From the Office of Health Informatics

Oracle Health (Cerner) Millennium Nurse Handoff MPage

September 30, 2026

The Handoff MPage is designed to be used during shift or unit handoffs, or transfer to another unit or facility. It is also used as a quick and easy way to do a chart review when caring for new patients.

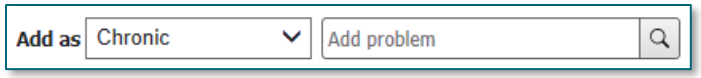
Nurse Handoff MPage

The components can be arranged by clicking the title in the navigator and dragging and dropping them in the order that fits an individual's workflow for chart review or report.

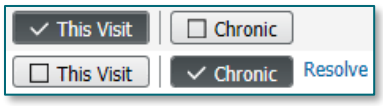
- **Reason for Visit**
  - Populated from the **Chief Complaint** documented in the Admission History Form.
- **Care Team**
  - Displays the clinical staff who have established a relationship with the patient and family members involved in the patient's care.
  - This also displays contact numbers and the provider's service.
- **Medications**
  - Displays the medications that are due in the next 12 hours.
  - Pulls in continuous fluids that the patient has running.
  - Pulls in what the patient has available for prn medications.
  - Pulls in the medications that have been administered in the last 12 hours. This is a quick method of finding out if an antibiotic was given in the ED or when the patient last had pain medications.
  - The status of the medication reconciliation by the provider displays in the upper right corner.
  - Clicking **Admission** or **Discharge** opens the provider medication reconciliation window in view only. Nurses can now see what decisions the provider made on all the medications that are documented on from home.



- **Problem List**
  - Pulls in previously documented **Problems and Diagnosis**, and crosses encounters.
  - **This Visit** is a diagnosis and cannot be used by nursing.
  - Nursing can update the problem list by using **Add as:** dropdown and selecting **Chronic**. Use the **search** box to add a new problem.
  - **Chronic** refers to any problem, whether it is new or ongoing.



- **Problems** can be resolved by clicking the blue **Resolve** link.
- **Resolved problems** can be viewed under **Resolved Chronic Problems** at the end of the **Problem List**.



- Click the problem to see more details and to modify or add comments as needed.

➢ **Health Concerns**

- Used primarily by ambulatory practices to track health concerns over multiple appointments.
- Provides a place for nursing to document general health concerns outside of the clinical problems being addressed (e.g., patient concerned about their level of fitness).
- This should only be used to document health concerns that are not covered by the problem list and/or other histories.
- Use the  dropdown to select a category. Free text in the **Description** and click **Save**.
- Clicking a documented health concern opens a box to the right, providing a location to **Resolve**, **Modify** or **Remove** the health concern. Additional details are also viewed in this box.

➢ **Goals and Interventions**

- Used primarily be Ambulatory practices to track patient goals over multiple appointments and is **not required for inpatient nursing**.
- This component is for goals and interventions across encounters whereas problem-based care plans are specific to one encounter.
- **Goals and Interventions** cross to the Patient Discharge Instructions.
- Click the  sign to open the **Goals and Interventions** window. From here you can add a **Goal** or click  to open intervention documentation fields.

➢ **Home Medications**

- Pulls in previously documented home medications and their compliance.
- Status of Medication History displays in the upper right corner. Click **Meds History** to go to Documented Medications by History.



- Click a medication to open the order details box.
- Who and when the last medication history was documented by displays below the medication list.

➢ **Histories**

- Pulls in previously documented information from the **Problem List**, **Procedure History**, **Family History**, and **Social History**.
- The **Problem List** can be updated from this component, and the other history controls are read only.

- Nursing needs to complete the **Problem List** reconciliation and click the **Complete Reconciliation** button if not completed during the admission process.



- While reviewing **Procedure**, **Family**, or **Social History**, if there are any updates that need to be made, click the **Histories** component title to open the tool to make the updates.

➢ **Vital Signs**

- Displays vital signs in column format, including Oxygen Saturations, Oxygen Delivery, Birth Weight if documented, and Dosing Weight.
- Click a value to see the associated ranges.
- Click the vital sign name to see the trend for that vital sign.
- Click the  to go to Interactive View and I&O.

