2025

SystmOne for Clinical Staff

USER GUIDE

PRIMARY CARE SYSTEMS TRAINING TEAM

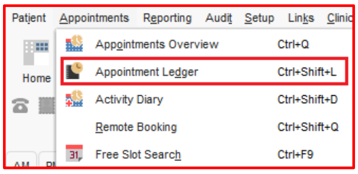
Contents

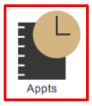
Introduction

This user guide is aimed at providing clinical staff with clear and practical instructions on how to effectively navigate and utilise SystmOne for managing patient care and data.

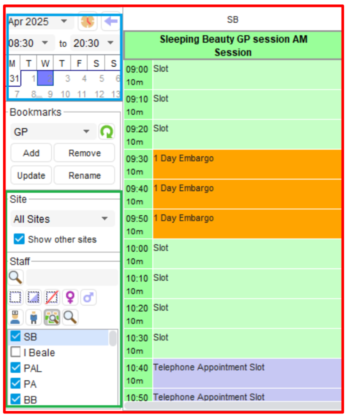
Appointments

Appointment Screen Overview





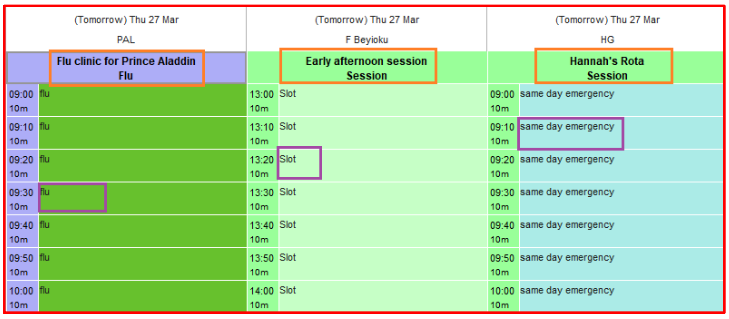
The Appointments Ledger (diary) can be accessed via the **Appointments Menu** – **Appointments Ledger** or via the **Appts** icon on the large toolbar.



The left hand column gives different filtering options (highlighted in **green**) for the main screen including site and clinician, only male or female clinician and role.

The calendar (highlighted in **blue**) in the left hand column allows you to navigate to different days and view multiple days by clicking and dragging across the days e.g. a week or all of the Thursday's in a month. Alternatively, you can hold down the **Ctrl** key on your keyboard and select the days you wish to view.

To return to today's date just click on the yellow clock above the calendar. The blue arrow next to the clock will take you back to the last set of dates you were viewing.



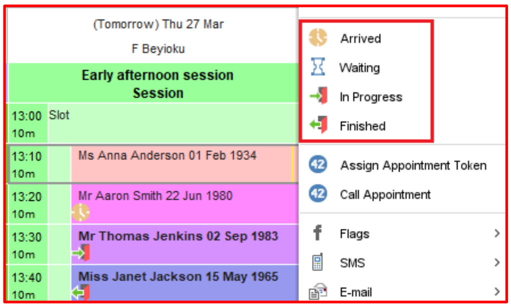
Rotas (highlighted in **Orange**) – The clinician's name and/or clinic name will appear at the top. Rota's may appear in different colours. Your practice will have their own preferences.

Slot Types (highlighted in **Purple**)– Different slot types may be shown in different colours, examples may be Book on the day, Same day embargo, telephone appointment.

Appointment Statuses

SystmOne has several appointment statuses to help clinicians and administration staff manage patient bookings efficiently.

Reception staff may mark your patients as arrived.

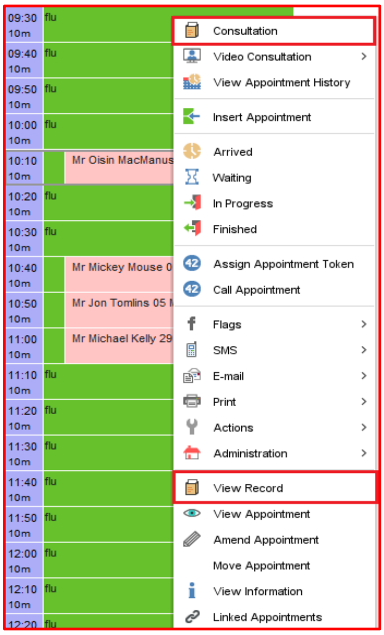


(Right click and change the status from ***Booked*** to ***Arrived*** – slot colour change from Salmon pink to Purple).

The main appointment statuses are:
Booked – The appointment has been scheduled for the patient.
Arrived – The patient has been checked in for their appointment.
In Progress – The patient is currently being seen by a clinician.
Finished – The appointment has finished.
Did Not Attend (DNA) – The patient did not show up for their appointment.
Cancelled – The appointment has been cancelled, either by the patient or the organisation.
Waiting – The patient has arrived and is waiting to be seen.

Viewing a Patient Record

A booked appointment is easy to identify, as the slot colour will be a salmon pink colour and will be populated with patient details. Hover over the slot to expand the details.

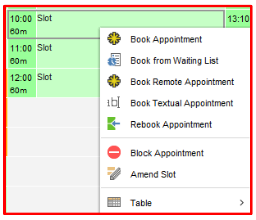


If you want to check the record before you see your patient, you can retrieve the patient record by right clicking and selecting **View Record.** This will allow you to view the record and then discard until you are ready to add your consultation notes. If you have viewed the record and are ready to add your consultation notes, click the **Start Consultation** tab within the patient record and this will link to the appointment and update the appointment status.

If you wish to start a consultation without viewing the record, select **Consultation** from the right hand options.

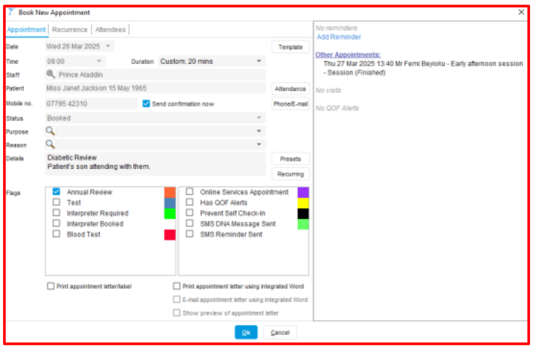
- The slot colour and status slot status will change to "**In Progress**" when you are in consultation mode.
- When the patient record is saved after entering the consultation details, the colour and slot status will change to "**Finished**".

Booking an Appointment



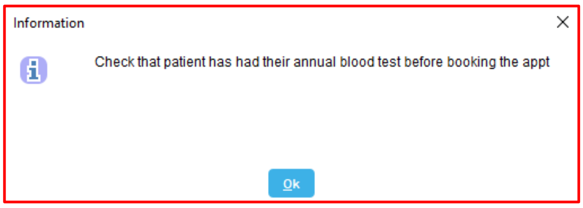
Right click on a free slot to book an appointment, you will be prompted to search for a patient. If you have a patient record open, it will automatically select and book an appointment for that patient.

Once you have searched for a patient, a **Book New Appointment** window will appear.



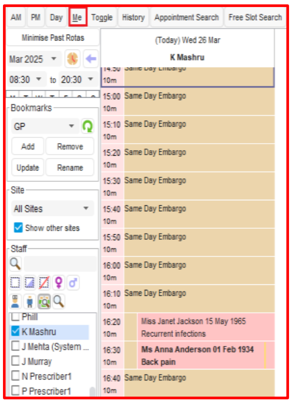
On the right hand side, you will find information on other appointments that patient may already have booked and other patient alerts.
The **Duration** of the appointment can be amended where appropriate/available by clicking the drop down box next to duration.
The **Details** field can be used to type in any useful information, e.g. ***Patient's son attending with them***.
To confirm the appointment with the patient, you can send an SMS message.

