

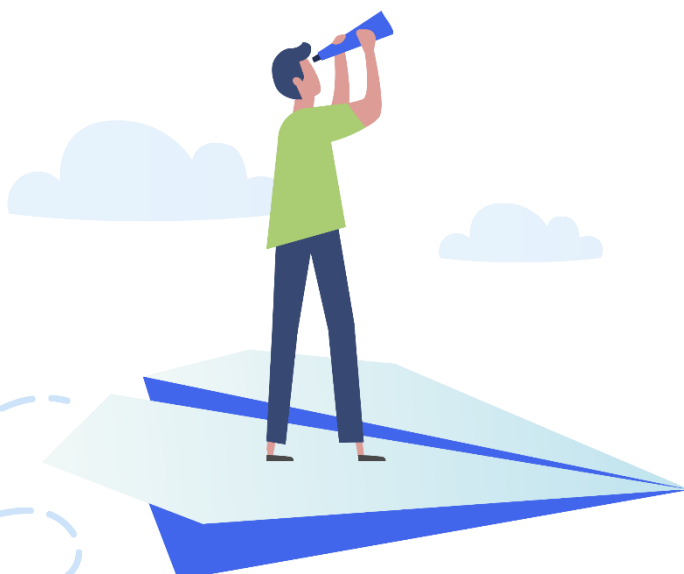


Vision Anywhere for Windows Desktop

V3.8.2 Release Guide

Version 1.2

25th July 2021



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Registered name: Cegedim Rx Ltd. Registered number: 02855109

Registered name: In Practice Systems Limited. Registered number: 01788577

Registered address: The Bread Factory, 1a Broughton Street, London, SW8 3QJ

Website: <https://www.cegedimrx.co.uk>



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Vision Anywhere for Windows Desktop v3.8.1 Release Guide

Summary of Changes

January 2021

Vision Anywhere release v3.8.1 brings together **Vision Anywhere** releases v3.7 and v3.8.1 and contains the following new features and improvements:

- **SNOMED CT Browser** - You can now browse and select from a structured view of SNOMED Clinical Terms. The browser allows you to:
 - Display **SNOMED CT** terms.
 - View details about each concept.
 - Select a clinical term.
 - Search on a full concept ID to select a specific SNOMED Clinical Term.
 - Easily identify **SNOMED CT Preferred Terms**.
 - Select **Synonyms** and easily find **Child** and **Parent** terms.
- **Other SNOMED CT enhancements:**
 - **Preferred Term - SNOMED CT** concepts that are included in the **SNOMED CT** preferred terms list, now display with a **PT** flag  against each term.
 - **Viewing Concept IDs of existing records** - Simply select **View more details**  on the entry required.
 - **Direct entry of Concept IDs** - You can now also enter the Concept ID into the dynamic data entry bar in the current Encounter.

 See [Using the SNOMED CT Browser](#) on page 10 and [Viewing SNOMED CT Details](#) on page 13 for details.

 See [Recording Immunisations](#) on page 14 and [Viewing Immunisations](#) on page 18 for full details.

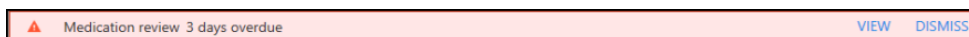
- **Immunisations** - The **Immunisation quick entry form** has been updated to include:
 - Next dosage due
 - Status
 - Method
 - Site
 - Location
- **Preferred Pharmacy** - You can now view, add and update a patient's **Preferred Pharmacy** from within **Vision Anywhere**. Where recorded, this prints on the top left-hand corner of the patient's prescription and you can view it from:
 - Patient Banner.
 - Patient Summary.

 See [Preferred Pharmacy](#) on page 19 for details.

- **Medication Reviews** - Where recorded in **Vision 3**, you can now view the details of any Medication Reviews that are due or overdue:
 - **Medication Review Due Alert** - If a medication review is due or overdue, an alert banner displays. If the medication review is:
 - **Due in the next 14 days** - The banner displays orange:



- **Overdue** - The banner displays red:



Select either:

- **View** to see the details of the review, or
- **Dismiss** to close the banner.

 See [Medication Reviews](#) on page 22 for full details.

- **Decision Support** - You can now choose to enter a reason when you override any decision support warning on either an acute, a new Repeat or a Reauthorisation of an existing Repeat. When you select



Save on a medication with decision support warnings, the **Decision Support Summary** screen displays:

Decision Support Summary

Please review your decision support and consider any next steps:

^ **Drug Dictionary (7)**

Contraindications and Cautions relevant to this patient (7)

Other warnings (2)

Reason for overriding these warnings

Prescribe
Cancel

Enter any comments required in the **Reason for overriding these warnings** section. Audit information for overrides is held in the **V360 Clinical Portal Audit Viewer** and **Vision 3 Event Viewer**.



See [Audit Viewer Help](#) and [Event Log Help](#) for details.

- **Repeat Medication** - The **Last ordered date** now displays on the reorder form.
- **Death Administration** - You can now record all death administration information in one screen.

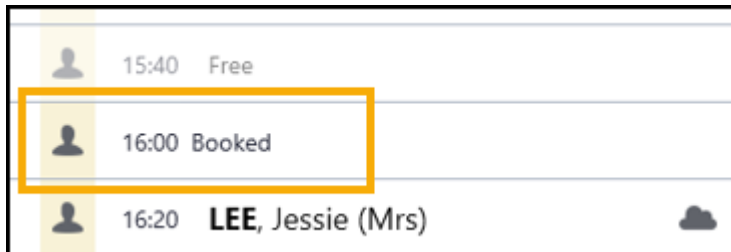




See [Recording Death Administration](#) on page 24 and [Viewing Death Administration](#) on page 26 for details.