➢ **Implant History**

- Pulls in previously documented implants.
- While reviewing if there are any updates that need to be made, click the **Histories** component title to open the tool to make the updates.

➢ **Clinical Notes**

- Pulls in anything under Clinical Documents, including but not limited to, Admission Notes, Progress Notes, Nursing Notes, and Consultation Notes.
- Click the note to be viewed and the reading pane opens to the right.
- Notes can be easily printed from the reading pane as well.

➢ **Assessments**

- Pulls in the most recent documentation from certain documentation fields within the System Assessments Interactive View and I&O band.
- Ideal location to see what the previous nurse documented for lung sounds, bowel sounds, pulses, cardiac rhythm, etc.

➢ **Immunizations**

- Pulls in previously documented immunizations.
- Click the  dropdown to document an immunization that was given outside of the Northern Light Health system or Chart Not Given.

➢ **Lines/Tubes/Drains**

- Pulls in documented Lines, Tubes, and Drains with location and insertion date.

- **Insertion date** needs to be documented within the dynamic group for the insertion date to pull to the MPage component.
- If the peripheral IV or Central Line dressing is overdue, the inserted date displays in red.
- Click the Line, Drain or Tube to see the most recent documentation within Interactive View and I&O.
- Inactivated dynamic groups display in the **Discontinued** section.

➢ **Anesthesia Records**

- Pulls in previous anesthesia records.

➢ **Labs Flowsheet**

- Pulls in lab results in column formatting.
- Click a value to see the ranges.
- Click the lab's result name to see the trend for that lab.

➢ **Imaging**

- Imaging tests that have been ordered for the patient display here.
- Clicking the imaging name opens results in a separate window.

➢ **I&O**

- Pulls in documented intake and output for a 24-hour period.
- Identifies where the intake and output came from.
- Select **View Details** to see the calculated fluid balance.

➢ **Microbiology**

- This is where you would see any microbiology orders.
- Select the component title or go to Results Review to see additional information on these orders such as any antibiotics they are on.

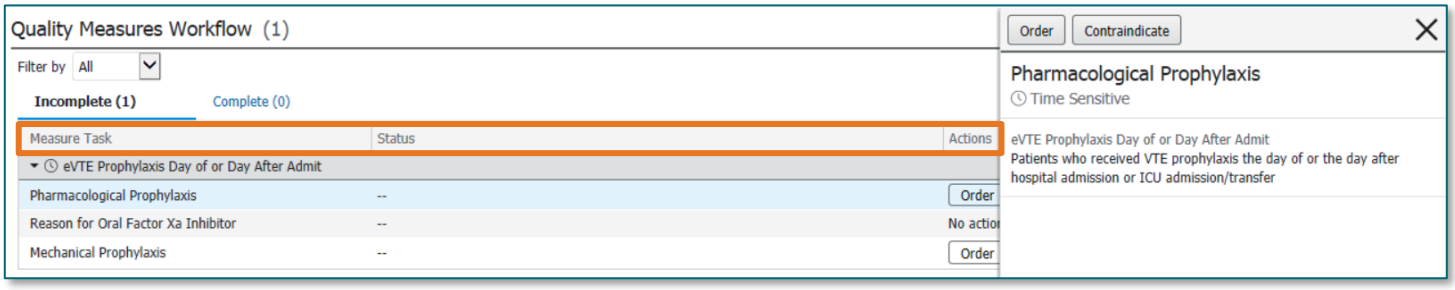
➢ **Pathology**

- This is where you would see any pathology orders.
- Select the component title or go to Results Review to see additional information on these orders such as identifying disease, injury, or abnormal changes.

➢ **Outstanding Orders**

- Pulls in orders that have not been completed.
- Click the order to open the additional details window.

- **Quality Measures Workflow**
  - Information populates here if the patient has any Quality Measures, like a diagnosis of stroke or VTE.
  - This contains Measure Tasks that should be ordered or documented on the patient based off the Quality Measure defined, as well as the Status of that order and Actions.
  - Clicking a Measure Task opens the additional details window to the right.



  - There is also a Completed list of Measure Tasks and the corresponding Status.