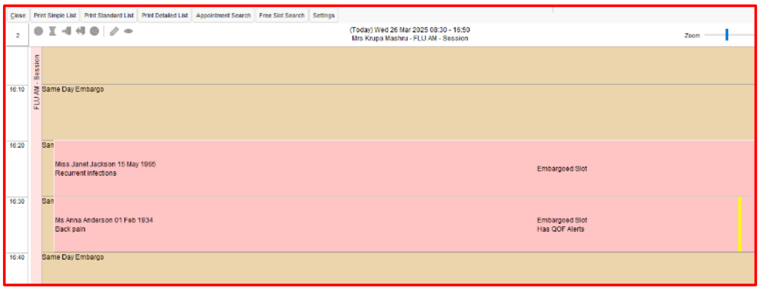
If your organisation uses appointment templates, these can be applied via the **Template** button, e.g. Diabetic Review template would prompt you to check that the patient has had their annual blood test before booking the appt.



Consultations

In the **Appointments Ledger**, you can select the **Me** button and you can double click to zoom into your rota, showing more detail.





All consultations where an appointment has been booked, should be started from the **appointment slot.** This will enable them to be linked.

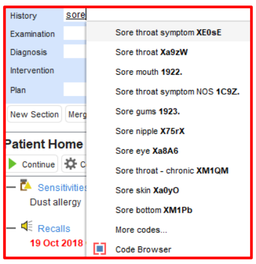
Right click and select **View Record** if you want to check the record before you see your patient. If you are ready to start recording your consultation, click the **Consultation** button and this will link your notes to the appointment and update the appointment status. If not, discard the record until you are ready.

Recording Consultations

To record a consultation:

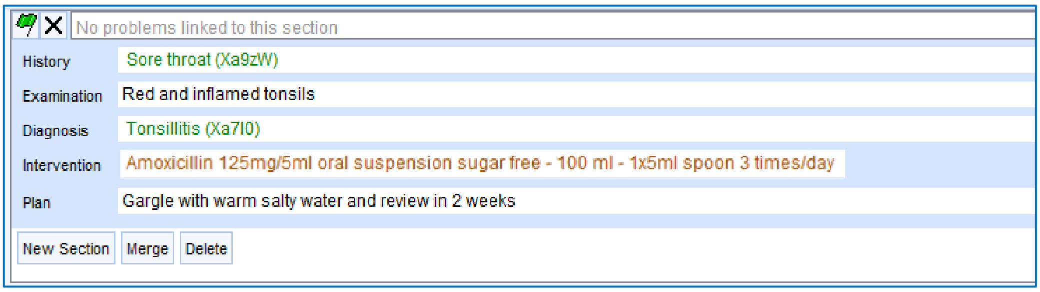
- Right click on the slot and select **Consultation** which will retrieve the patient record in consultation mode.
- Below is the consultation screen:

When you start typing in any of the field, you will notice that recommended codes will appear, you can select a code from the list. You will notice the coded data will turn green. Remember to use codes wherever possible.



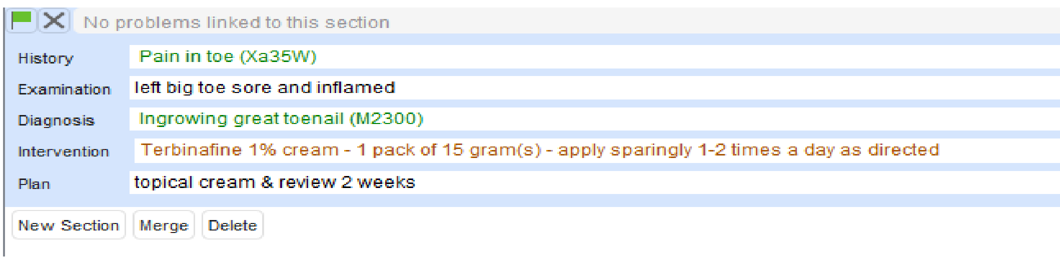
➢ **History**: The background of the presenting complaint, as given by the patient.

- **Examination**: Your observations of the patient and the results of any physical examination, e.g. BP readings.
  You can **right click** and see these options:
  1. **Insert code** (remember that free text cannot be reported on). Codes will show in green.
  2. You can **Insert BP** readings, e.g. specifying if a BP is from sitting or standing reading (120/80).
  3. **Insert numeric** e.g. temperature – add the most used values in your favourites to speed up your consultation.
- There are shortcuts to record readings, e.g. type in BP (space) 125/95 enter.
- **Diagnosis**: Your conclusions about the patient's condition.
- **Intervention**: Action taken, for example drugs prescribed, recalls, referrals, pathology requests, vaccinations. Any acute or repeat issues created whilst a complaint is selected are automatically displayed in the "Intervention" section of the relevant complaint.
- **Plan**: Future course of action, advice given to the patient, details of any treatment plan or narrative on any referrals made.

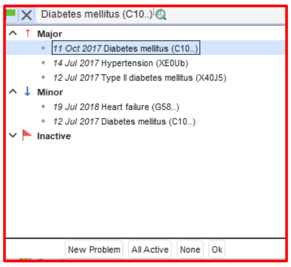


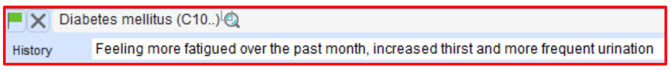
If your patient discusses more than one problem with you, you can use the **New Section** tab to bring up a new window to separate the issues in the Journal.

Button	Description
New Section	Record the details of a new complaint with the current consultation
Merge	Merge the selected complaints. **Note:** You cannot undo a merge
Delete	Delete the selected complaint(s)



You can **Link** the consultation to a **New or Existing problem**. Click on the **green flag** icon at the top right of the consultation to bring up the problem window.

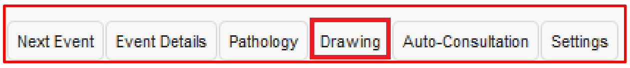




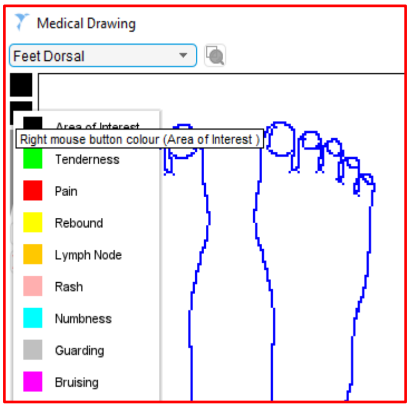
Medical Drawing

To add a drawing:

- Click the **Drawing** button.



You can create detailed visual representations of anatomical areas or conditions here.

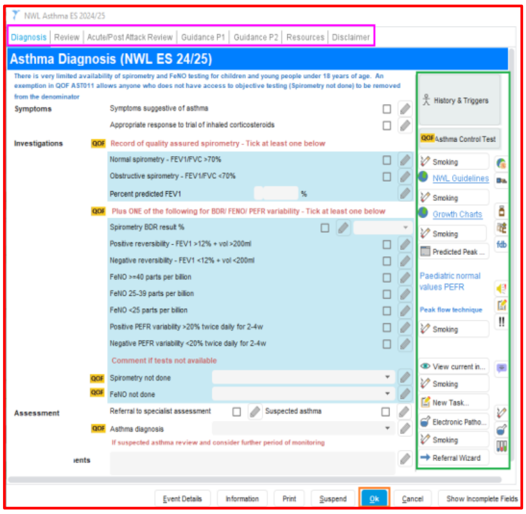


- Select the **body area** from the drop down.
- Right click to display the **legend** colours.
- Use the **slider** for the thickness of the line you want to draw.
- Apply the right click and move cursor over the area you want to draw on.
- Use the **undo** button if you make a mistake or **X** to start again.
- Once you **SAVE** the record, the appointment status is updated to **finished**.