- **Inactive GP** - The warning banner for inactive GP now only displays on a patient record if both their Usual and the Registered GP's are inactive.

Shared Care only

- **Appointments** - Where a service is shared, and a joint appointment book used, if there is no sharing agreement in place, appointments for patients that are not registered at your practice display as **Booked**. No patient information is available:



	15:40	Free	
	16:00	Booked	
	16:20	LEE, Jessie (Mrs)	

SNOMED CT

SNOMED CT stands for **S**ystematised **N**omenclature **o**f **M**edicine - **C**linical **T**erms and is a common, standardised clinical coding language.

SNOMED CT is the most comprehensive and precise clinical health terminology product in the world, it includes:

- Diagnosis and procedures.
- Symptoms.
- Family history.
- Allergies.
- Assessment tools.
- Observations.
- Devices.
- Other content to support healthcare delivery.

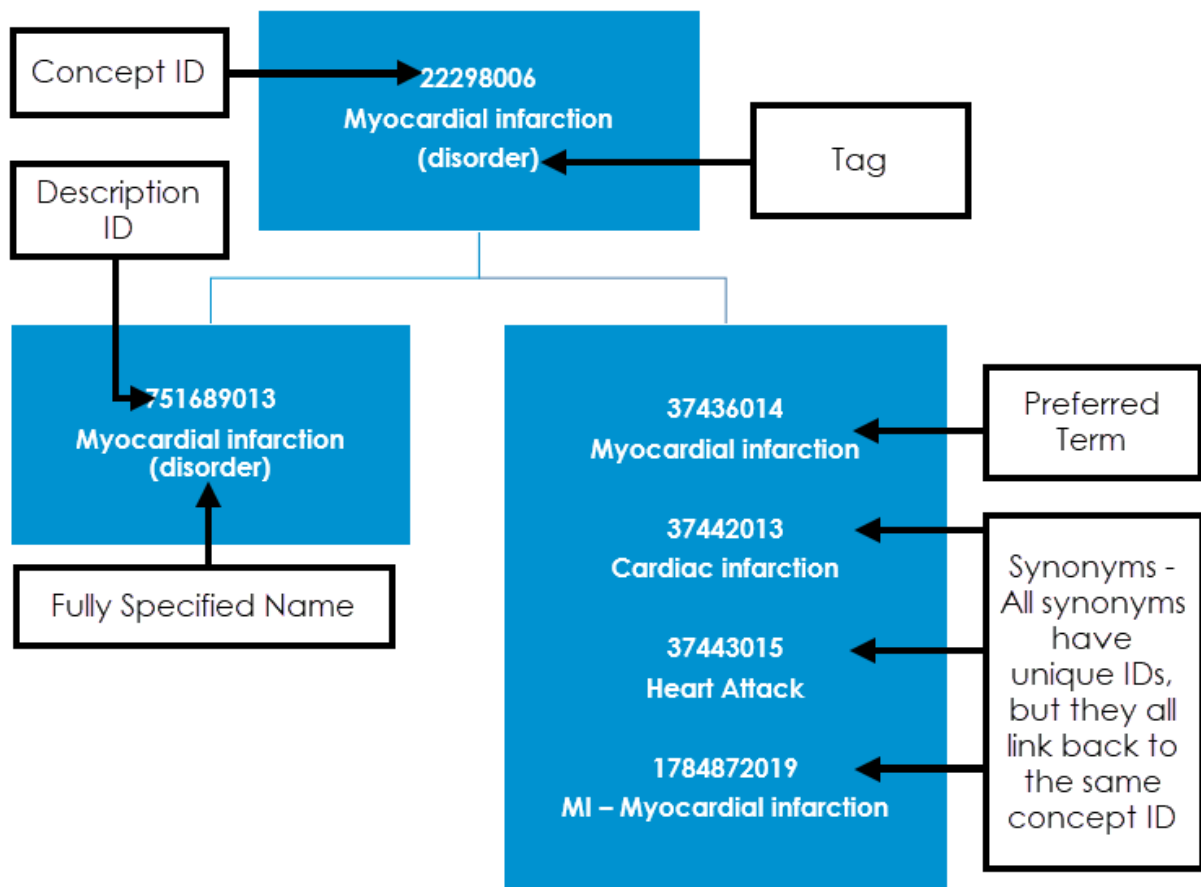
Vision Anywhere uses SNOMED Clinical Terms to record data, this results in:

- Consistent recording and retrieval of information.
- Advanced data analysis.
- Real-time decision support.
- Meaningful sharing of information.

SNOMED Clinical Terms are built of three building blocks:

- **Concepts** - These are unique codes.
- **Relationships** - These are the links between to other concepts.
- **Descriptions** - These are the fully specified names and the synonyms, **it is these you select from for recording purposes.**

For example:



- The **Tag** displays after the **Fully specified name** (FSN) in brackets, this provides an indication of where in the SNOMED CT dictionary the Concept sits.
- A **Preferred Term** is designated to the description that most healthcare professionals use for a specific disorder, but you can select any synonym you require.

