VISION

DLM 260 User Guide

Including:

Prescribing Safety - Changes to Drug Check Options and Drug warnings

Event Log enhancement

Nurse and Independent/Supplementary Prescribing Changes

Patient Contacts and Next of Kin

Electronic MED3

Wales:

Repeat Dispensing Changes -

Mail Manager changes

Scotland:

Gold Standards Framework Scotland - Palliative Care Guideline and Reports

SCI Gateway - Mapping priorities

eAMS

GPC Scheduler

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Table of Editions and Contents

Date	Version	Contents	Output
05.09.07 20.09.07	260 - 1495	ESTU –Prescribing Safety, Event Log, Repeat Dispensing Wales, Predicted PF for Children, JTHO - GSFS and Next of Kin	PDF
04.10.07	260 - 1526	NI Nurse Prescribing, Immunisations	
08.10.2007	260 - 1531	Mail Manager, Prescribing Safety update, Event Log update	
24.10.07	260-1544	ESTU/JTHO	pdf
29.10.07	260-1544	DOKE comments 24/10 re Prescribing Safety Mail Mngr - Cautionary note re bulk action unread messages Mail Mngr - New option per user to complete/add action	
31.10.07 07.11.07 14.11.07	260-1544	Nurse prescribing chart EWSNI Change to lactation checking TTP 16823, 16923	pdf
19.11.07 20.11.07	DLM 260-1566	Apps - Patient info in System Constants. later removed NI H&C and other 280 changes Remove above	
26.11.07	DLM 260-1578	Mail Manager - new File Tab	
27.11.07	DLM 260-1578	Remove Nurse prescribing not yet programmed Final edit	pdf
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09.01.08	DLM 260-1622	SCI Gateway Mapping priorities Update Nurse prescribing section Mail Manager - correct unassigned	pdf
28.01.08	DLM 260-1655	Hatching changed to shaded area on scripts for dangerous drugs	pdf
29.01.08	DLM 260-1655	Mark as Read icon in Mail Mngr Event Log viewer - select patient	pdf
07.02.08	DLM 260-1667	Palliative Care reports only available for Scotland	pdf
13.02.08	DLM 260-1667	GPC Scheduler Scotland for DC, ECS, and PTI	Pdf
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11.03.08	DLM 260-1728	Nurse prescribing amendments	pdf
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18.03.08	DLM 260 -1728	MED3 additional functionality GSFS manual problem gen.	pdf
19.03.08	DLM 260-1728	GSFS Diagnosis information recombine doc/HTML	
26.03.08	DLM 260-1746	Reassociate tif files	pdf/HTML
27.03.08	DLM 260-1746	Not necessary to keep MM open to collect messages. SCR changes Reg Links archive to network drive Problems now dated in CA MM multiple actions, flow chart	HTML
31.03.08	DLM 260-1746	SCI Gateway amendment	HTML
03.04.08	DLM 260-1746	Reg consent PC/ECS mistake	HTML
14.04.08	DLM 276-1749	eAMS in dlm 260 ECS extract twice a day SCI Gateway Refs "The patient context could not be set"	HTML
24.04.08	DLM 260-1761	SCI Gateway - new error message	HTML
28.04.08	DLM 260-1761	In Scotland, MM must be left open for messages	HTML
07.05.08	DLM 260-1761	Visual acuity 6/7; mail for GP2GP 'foreign staff' in MM remain unallocated.	HTML
09.06.08	DLM 260-1800	GSFS Switch on for Scotland in Options-Setup	HTML
11.06.08	DLM 260-1800	GSFS Care plan mandatory for OOH Summary Report DS1500 Read code not in Scottish dictionary	HTML
28/09/10	DLM260 – 1800	Style updated	Docx & PDF

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Summary of Changes

12.06.08

Consultation Manager

- The Add menu has a new option - MED3. This is a prelude to a pilot project for **electronic MED3 Doctor's statement**. See "Electronic MED3 Doctor's Statement" on page 28.

- The **Predicted Peak Flow** calculation has been disabled for **children** under 16.

- **Next of Kin** as well as Carers can now be recorded on the **Contacts** screen (new name for the Carers tab) in Consultation Manager - Patient Details, and Registration. See "Contacts (carers and next of kin)" on page 75.

- You will be asked to **confirm deselection** if you have a current form open, such as History, Therapy, BP etc and you then deselect the patient by one of the usual deselection methods. See "Confirmation of Deselection" on page 34.