Auto-Consultations

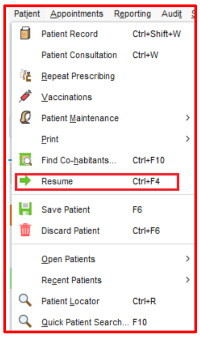
The NWL Primary Care Systems Development Team have created Clinical Templates within auto-consultations help to ensure that all information and coding is captured when completing an assessment for a patient.

In a patient record:



- Select **Auto-Consultation** tab – navigate to **Enhanced**
- **Services** or **QOF** from the drop down list – **Asthma** template.
- **Blue** highlighted fields relate to Enhanced Services, **Yellow** are QOF fields.
- There are various different fields, e.g. free text entry fields, drop down selections, check boxes, clinical tools, BMI calculator.
- Links to other items on the right hand side (highlighted in **green**) go directly to what you need to record without dipping in and out, e.g. send a task, send a referral.
- You can click along the tabs at the top of the template (highlighted in **pink**).
- When you have finished your entries in this template, click **OK** (highlighted in **orange**) at the bottom of the template and it will close.

- However, if you wish to return to it during this consultation, click **SUSPEND** and you can then **RESUME** (green ➔) from the Patient Menu allowing you to go elsewhere in the record without coming fully out of this auto consultation template and having to navigate to it again.



All data entered will automatically appear in the patient record in the Tabbed Journal, **SAVE** the record.

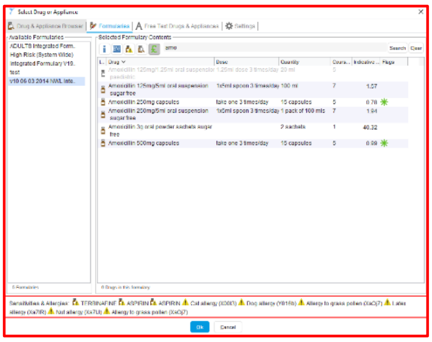
Prescriptions

Prescribing Acute Medication (One-off)

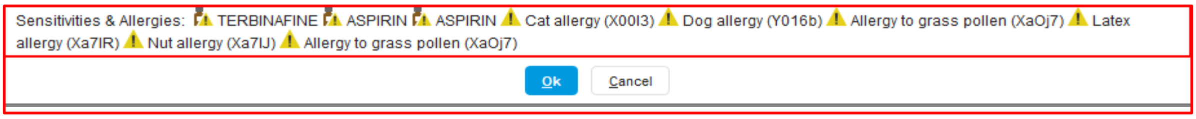
To create an acute medication:

- Click on the **Acute** button on the top toolbar or **right click** on the **Medication node** in the clinical tree and select **New Acute**.

- Use the NWL Integrated Formulary to search for the appropriate drug by entering at least the **first three characters** of the drug name in the Search field, e.g. AMO.

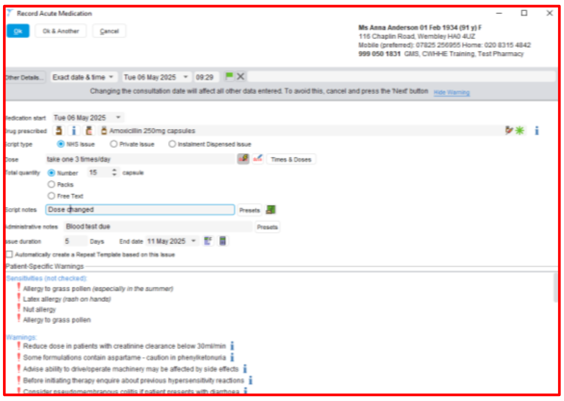


If the patient has any sensitivities or allergies recorded, these are displayed in a red box at the foot of the window.



- Select the drug you want to prescribe and click **OK**.
- Once you have select the drug, the dose and quantity will be worked out (this has been done by the meds management team).
- Dose calculator – It works by converting free text entered in the Dose field into a calculation to work out a numeric value for quantity or issue duration.
- Always check the dose, quantity – enter or amend the dosage for your patient if necessary.
- Check/amend the medication start date if required.
- **Script type** will remain as **NHS Issue**.
- Type any script notes – these will appear on the prescription.
- Script and Administration Notes.
- Type in any Script Note – This appears on the script and will go to the pharmacy (e.g. dose changed, dose increased, etc.).
- Type any Administration Note – Anything clinically relevant, e.g. blood test due, medication review due, e.g. stop medication on 01/02/2024 pre gall stones removal operation which will not appear on the script but will be shown in the patient record (in the Medication View and Tabbed Journal).
- If you decided at this stage, the medication should be on repeat, there is a tick box for this – **Automatically create a Repeat Template based on this issue.**

- Click **OK** once you have reviewed and confirmed the prescription details before finalising the issue.



When reviewing a patient's medication, it is very important to verify the dosage and administration instructions as well as checking for any potential interactions or allergies.

If there are any issues, a warning message will display and will ask if you want to proceed

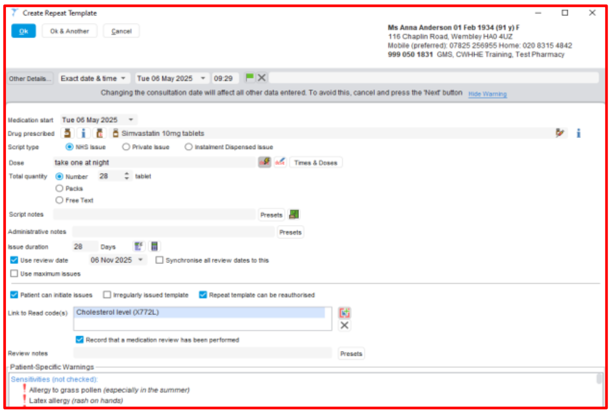
Prescribing Repeat Medication

The Repeat Template node automates the generation of recurring medication requests based on pre-defined intervals.

As this is a Repeat Template, you will need to check the extra options which include:

a. Review Date
b. Maximum Issues (check with your practice if they use this – set within Organisation Preferences)
c. Patient can request online
d. Repeat template can be reauthorized
e. Link to a problem or code(s)

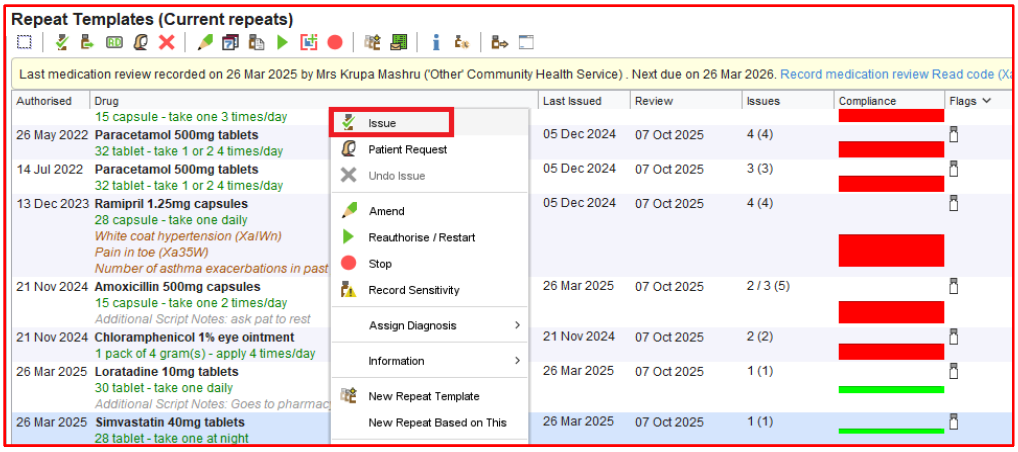
- Retrieve the patient record.
- Right click on the **Repeat Templates** node in the clinical tree.
- Select **New Repeat Template**.
- Proceed as above for Acute Medication.
- You can **link to a code** and select that a **medication review has been performed**.
- Click **OK**.