Within SNOMED CT, Concepts are associated with other concepts using two different types of relationships:

- The **is-a** relationship which enables concepts to be part of a structured hierarchy that group “like” concepts together. Each concept has a relationship to at least one “parent” concept and as you go down the hierarchy concepts become more detailed and specific.
- An **attribute** relationship can be used to further define each concept.

A Concept has **is-a** relationships, identifying what kind of concept it is, for example Clinical finding or procedure, and an **attribute** relationship which defines the particular concept, for example, for a procedure, it would include finding site, causative agent, laterality, method and many more.

➔ See [Using the SNOMED CT Browser](#) on page 10, [Viewing SNOMED CT Details](#) on page 13 and [SNOMED FAQ](#) for further details.

 For further information on SNOMED CT, see the NHS Digital SNOMED CT Browser or SNOMED CT eLearning.

Using the SNOMED CT Browser

The **SNOMED CT Browser** enables you to find and use a specific clinical term within an encounter quickly and easily. From the **SNOMED CT Browser** you can:

- Display **SNOMED CT** terms.
- View details about each term.
- Select a clinical term.
- Search on and select a specific **SNOMED CT** term.
- Easily identify **SNOMED CT Preferred Terms**.
- Select **Synonyms** and easily find **Child** and **Parent** terms.

To use the **SNOMED CT Browser**:

1. From a patient record, with an **Encounter** open, enter the search criteria required, for example, 'hear att', you can also use the **Concept Id**, for example '22298006'.
2. The smart list returns matching **Common Observations**, **Quick Entry Forms**, **Templates & Calculators** and **Clinical Terms**.
3. If the term you require is not offered or you are looking for more details, select **SNOMED CT Browser**:



Surgery consultation note ▼ 14-Sep-2020, 16:11 - Dr Peter Powys

hear att ✕

Common Observations (0)

Quick Entry Forms (0)

Templates & Calculators (0)

Clinical Terms (20) [SNOMED CT Browser](#)

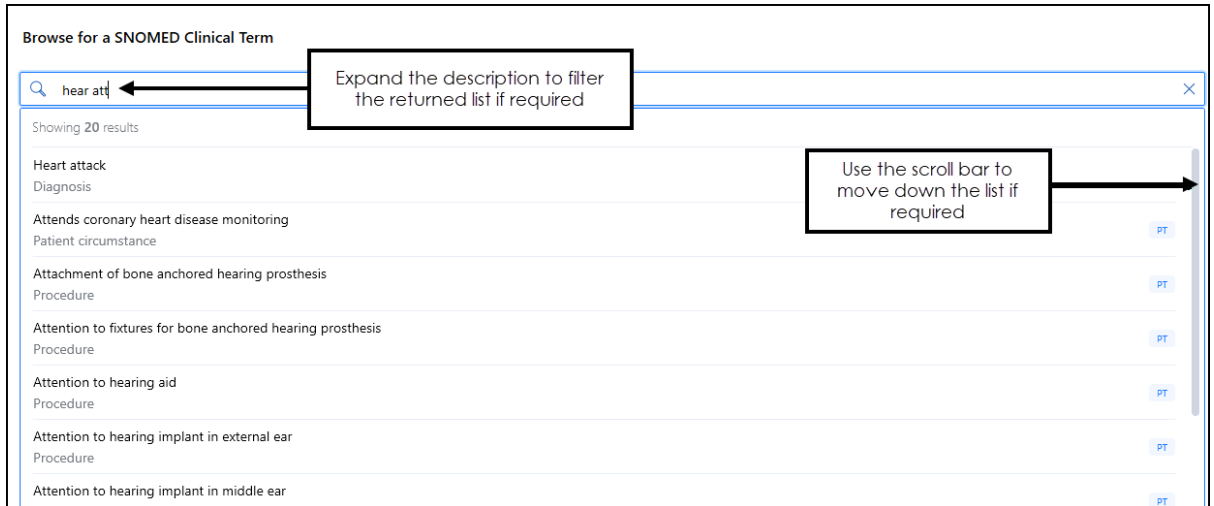
Heart attack
Diagnosis - add to this encounter

Attends coronary heart disease monitoring
Patient circumstance - add to this encounter