- Adding **Hepatitis A Viatim** gives due date for Hepatitis booster but leaves typhoid due date blank.

- If you have difficulty in opening tif files from GP2GP messages or Choose and Book referrals, associate tif files with a suitable program. See "Opening Tif files from Choose and Book or GP2GP" on page 35.

- Visual acuity SDA now includes 6/7 in picklist.

Prescribing Safety

- **Prescribing Safety for Scottish practices** as per requirements from NHS Scotland. This includes some mandatory changes to the Drug Check options in Consultation - Options - Setup which you may notice when DLM 260 is installed. See "Prescribing Safety" on page 7.

- **Prescribing Safety for English, Welsh and NI practices** introduces some changes to automatic drug check settings and audit trail.

- **Patient specific** will now become the default for all users in Drug Check options for contraindications, precautions and prescriber warnings, if their current option is less rigorous.

- You can now enter **a reason why you are overriding a prescriber warning** but want to proceed anyway. The free text reason is audited and appears on the Event Log. See "Drug Warnings Override Confirmation Required" on page 12.

- When prescribing a drug to which the patient has a Drug Allergy / Adverse Reaction recorded, you will be prompted with a **Drug Sensitivity Warning**. If you want to proceed anyway, you can enter your reason in free text why you are overriding the warning. This is audited and appears on the Event Log. See "Drug Allergy/Insensitivity Warning" on page 18.

- The yellow and green **Drug Check flags** have changed shape to help colour blind users. The colour of the text used for drug warnings has now been changed from green to blue. See "Drug Warnings" on page 17.

- **Methotrexate** warnings - see "Methotrexate" on page 19

- Drugs that are on the **black triangle** surveillance list will now be marked with a black triangle on the Therapy Add forms when prescribing. See "Black Triangle Drugs" on page 22

- More warnings are now given if you prescribe for a patient who is **pregnant** or **lactating** - see "Pregnancy Warnings" on page 14 and "Lactation Warnings" on page 16.

- In line with the Patient Safety Alert, Methotrexate and all other dangerous drugs will print out onto FP10s with the signature area shaded. See "Shaded area on prescriptions for dangerous drugs" on page 21.

Event Log

- **Event Log** (Vision front menu - Management Tools) has various enhanced features. Searches can be made for individual patients. You can search between date ranges, print the results and there are more Event Types from which to select, including any reasons entered which override prescriber warnings. See "Event Log" on page 25.

Nurse and Independent/Supplementary Prescriber Changes

- Nurse Prescriber changes are summarised in tables by region - see:"Nurse Prescriber changes" on page 36.

- "England - Current Nurse and Pharmacist Prescribing Rights within Vision" on page 39

- "Scotland - Current Nurse and Pharmacist Prescribing Rights within Vision" on page 41

- "Wales - Current Nurse and Pharmacist Prescribing Rights within Vision" on page 40

- "Northern Ireland - Current Nurse and Pharmacist Prescribing Rights within Vision" on page 42.

- Independent/Supplementary prescribers are now able to issue private prescriptions in Vision for England, Wales (nurse IPs only), and Northern Ireland

Northern Ireland

- Northern Ireland HPSS have now issued cut sheet prescriptions for Community Practitioner Nurse Prescribers and Independent/Supplementary Prescribers. See "Northern Ireland - Current Nurse and Pharmacist Prescribing Rights within Vision" on page 42.

- In Northern Ireland, Community Practitioner Nurse Prescribers and Independent/Supplementary Prescribers can print repeatable and batch issues under their own names.

- Independent/Supplementary prescribers in Northern Ireland are eligible to print private controlled drug prescriptions in Vision. This does not include

Pharmacist Prescribers who are not permitted to prescribe any controlled drug.

- If a private drug is selected and a Community Practitioner Nurse Prescriber is selected as the authorising signatory, then a warning is shown and the private controlled drugs is deselected.

Wales

- In Wales the IPC (private controlled drug) code must be added in Control Panel - File Maintenance - Staff - [edit user] - Identifiers (format PNNNNNN).

- For Wales, Independent Prescribers can print repeatable and batch issues under their own names. See "Wales - Current Nurse and Pharmacist Prescribing Rights within Vision" on page 40 and "Repeat Dispensing" on page 47.
- Scripts updated for GPs and Nurse IPs to include RA/RD.

Mail Manager

- To allow for National Services messages to be sent and received efficiently, please remember to keep the **Mail Gateway open** at all times if you are a LAN practice, and during working hours if you are on the Managed Service/VES.