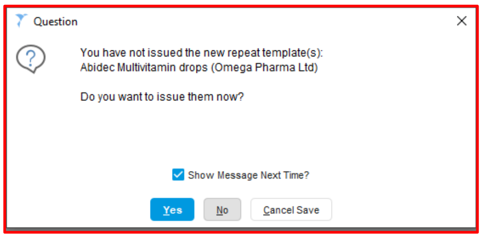
- This will now be listed in the **Repeat Template View**.

NHS
North West London

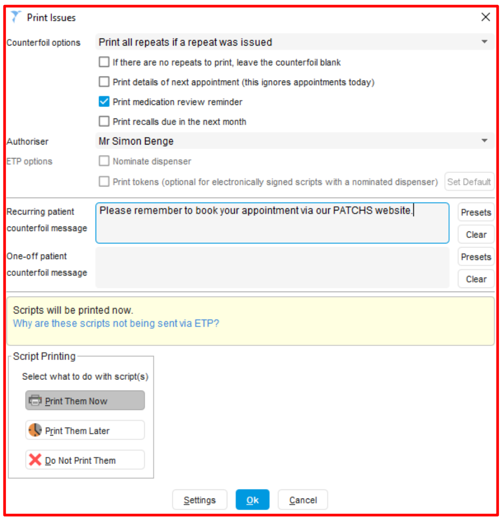
- **Issue** – Highlight the medication(s) you would like to issue. Select the **Issue** icon or right click and Issue.



Note: When you SAVE the patient record, you will be prompted if you have not issued new repeats.

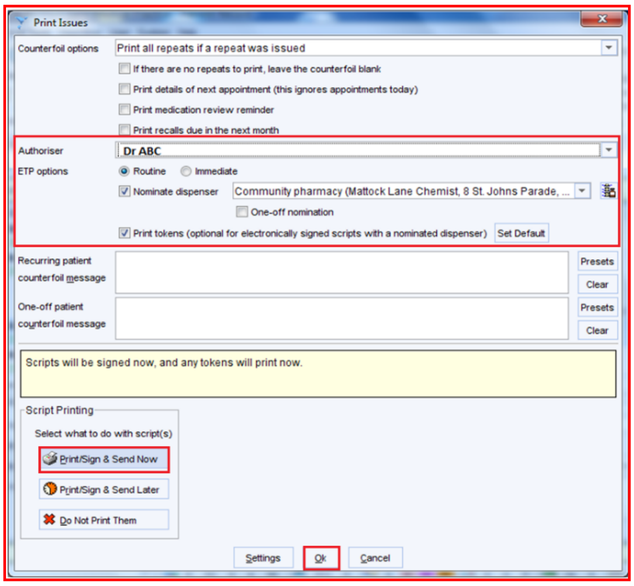


- **SAVE** the patient record, the Print Issues window appears.
- Show the drop down selection and various tick box selections.
- Type in any Script or Counterfoil Messages which appear above the repeats list on the right hand side of the script.
    - **Recurring patient counterfoil message** – Specify a message that will appear on all scripts that are issued for the current patient, e.g. please remember to book your appointment via our PATCHS website.
    - **One-off counterfoil message** – Specify a message that will only appear on the next prescription printed at your organisation for the current patient, e.g. please book your Annual Diabetic Review with the Practice Nurse.

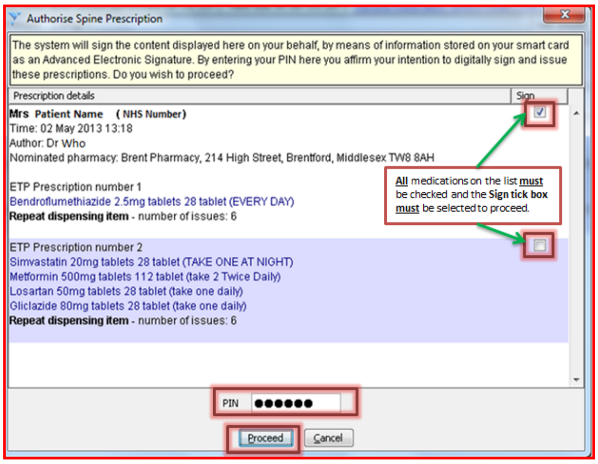


Electronic prescribing

If the patient has a nominated pharmacy, the medication will go via ETP.
The clinician can **Print/Sign and Send Now**.



This will take you to the **Authorise Spine Prescription** screen to **tick the medication in the list** to proceed.



Once the medication has been ticked, you can en**ter your smartcard number as the pin** and the prescription will go to the nominated pharmacy electronically.

The Clinical Record

Patient Search

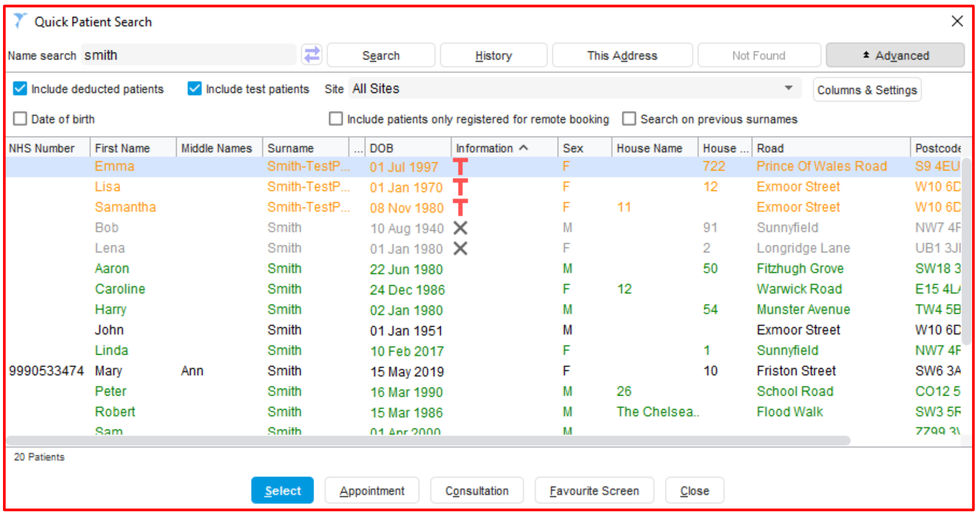
There are 3 ways to search for a patient:

- F10 quick function key
- Patient Menu – Quick Patient Search
- Search icon (magnifying glass) on the toolbar

The **search field** prompts for Name, however you can search by date of birth, name or (part of name) or NHS number if you have it.

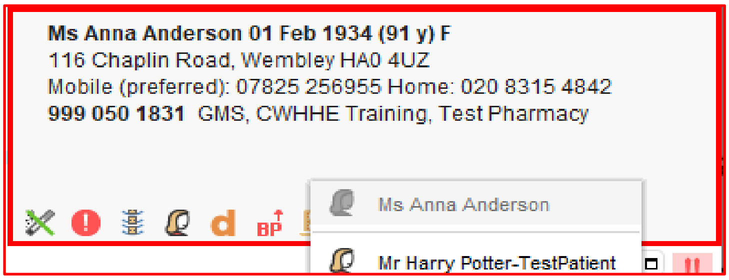
NHS number is best practice and performs an accurate search as this the patient unique identifier.