Attachment of base-catheter to tissue synthesis

Indicates this is a Preferred Term → PT

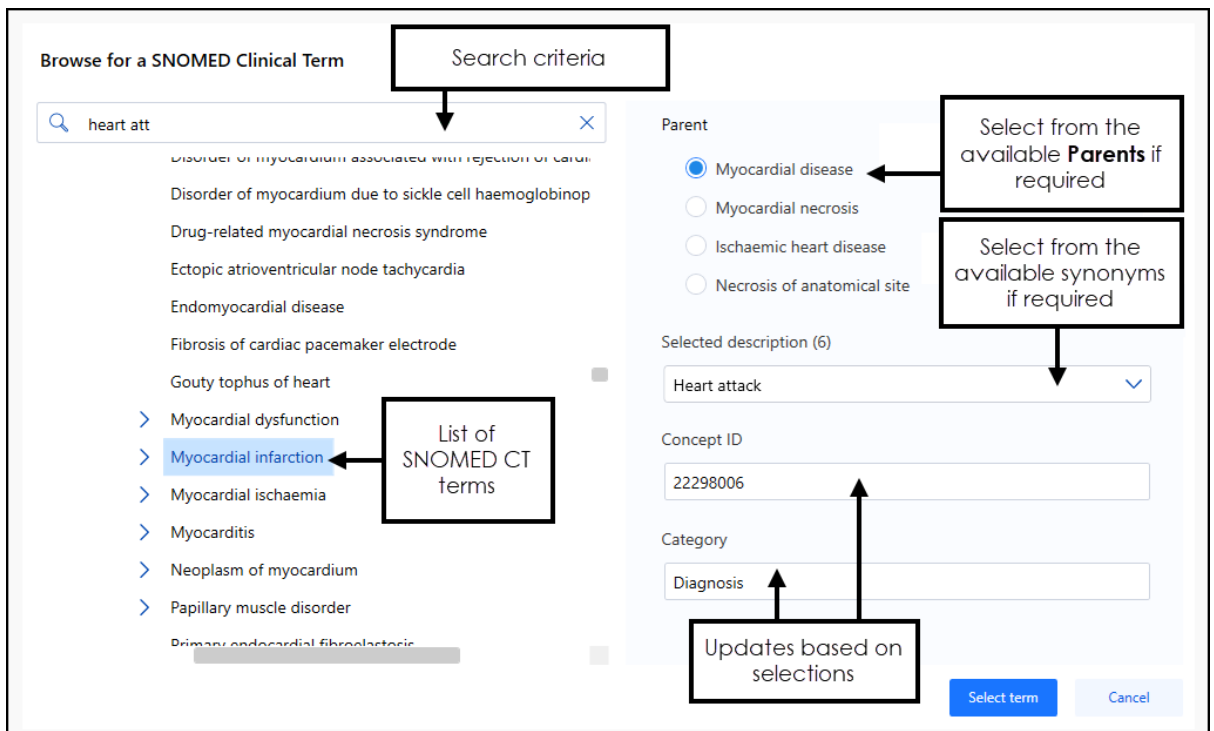
4. The **Browse for a SNOMED Clinical Term** screen displays with the list of terms matching your search:




5. Select the term you require.



 **Note** - You can change the search if required, for example, add or change the detail to update the list offered.

6. The **SNOMED CT** details display:


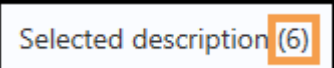


7. If required, select from the available options:

- SNOMED CT terms list** - Displays on the left, the most appropriate **SNOMED CT** term is highlighted by default. If the highlighted term is not appropriate, select **Expand**  to see more options within the selected section, or use the scroll bar to select a different term.

 **Important** - Some sections of the SNOMED CT term look to be greyed out, this means the top level of the list is not available for selection. The terms within a greyed out section, can be selected, use **Expand**  to see available terms.

- **Parent** - If the concept you select has more than one **Parent**, see example above, other options display. Select the most appropriate for the entry you are recording.
- **Selected description** - Select from the available list of synonyms to update the description if you require.


 **Note** - The number of descriptions available displays in brackets  brackets.

- **Concept ID** - Displays the **SNOMED CT** concept code of the item highlighted in the **SNOMED CT** term list to the right, this code does not change regardless of updates to the **Parent** or **Selected description**.
- **Category** - This is defined by the **Concept ID** and cannot be updated except by changing the term.

8. Select **Select term** .

9. The appropriate **Vision Anywhere** screen displays, for example,

Medical History or **Blood Pressure**, complete and select **Save** .

 See [SNOMED CT](#) on page 8, [Viewing SNOMED CT Details](#) on page 13 and [SNOMED FAQ](#) for further details.

Viewing SNOMED CT Details

In **Vision Anywhere**, every clinical entry added to a patient's record has an associated SNOMED Clinical Term.

To view the SNOMED Clinical Term details of a specific record:

1. Find the entry required, you can do this from:
 - **Search the patients record.**
 - **Categories** - Select the header of the category the entry falls under.
 - **Encounters** - Select the **Encounters** category, highlight the relevant encounter on the left and then select the entry required on the right.



2. Select **View more details**.
3. The **SNOMED Clinical Terms Details** screen displays listing:
 - **Description** - The term selected, by synonym where relevant.
 - **Description ID** - The SNOMED CT description code.
 - **Concept ID** - The SNOMED CT concept code.
 - **Category** - The SNOMED CT category the record is under.

SNOMED Clinical Term Details

Description

Description ID

Concept ID

Category

[Close](#)

4. Select **Close** to finish.

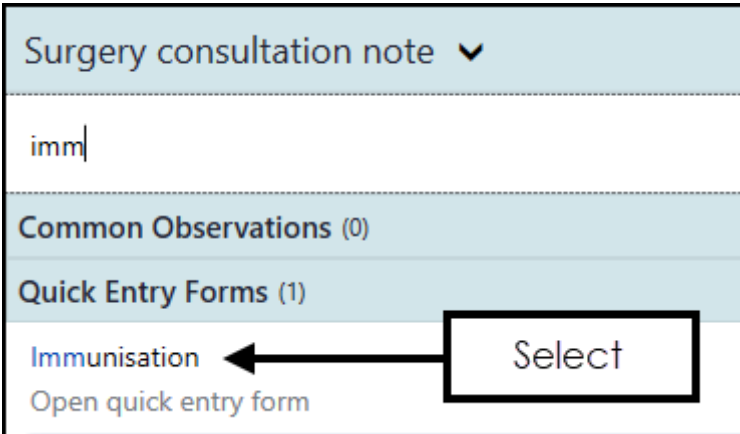
Recording Immunisations

To record an immunisation:



Training Tip – You should be aware of the immunisation stage you are recording before starting this process.