- In England, it is no longer necessary to keep Mail Manager open all the time, in order to maximise messaging performance and avoid messaging errors. Message spooler periodically collects messages whether Mail Manager is open or not.

- In Scotland, it is still necessary to keep Mail Manager open all the time for message processing, and minimised at the bottom of the screen. for each user, in Tools - Options - Message tab, tick the Refresh box, set the interval to 10 minutes, and tick the option Process messages when refresh selected.

- In England, after DLM 260, Mail Manager will start to **archive automatically** messages relating to ETP, Choose and Book, PDS Update and GP Summary, if the message has been successfully acknowledged (i.e. Sent or Complete). Any rejected message in error will remain in the Incoming/Outgoing folder for your attention.

Note - The first time that you open Mail Manager after receiving DLM 260, the automatic archive process will start. **This might take some time** if you have not already been manually archiving messages on a regular basis. You are able to exit Mail Manager whilst the automatic archive process is initially running as it will recommence when Mail Manager is next started.

- You can **Mark as Read a number of messages at the same time**. See "Bulk Mark as Read" on page 63.

- You can **add the same action message to several messages** at once. See "Actioning Multiple Messages" on page 60.

Note - You should use the bulk action facility with caution and restrict it to messages that have been read. Adding a bulk action does NOT mark a message as read. There is a clinical risk of actioning items that have not even been viewed, let alone, read.

- **File All** or **File Abnormal** will now file **all** tabs of a multi-specimen message. A new option, **File Tab**, available by right clicking within a result, will file all results from the currently displayed tab only. See "File All, File Abnormal and File Tab for multi-specimen messages" on page 65.

- If double clicking on a message, next screen's default (set in Tools - Options - Messages) can be either Complete (the message) or Add an action. See "Default options when double clicking a message" on page 61.

- All incoming xml messages will automatically be assigned to the **Usual GP's** mailbox rather than the registered GP's mailbox.

- **Reminder** - You can remove mailboxes from your Mail Manager view by removing your rights to their Mailbox in Control Panel - Mail Maintenance - Staff Access. See "Mail Manager Training Tip - Remove Mailbox from Mail Manager View" on page 68.

- **Reminder** - Temporary access to a person's mailbox, e.g. a holiday period, can be gained by entering date ranges in Control Panel - Mail Maintenance - Staff Access.

GP2GP

- Staff details from incoming GP2GP messages are automatically added to the Staff section in Vision File Maintenance as inactive staff, and a mailbox is created in Mail Manager. Display of these inactive staff will be completely hidden from DLM 280 and in the meantime, make sure any Display Inactive or Active Only options are selected accordingly when searching for current active clinicians in your practice. Mail for such staff in Mail Manager will be unallocated.

Summary Care Record

- If you are running the Initial Upload on a VES system, it is imperative that you do not end the session on the machine that is running the Initial Upload until it has completed. See "Running the Initial Upload on VES" on page 73.

- If you do not add a patient preference, yet add and save supplementary data to the National Summary pane (either manually or through Management Options), the status of the summary will remain as outstanding. See "SCR Status – No Preference with Supplementary Data" on page 73.

- If a patient's previous practice send a summary to the Spine subsequent to a summary being sent from Vision, thus creating a more recent summary - see "Multiple Summaries" on page 74.

- Reminder that you must start a face-to-face consultation in order to record a patient's preferences. See "Training Tip - Recording Patient Preferences" on page 72.

Clinical Audit

- Problems are now displayed with a date and a problem description, when viewing patient data under the Month/Year tab.

Registration Links

- The Quarterly Archive no longer needs to be saved to a floppy disk drive, but will automatically go to a network drive (if there is no drive A) - usually P:\archive.

Gold Standards Framework - Palliative Care (Scotland and other countries)

- A **GSFS guideline**, accessed from within Consultation Manager (mnemonic *GSFS1), can be used to enter palliative care data. Written in accordance with the Gold Standards Framework for Scotland, this guideline can be used by all countries. See "Gold Standard Framework Scotland - Palliative Care" on page 78

- In Scotland only, the data is picked up by three **Palliative Care Reports**, a new menu option on the Reporting menu (from Vision front menu). See "Palliative Care Reports (Scotland only)" on page 113

- At present, only Scotland will eventually have the messaging component as part of their ECS (Emergency Care Summary). In Scotland only, switch Palliative Care Extract on from the Vision front menu in Options - Setup to enable the GSFS messaging.