- Searching by name sometimes shows different status colours for the results, as shown below:
  - **Black** – permanent GMS patient.
  - Grey – Deducted patient. **Note:** You must have selected the **Include deducted patients** option for deducted patients to be shown in your search results. Hover over the grey **X** to display date of deduction. Deceased patients will have a tombstone next to their details, hover over to show date of death.
  - **Orange** – Test patient.
  - **Green** – Patient applied for GMS.



The Patient Demographics Box

- When you retrieve a patient record the demographics box will display patient details in the top right hand corner of the screen.
- You can open multiple records, up to 4 records at one time, however there will be a **red** border around the demographics box. Use with caution, make sure you are working in the correct patient record.
- If you want to switch between open records, right click on the demographic box to toggle between patients.



- To re-open a patient record, you can go to **Patient Menu** – **Recent Patients**. This will retain the last 15 patients records that you have retrieved.
- **Discard** – Red bin, this will not delete the record, simply closes the record without saving any changes.
- Hover over the demographic box – **additional information** is displayed – nominated pharmacy, usual GP, alternative correspondence address and telephone numbers. You can also see other organisations if the patient is being seen elsewhere.

Patient Status Alerts

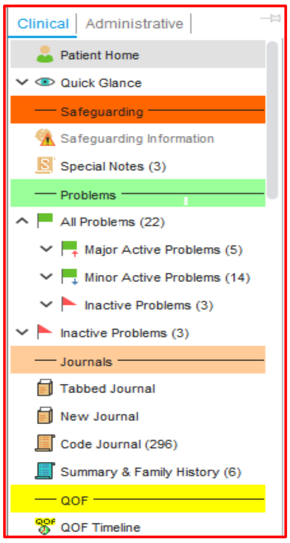
Patient status alerts are designed to draw important information to your attention when you retrieve a patient record, e.g. smoking status, asthma. These status alerts will vary for each patient.

Left Hand Side of the Divider	Right Hand Side of the Divider
SystmOne alerts	Local NWL/Practice alerts

- Once you retrieve a patient's record.
- Hover over a couple of the patient status alerts to show what they mean.
- You can sometimes click on them – this depends on how they have been set up, e.g. Smoker will take you to the smoking template.
- Some Patient Status Alerts appear on the **Patient Home** screen. The **Action** link may take you to a specific clinical template.

Trees

On the left hand side of the patient record, there are "Trees" – **Clinical** and **Administrative**.



- **Clinical Tree** – this tab is displayed by default when you retrieve a Patient Record. You can access all of the clinical data saved for a patient via the Nodes displayed on this tab.
- **Administrative Tree** – this tab is intended to allow you to view administrative information for a patient via the Nodes available in the tree, including all details entered at the point of registration.

If you right click on a node, a menu will appear with various action buttons. Usually the first option is to "add" or create a new entry.

Note: The exact nodes in each unit will vary according to how it is configured.

Clinical Tree Nodes

Patient Home

When you retrieve a patient record, the Patient Home view is always displayed which contains relevant outstanding actions.
The coloured pane on the right hand side is always there anywhere in the record, click to open a view and action window.

Quick Glance

This is known as a view and are created to include specific information within patient records, they can be set up by your practice.

This view provides a basic summary of the patient record and can be printed out (**right click** on the node – **print summary**).

- Click on the **down arrow** on the **Quick Glance node** to expand the options.

View the different summaries available and click back on the **up arrow** to **collapse** the node.

Special Notes

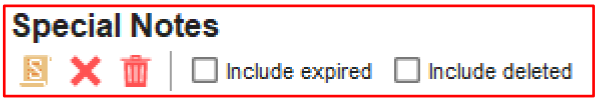
Special notes are like a reminder but are visible regardless of sharing preferences, if there is a special note within the patients record you will see the icon in the demographics box and the node will be highlighted.

There are three types of special note:

- **Special Note** – to alert other care providers that the patient has a palliative diagnosis.
- **Safe Haven** – to alert the care provider to any potential danger they may be in when seeing the patient (e.g. potentially violent patient or patient has a violent relative).
- **Frequent Callers** – to identify patients who frequently call the service.

Entering a Special Note

- Right click on the **Special notes** node – select **New Special Note**.
- Choose the **Type** of note you would like to enter.
- Ensure date and time is correct.
- Enter a special /safe haven/frequent caller note into the patient record.
- Click **OK** to save the New Special Note.



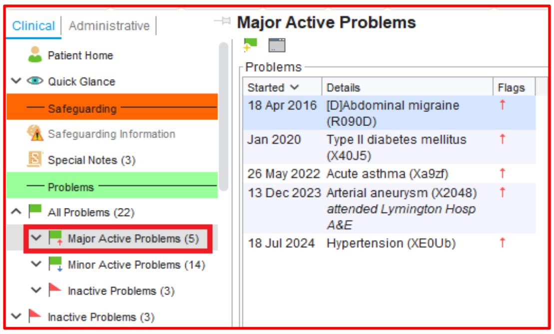
- **X** allows you to expire a current Special Note if it is no longer relevant.
- **Red bin** allows you to delete the Special Note.
- Nothing in the patient record should be deleted or marked in error unless it was incorrectly added, e.g. in the wrong patient record.
- You can also view expired and deleted special notes by adding ticks in the boxes.

Problems

These are read coded entries that have been assigned as a "problem".

Green flags – current/active problems.
Red flags – inactive problems.

If you click on them they will display all entries linked to that problem (Minor and Major).



Read coded entries are very important as free text cannot be reported on, for example data collection for payment, e.g. Enhanced Services. Also read code reporting was used to collect national data during the pandemic. This helps keep to a standard recording rather than free text.

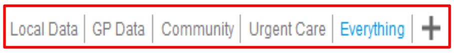
Journals

Tabbed Journal

The Tabbed Journal allows you to view the patient's medical history in tabbed entries.

If the patient has a long record this will be split into multiple pages which can be navigated with the arrow keys at the bottom of the page.

Tabs at the top of the page allow you to filter the record.



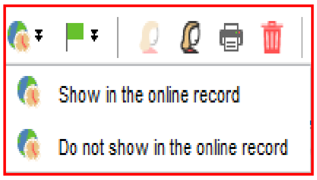
Tab	Description
Local Data	Shows data added by the **current organisation**
GP Data	Shows data added by SystmOne **GP organisations**
Community	Shows data added by SystmOne **community organisations**
Urgent Care	Shows data added by SystmOne **urgent care organisations**
Everything	Shows all data **available** to the current organisation in date order

You can create personal tabs which are only available on your profile. Click the **+** at the end of the tabs. A pop-up will then appear allowing you to enter a tab name and tab icon, then you can select that you want that tab to show, e.g. events recorded since my last event.

To delete your personal tab, you can right click on the tab and select **Delete Tab**.

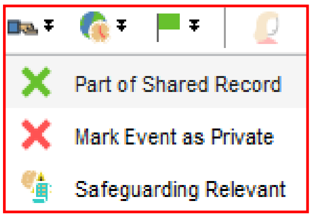
You can also use the **Search** field to search for a specific word in the journal, e.g. **Medication** and click **enter**. This will display only entries with the word medication.

There may be some information that should not be visible for the patient to see when using System Online. To hide information, click and highlight the entry and click on the **Online visibility icon** and then click "**Do not show in the online record**".



If a record is not visible to the patient, the icon will appear on the right hand side of the data entry.