1. Select a patient record, see [Selecting Patients - Overview](#) if required.
2. Open an **Encounter**, see [Adding an Encounter](#) if required.
3. Enter 'imm' and select the Immunisation quick entry form:



The screenshot shows a search interface with the following elements:

- A dropdown menu at the top displaying "Surgery consultation note" with a downward arrow.
- A search input field containing the text "imm".
- A section titled "Common Observations (0)".
- A section titled "Quick Entry Forms (1)".
- Under "Quick Entry Forms (1)", there is a single result: "Immunisation" with the subtext "Open quick entry form".
- A black box labeled "Select" is positioned to the right of the "Immunisation" result, with a black arrow pointing from the box to the word "Immunisation".

4. The **Immunisation** screen displays:

Immunisation

Immunisation type
DP (Diphtheria/Pertussis) ✕

Stage
First dose ▼

Next dosage due
12-Jan-2021

Administration of bacterial and viral vaccine

Status
Given ▼

Method
Intramuscular ▼

Site
None ▼

Batch number

Notes

Date
15 ▼ December ▼ 2020 ▼

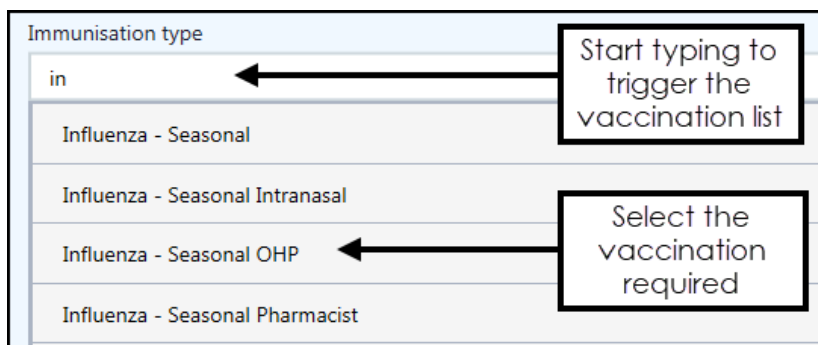
Time
10 ▼ 22 ▼


Given by
Dr. Winifred Wiltshire

Location
In this practice ▼

5. Complete as required:

- **Immunisation type** - Using keywords, select the immunisation required if not populated by the dynamic search bar:




 **Note** - Compound immunisations are written back to **Vision 3** as one combined immunisation. If you are a **Vision 3** practice, you may need to look at any reports you have written to ensure this data is included.

- **Stage** - Select from the available list as appropriate.
- **Next dosage due** - Automatically completes where a recommended next dosage date is available.
- **Status** - Defaults to **Given**, select from the available list if appropriate.
- **Method** - Defaults to the recommended administration method depending on the vaccination selected, update if required.
- **Site** - Select the site of vaccination as appropriate.
- **Batch number** - Enter the batch number of the vaccination if required.
- **Note** - Enter any comments required.
- **Date** - Defaults to today, update if appropriate.
- **Time** - Defaults to system time, update if appropriate.
- **Given by** - Defaults to:
 - In a practice setting:
 - The clinician logged in, update if appropriate.
 - The **Usual GP** if an administrator is logged in, update if appropriate.
 - In a shared care setting:
 - Blank

- **Location** - Depending on how you are logged into **Vision Anywhere**, defaults to:
 - Logged in as a practice user - **In practice**, update if appropriate.
 - Logged in as shared care user - **Out of practice**, update if appropriate.



6. Select **Save**.

 **Note** – Once an immunisations is recorded with all details, it is included in any relevant Clinical Audit, searches and recalls.

Viewing Immunisations

From the **Patient Summary** screen, **Immunisations (n of x)**, where n is the number being displayed and x is the total number of immunisations recorded, displays vaccination information:

Immunisations (10 of 14) >

14-Dec-2020	Pneumococcal conjugate vaccine Stage 1 - Given	← Immunisation given
14-Dec-2020	Pneumo conj Prevenar13 2 dose Stage 1 - Given	
14-Dec-2020	Influenza vaccination declined	
04-Oct-2020	Influenza - Seasonal Stage 1 - Given	
07-Jul-2020	Typhoid/Paratyphoid Stage 2 - Given	
12-Apr-2018	Anthrax Stage 4 - Given	
06-Nov-2015	MMR (Measles/Mumps/Rubella) Stage B - Given	
13-Aug-2014	Influenza - Seasonal Stage 0 - Refusal to start or complete course	← Immunisation refused
27-Jun-2013	Influenza - Seasonal Stage 0 - Given	
27-Jun-2013	Influenza vacc consent given	← Immunisation consent

Select **Immunisations** to display the full vaccination history:

Immunisations Search the patient's record 🔍

Showing all entries (2)

10-Feb-2014	Influenza - Seasonal Stage 0 - Given Next stage due 10-Feb-2015	Dr Diane Heys	Immunisation
13-Dec-2008	Influenza - Seasonal Stage 0 - Given	Dr Mel Earth	Immunisation

Preferred Pharmacy

Preferred pharmacy is used to record a patient's preference for their paper prescriptions. The name of the preferred pharmacy selected displays on the top left-hand corner of the patient's prescriptions.

You can view and change a patient's **Preferred pharmacy** from:

- **Patient Banner** - Select **Options**  and then **Preferred pharmacy**.