- Practices in Scotland should create a GSFS problem which forms part of the messaging (either using semi-automatic problem generation or if they prefer, manual problem generation). It is not necessary to create a GSFS problem in England, Wales or Northern Ireland.

SCI Pathology (Scotland)

- **SCI Pathology** will be released shortly, allowing Scottish practices to receive pathology messages into Vision Mail Manager via SCI Stores - see "Scotland - SCI Pathology" on page 131.

eAMS (Scotland)

- **eAMS** is now being implemented in DLM 260. This is the electronic Acute Medication Service which forms the first phase of ePharmacy. Very similar to ETP in England, eAMS prescriptions are printed with a barcode and given to the patient as well as an XML message transmitted to the ePharmacy database. See "Scotland - eAMS" on page 132.

SCI Gateway (Scotland)

- **SCI Gateway Referrals** - Medical Histories which are sent from Consultation as part of a SCI Gateway referral are mapped to SCI priorities, which are user definable. See "Scotland - SCI Gateway Referrals" on page 133

- Advice re three issues from NHSScotland regarding pre-population of SCI Gateway referrals that some practices have been experiencing intermittently - see "SCI Gateway " on page 135

GPC Scheduler (Scotland)

- **GPC Scheduler** is used to schedule the timings for the extracts for SCI DC (Diabetic Care), ECS (Emergency Care Scheme) and PTI (Practice Team Information). See "GPC Scheduler - Scotland" on page 137.

Prescribing Safety

Introduction

Following advice received from the NHS Scotland, we are making a number of changes to the Vision Prescribing and Medication modules, to enhance the safety checks built into the prescribing system. INPS believes these will improve the safety profile of Vision and that all practices should benefit from the enhancements. Primarily they are aimed at improving the highlighting of the results of the prescribing checks and allowing users to record why they override the warnings, if they do. All such overrides will be audited and viewable in the Event Log.

Dr M Robinson

Medical Director

INPS

Implementation

Upon receipt of DLM 260, the Prescribing Safety changes will immediately take effect for all users. Because of this, you might find that your previous settings have changed. You are advised to review these settings from **Consultation Manager – Options – Set-up – Drug Check.**

Some changes are specifically for Scottish practices, required by Scottish Enhanced Functionality (SEF) for NHS Scotland.

Whilst you are able to reduce the levels of warnings that are displayed when prescribing, it is no longer possible to disable the active drug check prompts in Vision.

> **Note** - All drug settings in the Consultation Manager Setup screen are on a per user basis. Please ensure that when you are changing these settings, you are not logged into Vision anywhere else in the practice as the changes will not be saved.

See:

Minimum Number of Days for Drug Check

Automatic Results Display On

Interactions

Drug Warnings Override Confirmation Required

Minimum Number of Days for Drug Check

Go into **Consultation Manager – Options – Set-up – Drug Check.**

The **minimum** number of days which the drug and sensitivity offset date can be set is now 30 days. In line with this, the Currently Relevant Option has been removed from the Drug Check screen; this means that all Drugs will be included in the drug checking process rather than just the drugs that are within a currently relevant date range. We have also removed the option for the drug checks to look at just Currently Relevant Clinical Data, in favour of **All Clinical Data** to be included in the drug and sensitivity checks.

> We recommend that all users set the date offset to 1 year. On receipt of DLM 260, **all** users who have an offset date of less than 30 days will be automatically changed to the **minimum 30 days** offset. For new users, the default Therapy drug check offset date is set to 1 year.

If you would like to review these options:

1. In Consultation Manager select **Consultation – Options – Setup – Drug Check**.
2. In the **From Last (Date offset)** box, type in the required period of time the drug check will cover; the minimum is 30 days. You can use the date shortcuts, for example, to enter 1 year, type 1y, 60d for 60 days and 8w for 8 weeks.

Automatic Results Display On

Go into **Consultation Manager – Options – Set-up – Drug Check.**

Contraindications, Precautions and Prescriber Warnings

- All users will be changed to the **Patient Specific** option for Contraindications, Precautions and Prescriber Warnings if their current option is less rigorous. More rigorous options will not be changed.

- There is no longer an option to switch these warnings off (Never Display has been removed as an option).

- The order of the drop down list has changed so that the most rigorous drug check options are now displayed first.

Practices in England, Scotland, Wales and Northern Ireland

Reminder of options:

- **Display All** – Shows all warnings regardless of whether patient has record of condition or not – some clinicians may want to choose between Display All or Patient Specific.

- **General** – Shows patient specific and more important warnings only.