If you feel the event should be kept private from other healthcare settings, click the "**Mark Event as Private**" icon. This will allow colleagues within the organisation to see the entry, but it is not visible to those outside the organisation. A red cross will be added next to the entry to indicate this.



A red cross will be added next to the entry to indicate this.
Users who are not able to see the information will see a red cross in the patient demographics box which indicates that some information is missing from their view of the record.

Only staff members who have safeguarding access rights on their smartcard can view this event in the patient's record.

The Filter option allows you to create and save a filter so that you can use it in different patient records.

1. Click on the icon.
2. The **Manage Filters** dialog is displayed.
3. Click **New Filter**.
4. Select the appropriate options from the **Filter Configuration** dialog (e.g. deselect all and only show **deleted items** or **data entry templates**).
5. Click OK.
6. Type a name for the filter and click **OK**. The filter is listed on the **Manage Filters** dialog.
7. Click **OK** to return to the Tabbed Journal. The filter is now available for quick selection from the Custom Filter drop down list.

To **remove** a filter - click on the full filter (**Show everything in the journal**)
To **delete** a filter – click on Manage Filters (pencil icon) and select **Delete Filter**.

The Tabbed Journal appears in date order with the most recent entry appearing at the bottom. This cannot be changed, unlike many areas in SystmOne where you can change the order.
There are page navigation arrows at the bottom of the Journal and the date of the entries appear on the bottom right hand side.

The centre of the screen shows the time and who added the entry and the content. There are different colours denoting different entries in the Journal:

Colour	Different Entries
Green	Generally coded information
Black	Generally free text
Brown	Medication
Blue	Template entry

The far right icons give more detail about the entry if you hover over them, e.g. face to face, linked to an appointment.

New Journal

The New Journal displays the details that have been added to a patient record in date order.

Within the **New Journal** – **Custom Filter**, you can quickly see what is visible in the patient's online record.

Online Full Clinical Record – This type of access will include all of the information seen for those patients with Detailed Coded Record Access but will also allow you to read free text entries in your records and attachments such as hospital letters.

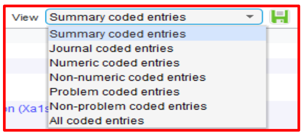
Online Detailed Coded Record – This will include access to view all the clinically coded information in patient's records – such as problems, procedure codes, diagnosis, medication, test results, immunisation and allergies. Patients will be able to see when a referral has been made or a letter received, but not able to read the contents of the letter. Clinical codes will give you information about what that consultation or entry was in relation to without the very specific information that the doctor or nurse typed into your records.

Code Journal

The Code Journal allows you to view a list of all the Read codes that are present on the currently retrieved patient record.

The number in brackets indicates the number of journal coded diagnosis contained in the Code Journal. You can sort the list of read codes displayed by clicking on the column headings in the list.

The coded entries view is displayed by default but you can select the View drop down list to specify what coded entries you want to view.



View	Definition
Summary coded entries	Only read coded entries that appear in the patient record summary are displayed (these entries are **blue** and have the icon next to them).
Journal coded entries	Only read coded entries that appear in the Journal as journal diagnoses are displayed.
Numeric coded entries	Only numeric read coded entries are displayed.
Non-numeric coded entries	Only non-numeric read coded entries are displayed.
Problem coded entries	Only read coded that have been added as problems are displayed.
Non-problem coded entries	Only non-problem read coded entries are displayed.
All coded entries	All entries in the patients record that have an associated read code are displayed.

Select your preferred view and select **Save** so that this will be your default view every time you retrieve a patient and look at the Code Journal.

QOF Timeline

The QOF timeline view in the patient record allows you to identify and manage any QOF work that needs doing for a specific patient.

The timeline shows the progress against each indicator applicable for this patient. The bars are colour coded to allow you to easily identify the status of the patient for each QOF indicator:
Green – those which have already been achieved for this QOF year.
Grey – those from which the patient is excluded.
Red – those which have actions outstanding in order for them to be achieved for this QOF year. You can right click in the red area to record achievement or exclusion or to view the achievement paths.

If an indicator needs to be actioned within a specific timeframe (e.g. it either needs to be added before a certain date, or does not need to be added until after a certain date), this is shown by a shortened bar that starts or ends at the corresponding date on the scale. The tooltip for the indicator shows the exact date period in which the indicator must be actioned for the patient to be achieved.

Medication

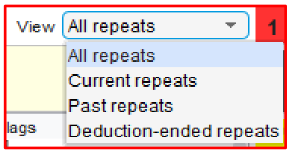
A list of all the patient’s medication is shown here in order of date prescribed. These can be ordered by clicking on the titles by drug name or medication type.

- Repeat medications will be identified in the flag column by this icon.
- Non-GP medications such as hospital or dental prescribed medication will be identified by a **H** icon or dental icon.
- The view can be used to change to **only view current medication** or the **last 6 months** of medication or a simple **summary** of all medications given.

Right clicking on the medication will give you a drop down list of all the options needed to deal with a medication request.

Repeat Templates

Shows all medications currently on a repeat prescription. This view can be filtered on the right-hand side to show **current**, **past** or **deduction ended** repeats.



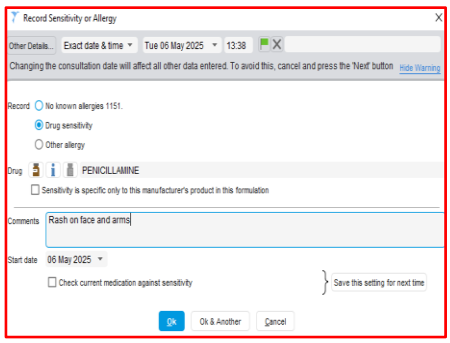
- Right clicking on the medication gives all the functionality in order to deal with repeat prescription requests.
- The number of repeats issued will show on the right hand side of the medication. Once the patient has reached the maximum number of repeats, they must be reviewed.
- The compliance indicator gives a visual indication of whether the patient is collecting their repeat script at the correct intervals and hence whether they are taking their medication as prescribed. The indicator will turn from green to orange or red if not compliant.

Flags can be applied to indicate if a medication has reached a review date or is a controlled medication in the right-hand column.

Sensitivities & Allergies

You can record if a patient has any sensitivities or allergies in this node.

To record a sensitivity or allergy



- Retrieve the patient record.
- Navigate to the Sensitivities & Allergies node.
- Right click on the node and select Record Allergy or Sensitivity.
- Enter details of allergen (e.g. drug, food, substance)
- Record the onset date of allergy if known.
- Save the allergy information into the patient’s record.

Communications & Letters

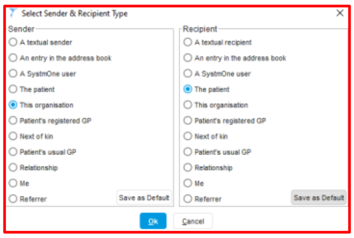
All scanned and electronic generated letters appear here.

There are 4 tabs:

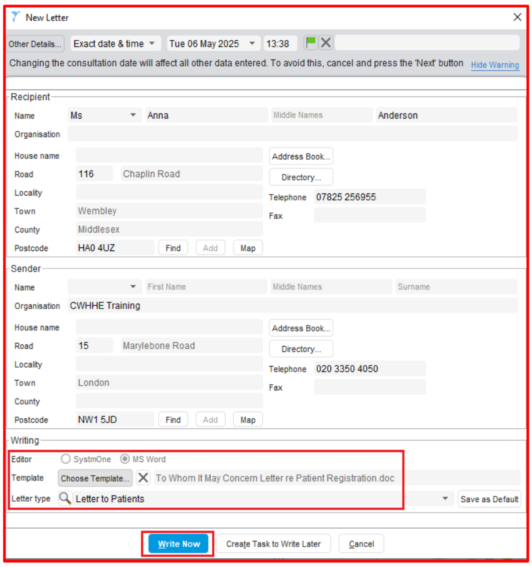
Tab	Shows
All	All communication
Incoming	For communications received by your organisation or other organisations that share the patient record
Outgoing	For communications sent by your organisation or other organisations that share the patient record
Other	For all other communications

The columns can be re-ordered by clicking on the column headers.