FORSTER, Nicholas (Mr) Known allergies

Born 01-Aug-1974 (46y) Gender Male NHS 811 112 7936

Preferred pharmacy

If a preferred pharmacy is set, the **Preferred pharmacy** screen displays with current preferred pharmacy details:



Preferred pharmacy
For management of paper prescriptions

Select Pharmacy
Boots The Chemist Clear

33 HIGH STREET, BIGVILLE, BERKSHIRE, AA1 1AA

01382 666555

bootsEDIT@pharm1.com

Select to
- Open location in Google Maps
- Call the pharmacy via your default phone app
- Email the pharmacy

Save changes Cancel

If a preferred pharmacy is not set, the **Preferred pharmacy** screen displays with no details:



Preferred pharmacy
For management of paper prescriptions

Select Pharmacy
Select pharmacy from the list... Clear

Save changes Cancel

To add or update the pharmacy selected, select from the available Select Pharmacy list and select **Save changes**.

 **Note** - To remove a preferred pharmacy with no replacement, select **Clear**.

- From the **Patient Summary** screen, select **Demographics**:

Demographics

Patient's GP	
Registered Practice	INPS Leeds Test Practice
Registration Status	Permanent
Registered GP	Dr. Susan Somerset
Usual GP	Dr. Susan Somerset
Preferred Pharmacy	Boots The Chemist Change
	 33 HIGH STREET, BIGVILLE, BERKSHIRE, AA1 1AA
	 01382 666555
	 bootsEDIT@pharm1.com


Where no **Preferred Pharmacy** is set, **Not set** displays

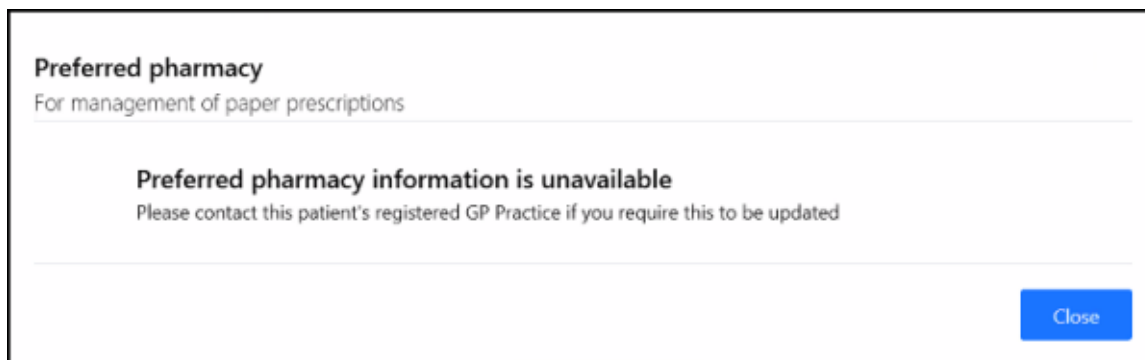
To add or update the pharmacy selected, select **Change** and the Preferred Pharmacy screen displays, select from the list available and select **Save changes**.

 **Note** - To remove a preferred pharmacy with no replacement, select **Clear**.

Any changes, in **Vision Anywhere** to a preferred pharmacy, are reflected in the patient record in **Vision 3**.

Preferred Pharmacy in a Shared Care Setting

In a shared care setting, **Preferred Pharmacy** is available for patients registered at Vision practices only. In patient Demographics, the **Preferred Pharmacy** for an EMIS patient displays as **Unknown** and from **Options**  - **Preferred pharmacy** a 'Preferred pharmacy information is unavailable' message displays:



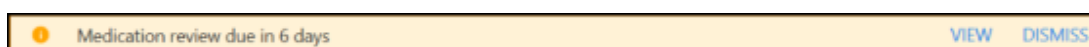
Medication Reviews

In order to maximise the effect of treatment(s) prescribed, a patient's active medication should be reviewed on a regular basis. A medication review can be carried out either with or without the patient present.

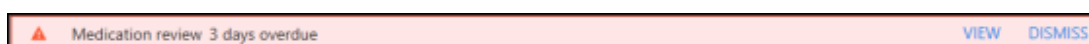
- If a patient has an active **Medication Review** on their record in **Vision 3**, that is yet to fall due, a blue alert banner displays on the **Medication** screen:




- If a patient has a **Medication Review** due or overdue in **Vision 3**, an alert banner displays on their record. If the medication review is:
 - **Due in the next 14 days** - An orange banner displays:



- **Overdue** - A red banner displays:



 **Note** - If there is more than one active Medication Review, **View** changes to **View All**.

To view the details of a due or overdue **Medication Review**, from:

- The alert banner, depending on the number of outstanding **Medication Reviews**, select:
 - **View** - The **Medication Review** screen displays with the details of the medication review outstanding, or
 - **View All** - The **Patient Alerts** screen displays, listing all active alerts for this patient and their status. Select the medication review required and the **Medication Review** screen displays with the details of the medication review outstanding.

Patient Alerts					
Title	Alert type	Status	Date	Info	
Asthma medication review	Medication Reviews	Due	Due today		
Coronary heart disease medic...	Medication Reviews	Outstanding	Due in 1 month		
Epilepsy medication review	Medication Reviews	Overdue	Overdue by 1 week		



The screenshot shows a web interface for a 'Medication Review'. At the top left is a back arrow icon. The title 'Medication Review' is centered at the top. To the right is a search bar with the placeholder text 'Search the patient's record' and a magnifying glass icon. Below the title, the text 'Medication review with patient' is displayed. Underneath, there is a light blue box containing the following information: 'Due date: 25-Jan-2019', 'Review status: Overdue', 'Reviewed by: Dr Tim Torbay', and '13-Aug-2014 , Dr Susan Somerset'.

