BloodSTAR User Acceptance Testing Nurse Scenarios

This document guides you through a set of common scenarios in the BloodSTAR system. Use this document to conduct structured testing, before undertaking a period of self-guided discovery.

Remember you can provide feedback throughout your testing by clicking the **Feedback** button at the top right corner of each page.

Logging In

For the purposes of testing you will use a web address specific to our user acceptance testing environment.

1.   Enter the address into your browser.

   https://test.blood.gov.au/UAT/BloodStar/

   You will be directed to the BloodPortal login screen.

2.   Enter the provided username and password and click Log In

   If you are a registered user of other NBA systems do not enter your regular BloodPortal login details. You will not be able to access the UAT environment with these credentials.

   You will be directed to a page where you can select your role and facility.

Your Home Page – Authorised Patients at Facility

When you begin your testing you will arrive at the your Home Page which displays all of the currently authorised patients at your logged in facility. You can return to this page at any time by clicking on the BloodSTAR logo or the **Home** menu item.

You can use the filtering options at the top of the page to refine the list of patients or to locate a specific patient at your facility.

Patient Record

There are a number of different ways that you can access a patient record.

Scenario: Accessing a patient record from Authorised Patients list

1.   Click the patient's name from the **Authorised Patients** list of the Home Page.

The patient record will be displayed. See below for details of the patient record.

Alternative Scenario: Accessing a patient record by searching

* Before executing these steps note down some patient details from the home so that you have some patient details to search for.

1.   Select **Search** from the **Patients** menu at the top of the page.

2.   Enter some search criteria and click search (see below for details on Search Scope).

3.   If results are returned, select **View** to display the patient record.

4.   The patient record will be displayed.

What is Search Scope?

Due to requirements of the Australian Privacy Principles and privacy legislation in individual states and territories BloodSTAR must only display patient information to users who have a valid need to access this information. Any user searching for a patient must constrain their search to the minimum search scope to avoid returning records that are unlikely to be the patient for whom they are searching.

Select the Search Scope to search that is most likely to return your search. For example if you are searching for a patient who receives treatment at your logged in facility, you should select the Search Scope Patients at [Facility Name].

If you select a search scope that is broader than which your role would normally be expected to have access to, you will be required to select a reason for selecting this search scope.

As you work through the system if your attempt to view a patient record for a patient that you would not normally have need to view, you will also be prompted to provide a reason.

The information in the system about a patient is deliberately limited. BloodSTAR is not a clinical registry of patients but is a system for gaining authorisation to access government funded immunoglobulin products.

Facility Identifiers

Facility Identifiers are the MRNs or URNs or other identifiers given to a patient at a facility. We use the generic term Facility Identifier recognising that different facilities refer to this identifier by different names. A patient may be a patient at multiple facilities. You can add a facility identifier for each of those facilities.

A facility identifier is made up of two parts:

- the facility; and
- The Patient ID (MRN, URN, etc).

In jurisdictions where the same identifier is used across all hospitals you should still add a facility identifier at each of the hospitals that the patient is receiving treatment. Failing to record these identifiers at each facility will limit access to the patient record due to privacy controls.

Facility Identifiers can be added to a patient record throughout the system as well as from the patient record.

Do not prescribe

Do not prescribe advisories can be added to a patient record by a medical officer when they recommend that a patient is not prescribed a nominated immunoglobulin product.

The system will use these advisories during the authorisation processes to alert prescribers and authorisers in order to avoid authorising a product that may be inappropriate for a patient.

Note that this functionality is not an adverse events register.

Authorisation Requests

The list of authorisation requests shows the history of authorisation requests made in the name of the patient.

Privacy Consent Records

All patients recorded in BloodSTAR are required to have provided their consent to the collection, retention and use of personal information. The consent records table shows the history of a patient's consent.

The patient's current privacy consent status is based on the latest consent record.

On withdrawal of privacy consent, any existing Authorisations in the patient's name will be immediately terminated and the patient will no longer have access to immunoglobulin treatment under the national blood arrangements.

Frequently Asked Questions

How do patients get into BloodSTAR?

Patients are only entered into BloodSTAR if they the subject of an authorisation request as such, the patient record can only be created at the time that a medical officer is submitting an initial authorisation request.

How can we avoid creating duplicate patients?

During the patient creation process (while entering an authorisation request) the system will identify potential duplicates and prompt the prescriber to check that the patient is the same person.

A secondary administrative process will be undertaken periodically to manage duplicate patient records. This process will include liaison with the patient's clinical team to ensure that data is maintained correctly.

How does the system protect patient privacy?

We will maintain the privacy of the patient by only allowing users who need the information to see the information. Generally as a medical officer or nurse you will be able to see patients in the system who are receiving treatment at the Hospital or Treatment facility at which you are logged in as well as patients at other facilities that you have treating relationship. This approach aims to balance the right to privacy of patients with the realities of shared care scenarios and aligns to the scope of information visibility in other in-hospital systems.