- **Patient Specific** – Only show those warnings for which patient has a associated record of the condition.

If you try to reduce the levels of warnings, for example from Display All to Patient Specific, you will be prompted with the following:

> *Are you sure you wish to reduce this warning level? This may have negative consequences for patient care?*

You can select Yes or No. This is also recorded in the audit trail and can be found in the Event Log.
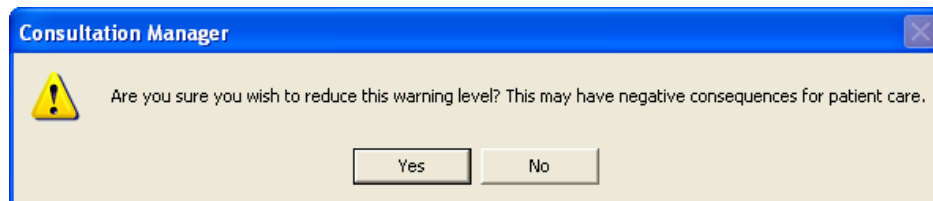
Interactions

Go into **Consultation Manager – Options – Set-up – Drug Check.**

Drug to Drug

Interaction warnings are still shown by red bars up to three levels but the setting options have changed. For Scottish practices, you can select High/Medium/Low, or High/Medium, to display drug to drug interactions, but you cannot select High.

- **High, Medium and Low (previously Level 1)** – Displays mild, serious and life-threatening interactions (i.e. Levels 1, 2 and 3).

- **High and Medium (previous level 2)** – Displays serious and life-threatening interactions**.**

- **High (previous level 3)** – Displays life threatening interactions only.

- **Context sensitive can still be ticked**- These interactions depend on the drug being prescribed and the patient's general condition and age.
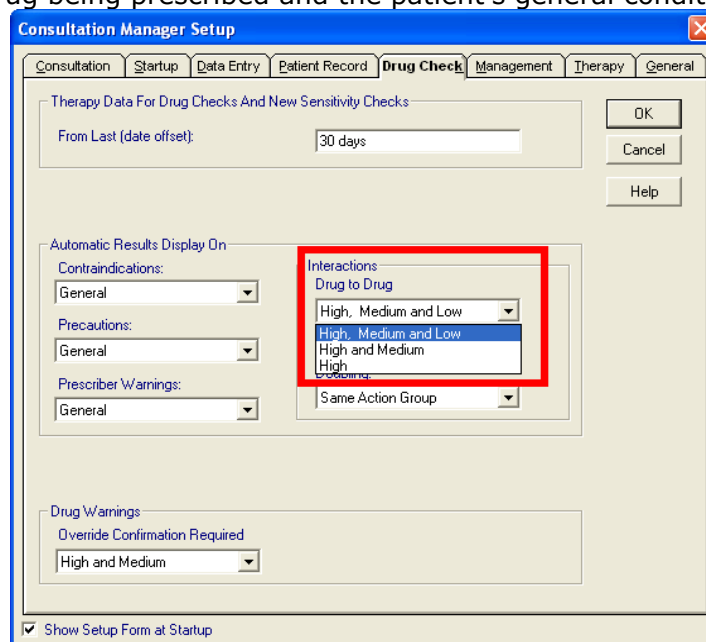
Practices in England, Wales and Northern Ireland have all three options. Practices in Scotland cannot select High and can only select High and Medium, or High Medium and Low.
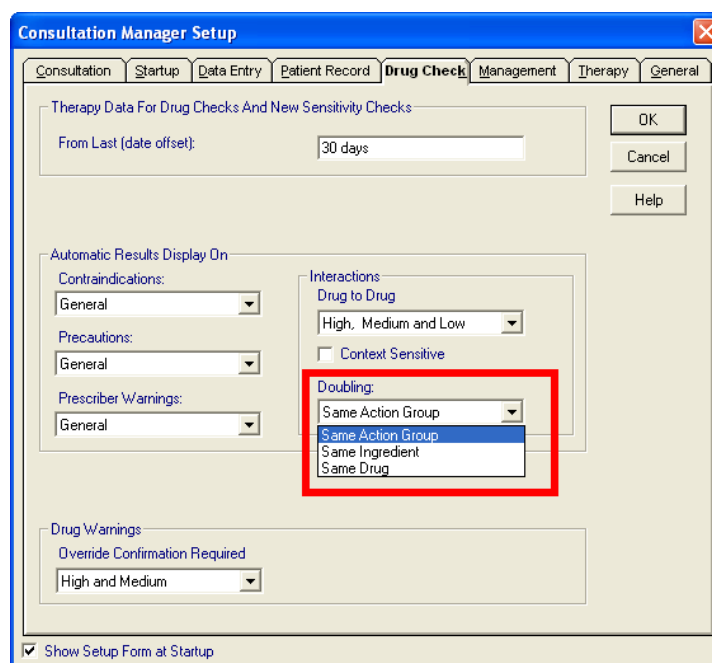
Drug Doubling

The order of the **Drug Doubling** picking list has changed so that the most thorough drug checks are displayed at the top of the list.