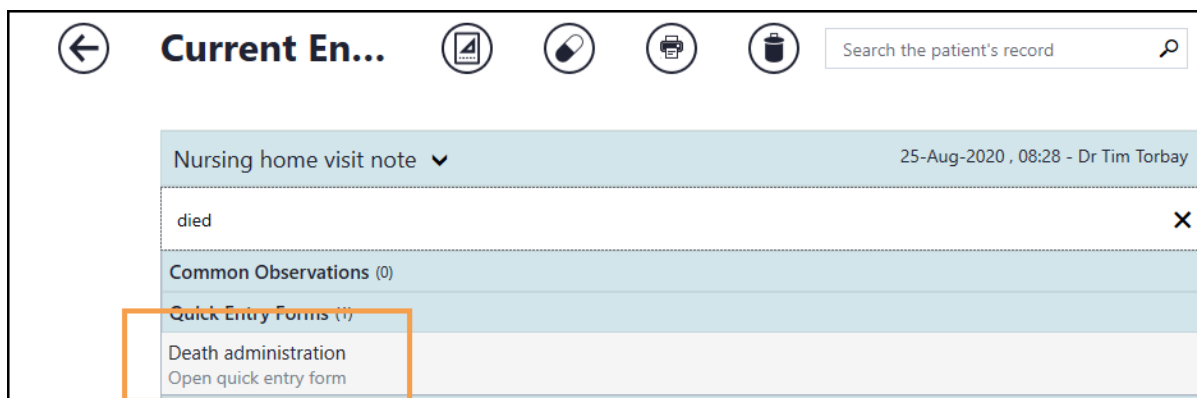
- **Search the patient's record** - Simply type *medi* into **Search the patient's record** and **Medication review record entries** returns, select to display the details.
- **Clinical Record Browser** – From **Patient Summary**, right click anywhere to access the toolbar. Select the arrow alongside the Patient Summary option and select **Clinical Record Browser**. Any **Medication Reviews** display as part of the patients record.

Recording Death Administration

The **Death Administration** form is a quick and easy way to record the details required when a patient dies.

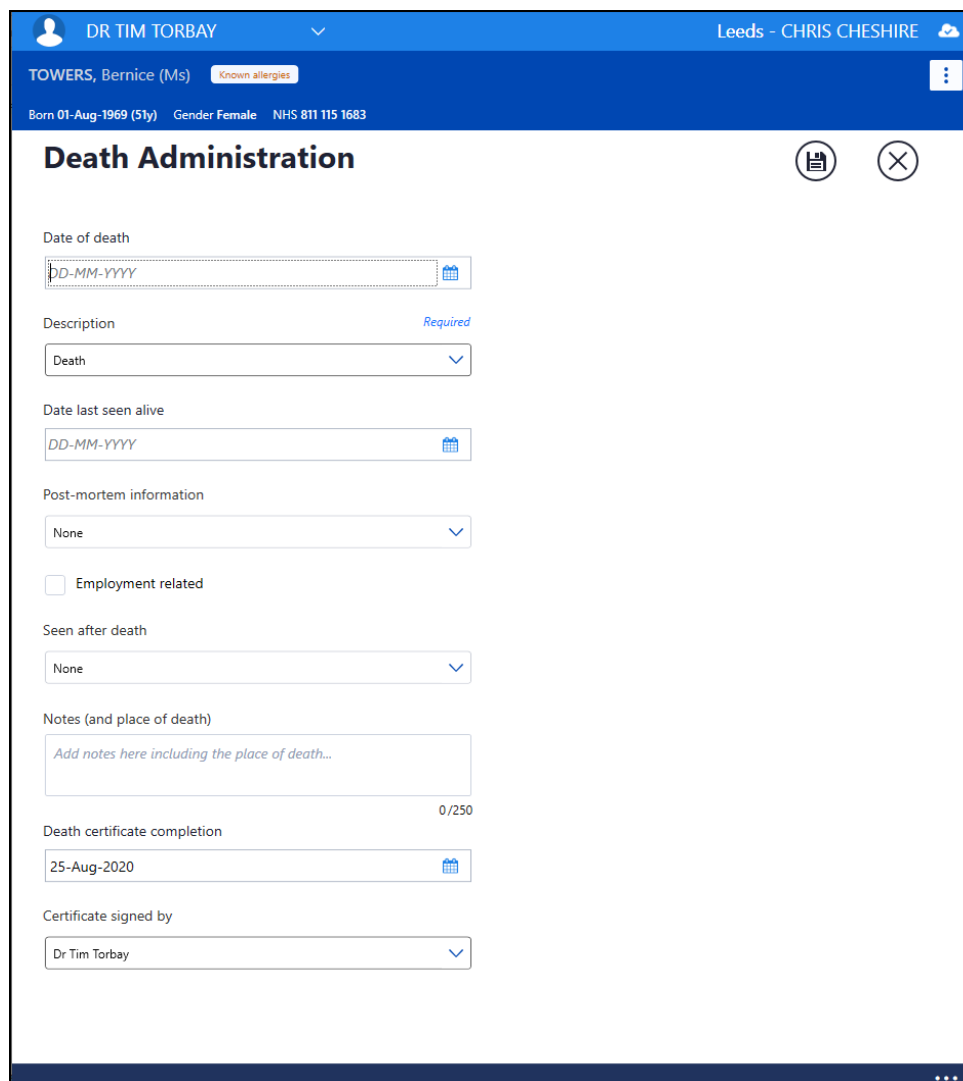
To record death administration:

1. With the patient selected and an appropriate **Encounter** started, enter **died** in the dynamic search bar.
2. From **Quick Entry Forms**, select **Death administration**:



The screenshot shows the 'Current Enc...' screen with a search bar containing 'died'. Below the search bar, a list of 'Quick Entry Forms (1)' is displayed, with 'Death administration' selected and highlighted by an orange box. The 'Death administration' option includes the subtext 'Open quick entry form'.