Adding a Facility Identifier (MRN, URN, etc) at your facility

The BloodSTAR system will always work best when data is complete and accurate. As such we encourage users to update data as they work. There are multiple ways that you might add a patient identifier for a patient at your facility. Some of these ways are:

- During the patient creation process, an identifier can be added
- Selecting **Add Facility Identifier** from the Patient Record and completing the form; or
- Where patient details are displayed in other parts of the system, if there is no patient identifier for the facility, a link is available to add an identifier.

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DOB: 27-Mar-1969		month.

Scenario: Adding a patient Identifier to a displayed patient

Where the system displays patient details but there is no patient identifier recorded for the facility, a link is available to add one.

1. From the Authorised Patients List select **+ Add MRN** against a patient that does not have one. (Note if all of the patients at your facility have patient identifiers you will not be able to complete this scenario.

2. Enter the patient identifier and click **Save**

The patient's record will be updated with a patient identifier for your facility and the Authorised patients list will be updated to display this data.

Note: There may be other UAT participants using the system and logged in at the same facility. As such, other participants may have already added identifiers to all patients.

Note: the patient identifier label (MRN, URN etc) will be configured according to your facility.

The Authorisation Record

The authorisation record is the place in BloodSTAR which displays authorisation status of a patient and details exactly what the patient is authorised for.

Scenario: Viewing an Authorisation Record

1.	From the **Authorised Patients** list (your homepage) click the Authorisations Number link for one of the patients on the table.

The authorisation record will be displayed.

Note: *In most places throughout BloodSTAR where an Authorisation Number is displayed you can click the link to display the authorisation record.*

Patient Details
The patient details panel summarises the identifying details of the patient.

In the screen shot above that this patient has been entered to the system without an MRN. The system provides you with the opportunity to add one by clicking the link.

Authorisation Details
The authorisation details tab sets out for which medical condition and indication the patient is approved for immunoglobulin treatment, the dosing regimen, the authorisation end date and the Treatment arrangements (which facilities are involved in the treatment)

Treatment Plan

The Treatment plan sets out the planned treatment episodes as forecast by the system at the time of approval. Over the course of the authorisation the treatment plan will be updated to display the quantities of product dispensed for each treatment and planned dates will be updated in order to ensure that the approved interval between doses is maintained.

Editing an Authorisation Record

The ability to edit an authorisation record is tightly controlled as most attributes of an authorisation must be approved by an Authoriser.

The patient's medical condition, indication and dosing regimen cannot be changed without the submission of a new Initial Authorisation Request (for medical condition and indication) or dose change request (for dosing regimen). These requests must be submitted by a medical officer and approved by an authoriser. Once approved the authorisation record will reflect the change.

An authorisation record can be edited in order to update the Treatment Arrangements (Treating, Administering and Dispensing Facilities) or to transfer the care to another Treating Specialist.

Editing of an authorisation is limited to doctors and nurses working at the patient's current treating facility.

Scenario: Transferring Care to a different specialist

1.   From the Authorisation Record, select **Edit**.

2.   When the Edit Authorisation page is displayed select **Change Treating Medical Specialist** in the Treating Medical Specialist panel.

3.   When the Select Treating Medical Specialist dialog is displayed start typing the specialist's name and when the correct specialist is displayed, select the desired specialist.

4.   When the selected specialist's facilities are displayed, select the facility at which you expect the specialist to treat the patient.

5.   Enter some notes to the current specialist to explain why the patient has been transferred to a different specialist.

6.   Click **Save**.

The system will update the Treating Specialist for the authorisation and will send a notification to the specialist with the notes entered in step 5.

Scenario: Updating the Treatment Arrangements

1.   From the Authorisation Record select **Edit.**

2.   When the **Edit Authorisation** page is displayed select new Treating, Administering and/or dispensing facilities.

3.   Click **Save.**

The patient's treatment arrangements will be updated in the authorisation record.

This patient will no longer be displayed on the Authorisation Patients at the current facility. They will now appear on the Authorised Patients list for users logged in at the new Treatment facility.

Treating, Administering and Dispensing Facility

The BloodSTAR application uses some specific terminology for Facilities

Facility – A place at which immunoglobulin a related function may take place. This activity may be Treatment, Dispensing or Authorising.

We use the generalised term of facility as a single facility may perform multiple functions and facilities may take many different forms such as a hospital, a medical centre, a practitioners private rooms, a defence facility, a correctional facility, etc.

Treating Facility – The facility at which a patient's treatment will be managed. This may differ from the facility at which infusions are administered.

Administering Facility – The facility at which immunoglobulin infusions are administered. This may differ from the facility at which the treatment (and the authorisation) is normally managed.

Dispensing Facility – The facility from which it is anticipated product for a given authorisation will be normally dispensed.

A full list of definitions used in BloodSTAR and the National Policy is available at available via www.blood.gov.au/bloodstar or directly at Definitions.

Requesting Product for Infusion - Planning Sheets

BloodSTAR provides nursing staff with functionality to order immunoglobulin product from the dispenser for patients who are scheduled to receive infusions.

The planning sheet functionality replaces the paper planning sheets that are currently used in many jurisdictions. The use of a planning sheet will provide assurance to dispensers that the requested dose is within the constraints of the authorisation.