Doubling provides an extra drug check at the end of Therapy Add so that the therapy item being added does not double with the patient's other therapy by being in either the **Same Action Group**, or **Same Ingredient**, or is the **Same Drug.**

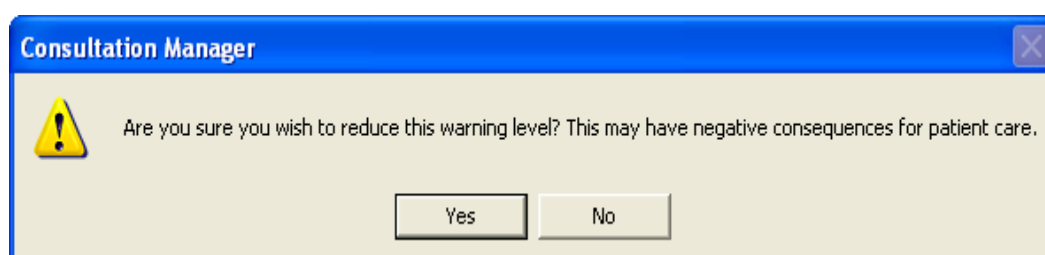**Note** The option **Same Drug** cannot be selected by practices in Scotland.

Practices in England, Wales and Northern Ireland have three options. Practices in Scotland cannot select Same Drug but can only select Same Ingredient or Same Action Group

As with Contraindications, Precautions and Prescriber Warnings, if you select to reduce the level of Drug to Drug or Doubling interactions, you will be prompted with the following:

> *Are you sure you wish to reduce this warning level? This may have negative consequences for patient care?*

You can select Yes or No. This is also recorded in the audit trail and can be found in Event Log.

Drug Warnings Override Confirmation Required

Go into **Consultation Manager – Options – Set-up – Drug Check**. There are new Drug Warnings options.
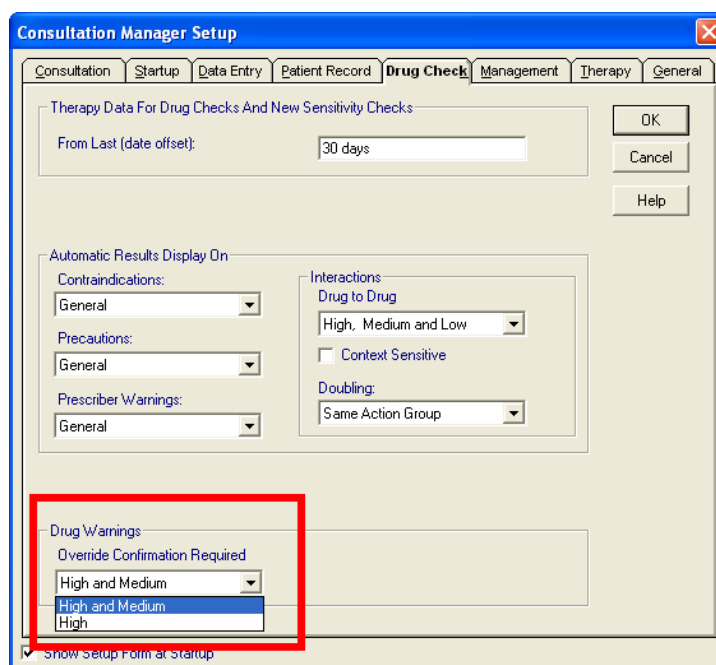You are now able to select the level of drug warnings which you require to initiate a second confirmation for drug override. This also allows you to add free text to record why you are continuing to prescribe a drug after receiving a high or medium drug warning.

> **Note**   Upon receipt of DLM 260 in England, Wales and Northern Ireland, the default setting for **Drug Warnings** will be **High**, and you are able to change this to High and Medium if you wish. **For Scottish practices, the only setting available is High and Medium.**

1. In Consultation Manager click **Consultation – Options – Setup - Drug Check**.

2. From the drop down box under **Drug Warnings - Override Confirmation Required** select either High or High and Medium (for practices in England, Wales and NI only - Scotland can only select High and Medium).