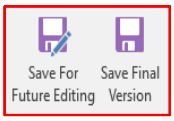
To create a New Letter



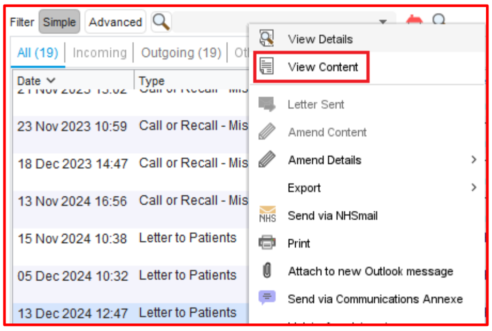
- Right click on **Communications & Letters** node.
- Select **New Letter**.
- The **Select Sender & Recipient Type** dialog opens.
- **Sender – This Organisation.**
- **Recipient – The patient** (*save as default*).
- Ensure **Editor** is **MS Word.**
- Choose **Letter Type** – this is very important, the system defaults to A&E.
- Choose **Template** (Select a NWL template
- Select **Write Now.**



- Enter the contents of the letter and either:
  - **Save For Future Editing** – This **allows you to edit the contents of the letter at a later stage**. There is no date and time in the Date Finalised column.
  - **Save Final Version** – This **PDF's the letter and you cannot edit in the future once the letter is finalised**. There will be a date and time in the Date Finalised column.



- Right click on any letter and **View Content**.



Referrals

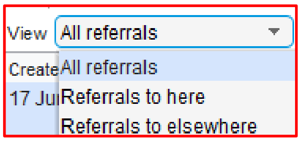
This allows you to view details of a referral from the patient record.

Two tabs are displayed:

- **Referrals In** – A list of referrals recorded as received for the patient are shown here.
- **Referrals Out** – A list of outgoing referral for the current patient (outgoing referrals include those sent by your organisation and also those sent by any other organisations with access to the patient record).

Within the Referrals Out Tab:
View:

- **All referrals** – View a list of all outgoing referrals.
- **Referrals to here** –Include outgoing referrals intended for your organisation.
- **Referrals to elsewhere** – Include outgoing referrals intended for other organisations.



Show open referrals – Include open referrals in the list displayed.
Show closed referrals – Include closed referrals in the list displayed (you must select this option in order to view any referrals marked as ended).

Record Attachments

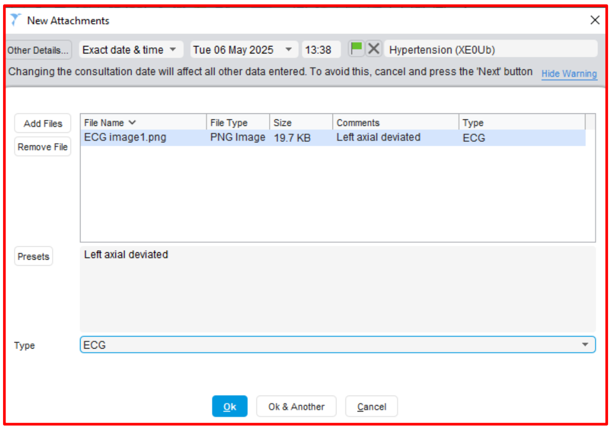
This node allows you to view and manage and files that are attached to a patient record, e.g. photographs, ECG files.

It is possible to attach electronic files of up to 5Mb in size to a patient record.

To add a file

1. Retrieve the patient record.
2. Right click on the **Record Attachments** node.
3. Select **Attach Files**.
4. Locate your file from the saved location.
5. You can remove files from this screen as well.
6. You can link the file to a **problem** using the green flag on the top right hand side of the **New Attachments** dialog.
7. Add any **comments** if required – presets can be created if using frequently.
8. Select a **Type** from the drop down list if required.

9. Click **OK** to save into the patient record.



The file is attached to the patient record and the filename of the attachment will be visible in the **Tabbed Journal** (right click on the entry and **View in Windows**).

You can also drag and drop to attach files to a patient record.

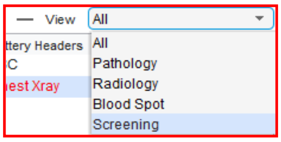
Pathology & Radiology

Left Hand Pane

Displays pathology/radiology reports by individual tests in the left hand pane:

- Report issue date.
- Battery headers e.g. Biochemistry, Histology.
- Specimen collection date if present in the message sent from pathology lab/radiology department.
- Report type e.g. pathology/radiology.

You can filter the reports displayed by report type, using the **View** drop down list at the top of the view.



To view details of a particular report type, **expand** the **Pathology & Radiology node** and then expand the relevant sub node, e.g. **Haematology – FBC**.

If you **right click** on a **pathology/radiology report** in the **left hand pane**, you have further options in relation to that report.

Upper Right Hand Pane

Displays general details including:

- The result indicator, e.g. Normal, Abnormal, Unknown.
- Any comments entered while filing.
- Who filed the report.
- Date of filing.

When a report has been archived and the patient informed, it is displayed in grey text on the Pathology Radiology view.

Note: Once a pathology/radiology report has been archived, it cannot be amended.

Lower Right Hand Pane

Gives details of the individual numeric results.

Vaccinations

Details of all vaccinations are implicitly shared to child health services, health visitors, school nurses, community services, district nurses and GP's unless the patient has given explicit dissent at the service where the vaccination is recorded.

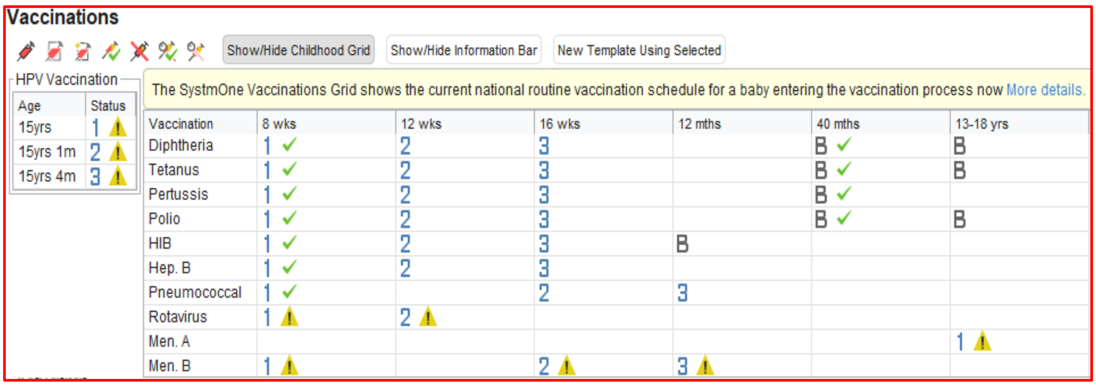
To add a vaccination

1. Right click on the **Vaccinations node**.
2. Select **Record Vaccination**.
3. Select **Vaccination** from the drop down list.
4. Enter **details** of the vaccine (e.g. batch number, date administered).
5. Record any relevant notes (e.g. site of administration, method).
6. Click **OK**.