Note: the use of the Planning Sheet functionality should be discussed with the dispensers that provide products to the facility to determine the appropriateness of this solution.

Scenario: Creating and Submitting a Planning Sheet

1.   From the **Treatment** menu select **Create Planning Sheet**.
        Enter a name for the planning sheet (remember to create something unique but meaningful and select the dispenser that you wish the request to be sent.

2.   The empty planning sheet is displayed ready to add patients.

3.   Select **Add Patient**.
        A list of authorised patients at your facility is displayed.

4.   Filter the list to find the patient that you wish to add to the planning sheet.

5.   Select the patient that you wish to add to the planning sheet.
        The Add Dispense Request dialog is displayed, showing brief information about the authorisation and the next dose that the patient is planned to receive. If there are two approved dose types (for example a Loading Dose and a Maintenance Dose) you may see both doses.

6.   In the **Add Dispense Request** dialog, select the dose or doses that you wish to add to the planning sheet.
        The doses displayed are the doses that have been approved. You may edit the dose however if you request a dose that is outside the constraints of the authorisation you will be required to enter a reason to justify this request.

7.   Select **Add.**
        The requested dose is added to the planning sheet.

8.   Repeat steps 4 – 7 as required, adding other patients to the planning sheet.

9.   Once all required patients have been added click **Close** to close the select patient dialog.
      The planning sheet is displayed and is ready for submission.

10.   Click **Submit**

The planning sheet will be submitted to the nominated dispenser who will receive the planning sheet in their BloodNet system.

The infusion plan for each patient on the planning sheet will be updated to show that the next dose has been requested.

Note: Dispensers are responsible for ensuring that product is dispensed in accordance with the authorisation.

Alternate Scenario: Requesting a dose that greater than the approved dose

1.   Follow steps 1 to 5 in the scenario above.

2.   After selecting a dose, edit the dose quantity to a figure greater than the defaulted value.
      The system will prompt for you're a reason for requesting a dose greater than the approved quantity. The system will also prompt for a reason if you request a different product, or are requesting the product for infusion prior to the planned date.

3.   Enter a reason for requesting an unauthorised dose.

4.   Continue the steps in the scenario above.

On submission of the form, the notes entered into the reason fields will be included in the request to the dispenser. As the dispenser is responsible for ensuring that product is dispensed in accordance with the authorisation, they may use your notes to justify dispensing the product as requested.

Frequently Asked Questions

How do I request product if I don't use the Planning Sheets functionality?

You may request product in whatever way suits your dispenser and meets with any local policy or regulatory requirements.

Where requests are received by a dispenser outside BloodNet, the dispenser will need to check the authorisation status of the patient, and check that the requested doses is within the authorised dose quantity and that the interval since the last dose is not shorter than the approved interval.

Adding the authorisation Number for the patient to a request outside the system will be a significant help to dispensers in checking authorisation and will help them to provide you with timely service.

How far in advance do I need to request product from the dispenser?

These timeframes should be negotiated with your dispenser.

The implementation of BloodSTAR does change the supply and inventory processes for most dispensers. As such dispensers may have new requirements for the timeliness of requests.

The implementation of BloodSTAR/BloodNet does not change the need for nurses and dispensers to communicate regarding optimal business processes.

What happens if I need a dose that is outside the constraints of the authorised dose?

You may still submit a request on a planning sheet. However it is advisable to provide a justification for this need so that the dispenser can consider this in determining whether the request should be fulfilled.

After product is dispensed

When product is dispensed, the BloodNet and BloodSTAR systems work together to link the dispense event to the infusion on the infusion plan.

Infusion Plan

This infusion plan does not constitute a prescription for immunoglobulin products.

Sequence	Dose Type	Approx Date	Product	Dose	Date Required	Dispensed	Status
1	Induction Dose	29-Jan-2016	Intragam P	177.00 g	29-Jan-2016	Q 180.00 g	Dispensed
2	Maintenance Dose	05-Feb-2016	Intragam P	36.00 g			Planned
3	Maintenance Dose	04-Mar-2016	Intragam P	36.00 g			Planned
4	Maintenance Dose	01-Apr-2016	Intragam P	36.00 g			Planned
5	Maintenance Dose	29-Apr-2016	Intragam P	36.00 g			Planned
6	Maintenance Dose	27-May-2016	Intragam P	36.00 g			ned
7	Maintenance Dose	24-Jun-2016	Intragam P	36.00 g			

Dispensing Details

Date	Type	Dispenser	Product	Qty
28-Jan-2016	Dispensed	Tidy Town - Pathology	Intragam P	180.00 grams

Close

What's Next?

Now take some time to explore the system and try out different scenarios. Your aim here is not to try to break the system (we have a team of functional testers with this responsibility) but rather to test that the system deals with real-world scenarios that are applicable to your work.

Don't forget to provide us with your feedback as you go and take a few minutes to complete this https://www.research.net/r/BloodSTAR-NurseUAT.

Questions

To learn more about **BloodSTAR** visit the NBA website at www.blood.gov.au/bloodstar, contact support on 13 000 BLOOD (13 000 25663) or email support@blood.gov.au.