Practices in England, Wales and Northern Ireland have two options. Practices in Scotland can only be set to High and Medium.

3. Click OK.

Override reason

If you have High, or High and Medium selected, on prescribing a drug that has such warnings, you will be prompted with an initial drug warning followed by a further prompt where you can enter an override reason.

In this example, the patient has been prescribed Beclomethasone for Asthma. The system displays the relevant high and medium drug warnings and asks if you would still like to prescribe the drug:
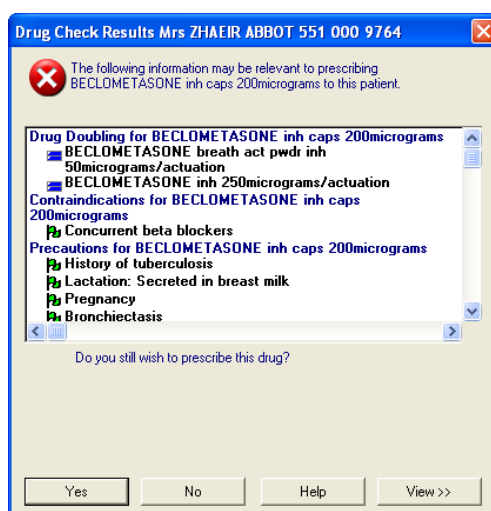
If you select No (Alt N), you will no longer prescribe the drug.
If you select **Yes** (or Alt Y) and continue to prescribe the drug, you will be prompted with the following screen where you can optionally record the free text reason why you have decided to prescribe the drug and bypass the warning. Click **Proceed** (Alt P) to continue to prescribe.
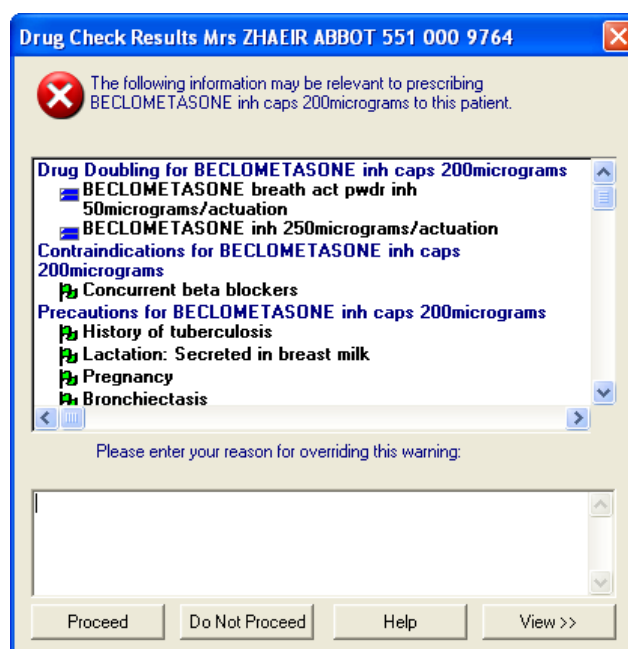
Note - If there are two or more warnings, there will only be one reason for override as they all relate to the same drug.

You do not have to enter a reason for override if you do not wish to do so. An audit trail of any free text entered or whether you have bypassed the opportunity to enter free text can be found in the Event Log (see "Event Log for Prescribing Safety" on page 17).

Pregnancy Warnings

A pregnancy warning can be given whilst adding a therapy item - previously specific warnings against pregnancy would occur if the pregnancy had been Read coded into History.

Now, the Drug Check Facility will recognise that a patient is pregnant if one of the following conditions is met:

1. One of the following Read codes or any of its sub-codes is entered on the patient record within the last year, which are **NOT** followed by a Pregnancy Outcome entry:

    - 62 Patient Pregnant

    - 27 Obstetric Examination

    - L Complications of pregnancy, childbirth and the puerperium

    -

Note The Drug Check will recognise pregnancy diagnosis if these Read codes are entered using the Medical History form or the Maternity SDA.

#62 Patient Pregnant on Medical History

Maternity Care Plan

2. Pregnancy Drug Warnings will also appear if there is an LMP date recorded in the last year in the Pregnancy Dates SDA (not Medical History) which is **NOT** followed by a Pregnancy Outcome entry:

> **Note** If the pregnancy record is older than one year, the pregnancy drug warning will not display.