Childhood Vaccination Grid

Show/Hide Childhood Grid provides a clear, organised display of a child's vaccination schedule and history. It allows healthcare providers to easily monitor and track a child's immunisations, ensuring that they are up to date with the national immunisation schedule.

- The grid presents a visual table with **vaccine names** on one axis (rows) and **age ranges** or specific intervals (months/years) on the other (columns).
- Each cell represents a vaccine that should be administered at a specific age or time interval.
- The grid uses colour coding to show the status of each vaccination:
  - **Green** – Completed vaccinations.
  - **Red** – Overdue vaccinations.
  - **Yellow** – Scheduled or upcoming vaccinations.
- It includes routine childhood immunisations recommended by public health bodies, e.g. 6 in 1 vaccine, MMR, meningitis vaccines.
- Clicking on a vaccine within the grid can provide detailed information such as the vaccine batch number, date of administration and any recorded reactions or notes.



North West London

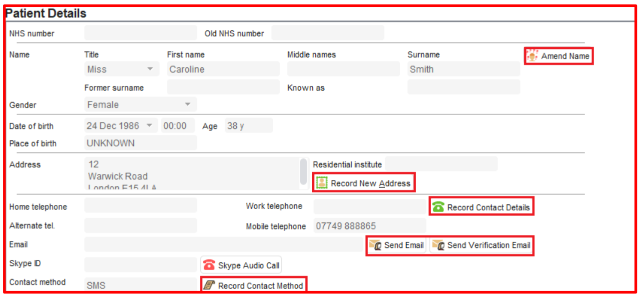
Administrative Tree Nodes

Patient Details

This node allows you to amend a patient's details.

You can amend the following:

- Amend Name
- Record New Address
- Record Contact Details
- Send Email/Send Verification Email
- Record Contact Method



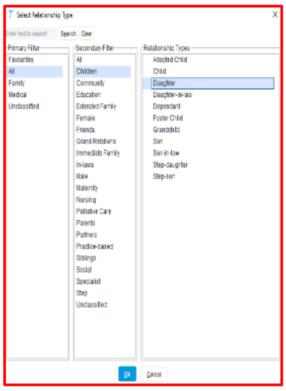
Groups & Relationships

You can record a relationship between the patient and a person (medical or non-medical).

The following filters are available, which are designed to help you find the relationship type you are looking for quickly:

All – Allows you to view all categories of relationship.
Family – Various personal relationship categories are listed, e.g. parents, extended family.
Medical – Non-personal relationship categories are listed, e.g. community nurse, school teacher, Macmillan nurse.
Other – If you are unable to find a suitable relationship type, you can select Unclassified e.g. probation officer, carer, person of religion, commissioned advocate.

Recording a New Relationship



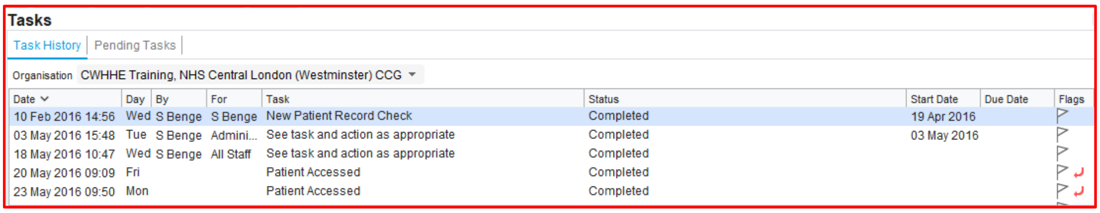
1. Right click on the **Groups & Relationships** node.
2. Select **Record Relationship**.
3. Select the relationship from the **Select Relationship Type** dialog (using the Primary filter, secondary filter, relationship types).
4. Click OK.
5. Select the appropriate option from the **New Relationship** dialog.
6. Select the **relationship type** and appropriate options.
7. Click **OK** and add a **reciprocal relationship** is required and click **OK**.

Tasks

This is accessible via the **Appointments, Visits and Tasks** node in the Administrative tree, expand the arrow and select **Tasks**.

There are two tabs available:
Task History – shows a list of all sent tasks associated with this patient.
You can use the **Organisation** drop-down list to show only those tasks sent by a particular organisation or select **All Organisations**.
Pending Tasks – allows you to view tasks that have been created but not yet sent. They will be sent automatically when you save the patient record. These tasks cannot be processed (e.g. actioned or

marked as “completed”) until they have been sent. To cancel a pending task, right click on it and select **Cancel Pending Task**.


Tasks

Task History | Pending Tasks

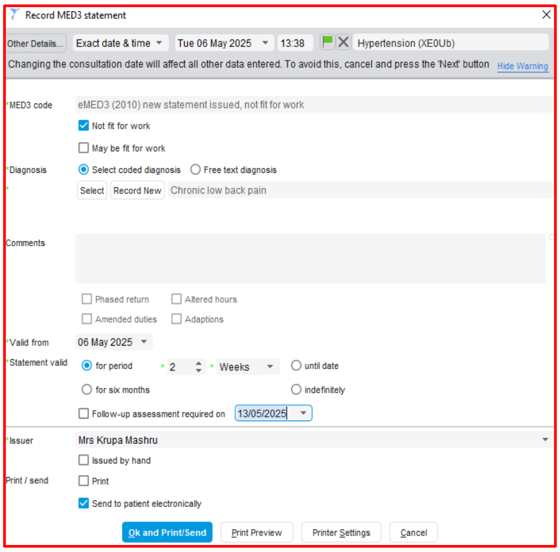
Organisation CWHHE Training, NHS Central London (Westminster) CCG

Date	Day	By	For	Task	Status	Start Date	Due Date	Flags
10 Feb 2016 14:56	Wed	S Benge	S Benge	New Patient Record Check	Completed	19 Apr 2016		
03 May 2016 15:48	Tue	S Benge	Admini...	See task and action as appropriate	Completed	03 May 2016		
18 May 2016 10:47	Wed	S Benge	All Staff	See task and action as appropriate	Completed			
20 May 2016 09:09	Fri			Patient Accessed	Completed			
23 May 2016 09:50	Mon			Patient Accessed	Completed			

Med3 Statements

The Med3 note functionality allows you to record and print Med3 statements that are assured by the Department of Work and Pensions.

Issuing a Med3 Statement



1. Right click on the **Med3 statements** node.
2. Select **New Med3 Statement**.
3. Select the appropriate option:
4. **Not fit for work** – the appropriate Read code will be added to the patient record.
5. **May be fit for work** – the appropriate Read code will be added to the patient record.
6. Record a diagnosis:
7. Click **Select coded diagnosis** to use a Read code that is already in the patient record, or Record New.
8. Click **Free text diagnosis** to add a new free text to the patient record and use it on this Med3 statement. The free text will be added to the patient record at this point.
9. Type in any **comments** required or click Presets to set up/use.
10. If required, select the options available if you have assessed the patient as **May be fit for Work** (e.g. phased return, altered hours, etc.)
11. Record the appropriate date in the **Valid From** field.
12. Record a duration in **Statement Valid** field (for example **for period 2 weeks**).
13. Select **Follow-up assessment required** and record a date if the patient needs to be assessed again.
14. The issuer will have your name in the field.
15. Click the appropriate button:
    - **Issued by hand** – allows you to record that a paper Med3 statement has been issued to the patient, showing the details selected on this dialog. The appropriate Read code will be added to the patient record. This adds a tick to **Print** as well and there will be a “**Issued by hand**” watermark on the Med3 statement when you print it.
    - **Print** – This allows you to print the Med3 statement.
    - **Send to patient Electronically** – This allows you to send the Med3 statement to the patient via the Communications Annexe.

Print preview allows you to view a preview of the Med3 statement.