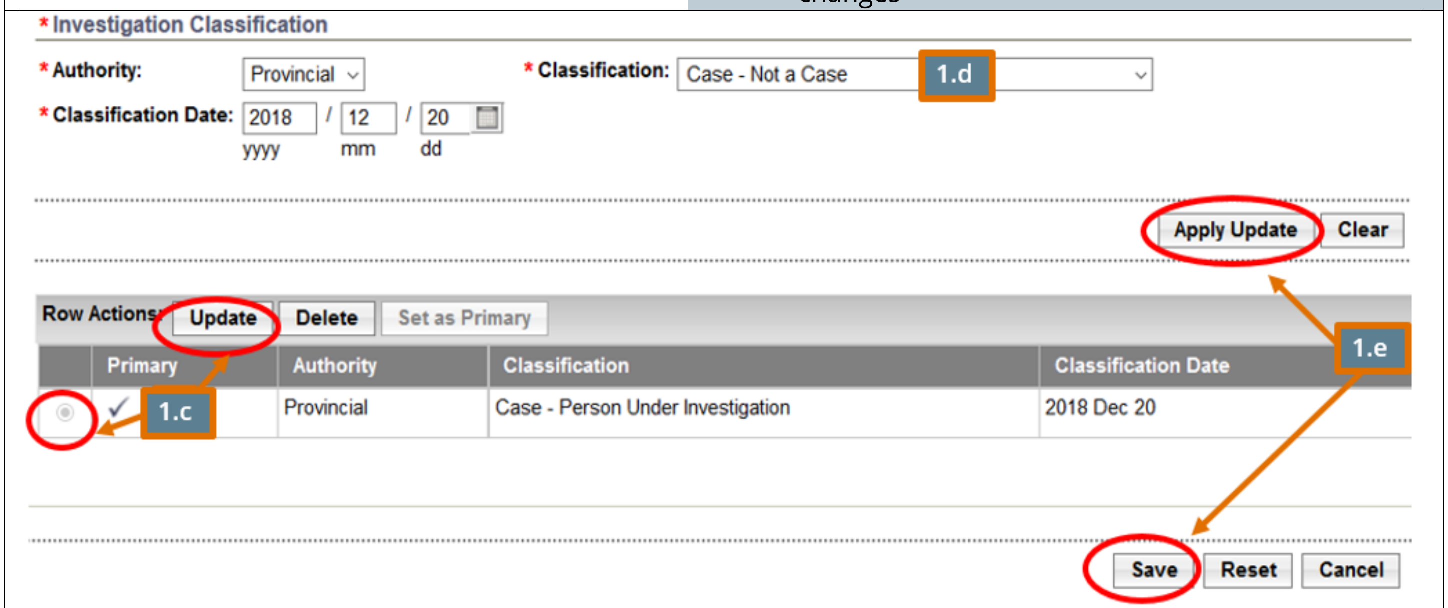
Closing an Investigation

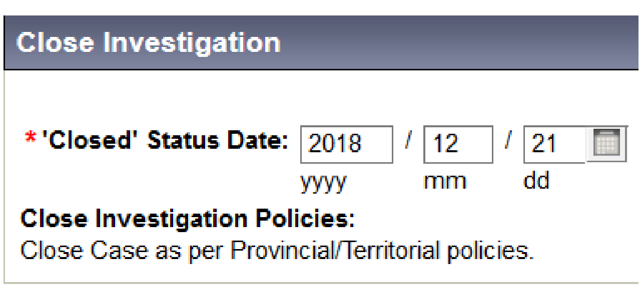
1. Change Disease Classification

With the **Client/Subject** and **Investigation** in context:

LHN > Investigation > Investigation Details > **Disease Summary**

a) Select **UPDATE**
b) You will be taken to the *Disease Even Details* page. Scroll to the table at the bottom of the page.
c) Select the radio button **(❍)** next to the classification and select **UPDATE** from *Row Actions*. The information from the selection will populate above the table where you can edit the information.
d) Change the Classification field to ***Case – Not a Case***
e) Select **APPLY UPDATE** then **SAVE** to save your changes

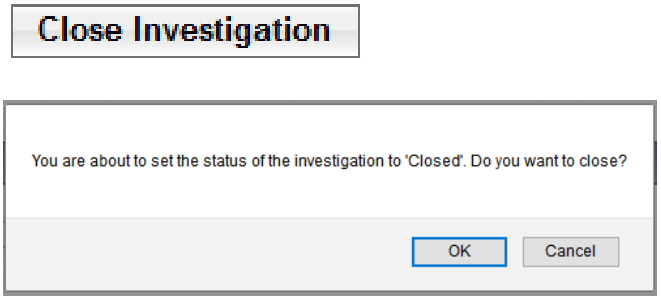




2. Close Investigation

LHN > Investigation > Investigation Details > **Close Investigation**

a) The *Close Investigation* page will open.
b) The *Closed Status Date* field will populate to today's date and can be changed as needed.



c) Select **CLOSE INVESTIGATION**. You will get a warning asking are you sure you want to close. Select **OK**

You will get a confirmation that your Investigation is closed. The Investigation ID banner will also now note that the status is now set to Closed. This will also be noted when you go to the client's Subject Summary page in the Investigation Module

Reopening a Closed Case

Please contact **panorama@fnha.ca**