- **ICU Liberation Bundle**
  - Pain Scores populate here.
- **Order Profile**
  - Quick view of the orders placed on the patient's chart.
  - Option to change orders being viewed with dropdown: All Active Orders, to All Active Meds, or All Orders 5 days back, etc.
- **Oxygenation/Ventilation**
  - Arterial, Venous, and Capillary Blood Gases are seen here.
- **Actions & Situational Awareness**
  - Only non-clinical information should be documented here.
  - This is NOT part of the legal medical record.
  - This documentation does not cross encounters.
  - Entries can be modified by the one documenting the entry.
  - This content does flow to the providers MPage via I-PASS.
  - Examples of what could be documented here: Family staying at local hotel and contact number, who is not allowed to visit, who it is okay to share information with, split family dynamics, provider returning in the next shift to speak with family, etc.
  - The actions can be used as a checklist. When entering actions, you can make it available to all or just the selected care team.

- When the action is completed or no longer applicable, the action can be removed by clicking the check box or clicking the dropdown arrow that appears on the right and selecting **Delete**.



- Comments can be added in the comment text box. Comments on the right do not necessarily match the action on the left.

➢ **Discharge Planning**

- Certain documentation by Care Managers and Nursing pertaining to discharge populate in this component.
- Examples are: Estimated Date of Discharge, Lay Caregiver, and Anticipated Discharge location.

➢ **Patient Provided Health Information URLs**

- Click the + dropdown to access the **Patient Provided Hyperlink Form** where the URL can be pasted.
- Use Ctrl C to copy and Ctrl V to paste.
- Examples of what may be added but not inclusive: Link to a site that provides information on a patient's rare condition or clinical trial, or advanced directive.

➢ **Calculators**

- This component contains calculators for equations, criteria, decisions trees, converters, and special ties as well as a search feature.

➢ **Risk Indicators**

- Pulls in Readmission and Boost Risk Indicators, as well as the date it was documented.
- Click the risk value to open the additional details window.

➢ **Scales and Assessments**

- Pulls in rating from various scales and assessments completed such as the CIWA Scale and Initial Depression Screen Score.
- Clicking the + dropdown arrow populates a dropdown list of available scales to document scores/results on.
- Clicking the name of a scale or the result opens the additional details window.

➢ **Media Gallery**

- Images captured using Camera Capture flow into this component.

- **Code Status**
  - Patients' current code status, the time and date it was entered, and any additional notes.
- **Referrals**
  - Provides view only visibility to current or historical referrals for the patient for the last three years.
- **Social Determinants Assessments**
  - Previously documented SDoH documentation.
- **Age Friendly**
  - Pulls in high level documentation from the 4M's Framework.
    - What Matters
    - Medication
    - Mentation
    - Mobility

Handoff Workflow between Oncoming and Off going Nurses

STEP 1: Nurse coming on-shift receives report from nurse going off-shift.

STEP 2: Nurses should review outstanding tasks, upcoming or overdue activities, orders, and results in our Organizer View (CareCompass, LaunchPoint, Tracking Board, etc..).

STEP 3: Access the Handoff Workflow MPage and review pertinent clinical results and documentation that occurred during that shift.

STEP 4: Review Medications component for missed medications doses and IV stop times.

STEP 5: Document nurse report given in the Nursing Handoff/Transport Communication section of any Quick View band within iView.

- Report Given, including whether the report occurred at the bedside
- Name of the person who gave and received the report
- Handoff comments as applicable
- Whether the Orders and Plan of Care were reviewed
- Lines traced when a line is present at the time of handoff; otherwise select N/A (not applicable)

NOTE: Only one nurse needs to document each handoff. Follow department or manager guidance to determine whether the nurse giving or receiving the report completes the documentation.

Handoff Workflow for Patient Transfer from Facility to Facility

STEP 1: Access the Handoff Workflow MPage and review pertinent clinical results and documentation that occurred during that shift.

- This is an easy way to report on imaging results, lab results, etc.

STEP 2: Reviewing the Medications component is a quick and easy way to report off what the patient has received in the last 12 hours and when the last dose of pertinent medications was given such as antibiotics or pain medications.

STEP 3: Document nurse report given in the Nursing Handoff/Transport Communication section of any Quick View band within iView.