3. The **Death Administration** screen displays:



The screenshot shows the 'Death Administration' form for patient TOWERS, Bernice (Ms). The form includes the following fields:

- Date of death:** DD-MM-YYYY
- Description:** Death (Required)
- Date last seen alive:** DD-MM-YYYY
- Post-mortem information:** None
- Employment related
- Seen after death:** None
- Notes (and place of death):** Add notes here including the place of death... (0/250)
- Death certificate completion:** 25-Aug-2020
- Certificate signed by:** Dr Tim Torbay

4. Complete as appropriate:

- **Date of Death** - Enter the date of the patient's death.
- **Description** - Defaults to **Death**, select from the clinical terms available if required.
- **Date last seen alive** - Enter a date if required.
- **Post mortem information** - Defaults to **None**, select from the list if appropriate.
- **Employment related** - Tick if the death is related to the patient's employment.
- **Seen after death** - Defaults to **None**, select from the list as appropriate.
- **Notes (and place of death)** - Enter any free text comments appropriate, up to a maximum of 250 characters.
- **Death certificate completion** - Defaults with today's date, update if required.
- **Certificate signed by:**
 - If you are signed in as a clinician, this defaults to your details, update if appropriate.
 - If you are not signed in as a clinician, this defaults to the patient's Usual GP, or if there is no active Usual GP, their Registered GP. Update if appropriate.



Note - If you are a Vision 3 user and the patient's practice is on Vision 3 release DLM 730 or lower, you can only update the **Certificate signed by** to **Other**.

- **Shared Care Setting - Certificate signed by** defaults to **Other** and cannot be updated.



5. Select **Save**.



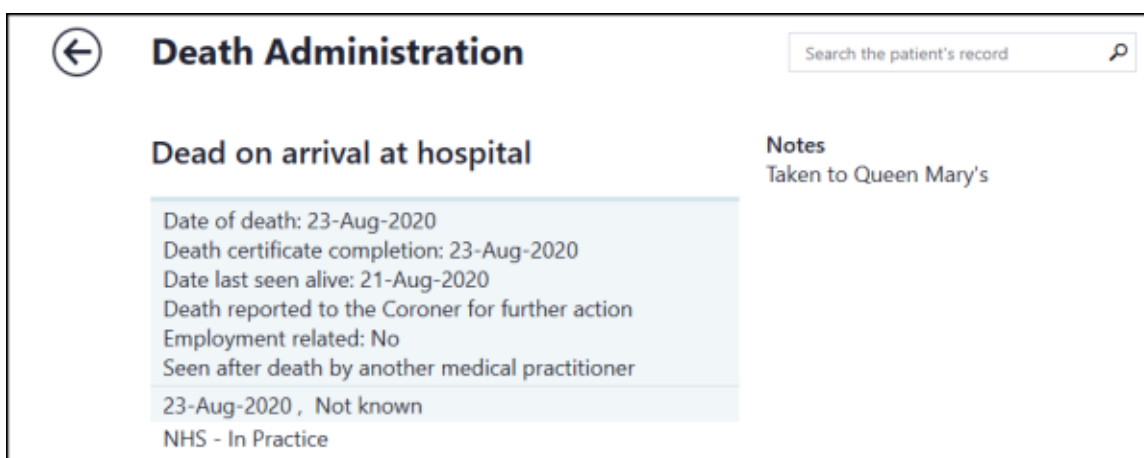
See [Viewing Death Administration](#) on page 26 for further details.

Viewing Death Administration

You can view **Death Administration** data from:

- **Encounters** - From the **Patient Summary** screen, select **Encounters** and then the **Encounter** required to see the detail.
- **Search the Patient Record** - Enter *death* into **Search the Patient Record** and the smart list returns any matching entries, select the entry required and the **Patient Record Search** screen displays with those entries.
- **Clinical Record Browser** - Right click anywhere on the patient record, select **Patient Summary - Clinical Browser**, all clinical entries display under the **Encounter** they were added within.

The **Death Administration** screen displays:



The screenshot shows the 'Death Administration' screen. At the top left is a back arrow icon. The title 'Death Administration' is centered at the top. To the right is a search bar with the text 'Search the patient's record' and a magnifying glass icon. Below the title, the main content is divided into two sections. The left section is titled 'Dead on arrival at hospital' and contains a list of details: 'Date of death: 23-Aug-2020', 'Death certificate completion: 23-Aug-2020', 'Date last seen alive: 21-Aug-2020', 'Death reported to the Coroner for further action', 'Employment related: No', 'Seen after death by another medical practitioner', '23-Aug-2020 , Not known', and 'NHS - In Practice'. The right section is titled 'Notes' and contains the text 'Taken to Queen Mary's'.