Reminder - Recording Pregnancy Outcome

Pregnancy Outcome can be recorded in the Outcome SDA so that it is recognised by the Drug Check facility. This can be added in the Maternity Management plan. Please ensure that a birth status is recorded, i.e. Live birth.

Lactation Warnings

For lactation to be recognised by the Drug Check facility, one of the following should be evident on the patient record:

1. There is a live birth recorded in the Pregnancy Outcome SDA with an event date within the last two years (or if blank, the event date of this record). See Reminder - Recording Pregnancy Outcome on page 15. It this test fails, then it checks the Outcome for Live Birth with a date of discharge within the last two years (or if blank, the event date of this record).

2. One of the following Read codes is entered in Medical History within the last two years:

   - #1551   H/O Infant Breast Fed
   - #26B6   O/E Lactating Breast
   - #62E3   Feeding Intervention Breast
   - #62P1   Breast Fed
   - #62P5   Breast Feeding Started
   - #ZV241   Examination of Lactating Mother
   - #L46   Obstetric Breast and Lactation Disorders NOS

Drug Warnings

The colour of the text used for drug warnings has now been changed from green to blue. This is to ensure that there is no confusion with regards to the severity of the drug warning:
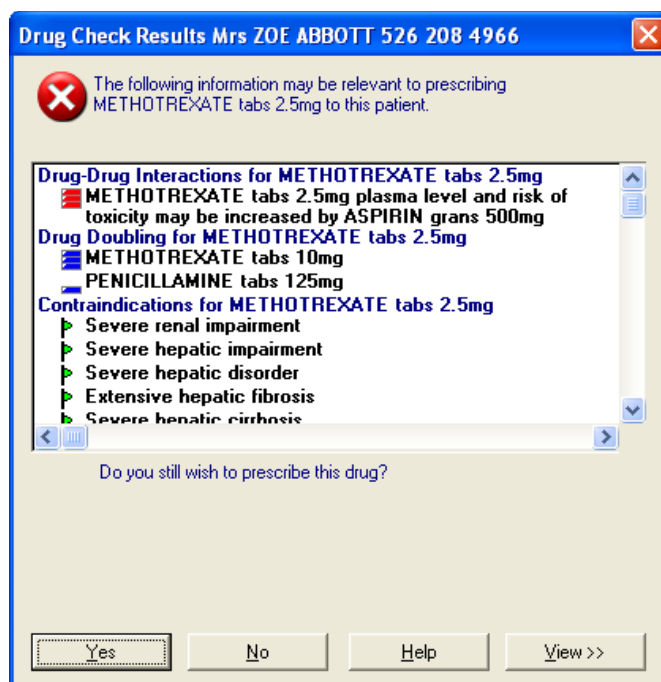
The shapes of the green and yellow drug warnings flags have been altered so that they are easily visible to those who are colour blind. The smaller flags represent less important warnings.

▶	No contraindications exist for the patient.
�	General Warning.
▶	Patient Specific warning.

Event Log for Prescribing Safety

All high risk alert overrides, viewed drug warnings (dependent on settings) and any changes to the Drug Options set-up screen in Consultation Manager are now recorded as part of the audit trail and can be searched for in the Event Log module. The searches can be run for all users or on a per user basis and you are also able to search on specific date ranges. See Event Log on page 25.

Drug Allergy/Insensitivity Warning

When prescribing a drug to which the patient has a Drug Allergy and Intolerance recorded, you will be prompted with the following Drug Sensitivity Warning and will be asked: *Do you still wish to prescribe this drug?* Note the details of the Allergy/Adverse reaction are displayed on this warning.
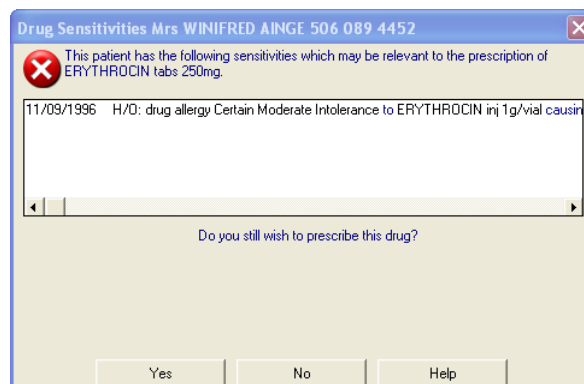
If you select **No** (Alt N), you will be taken back to the therapy add screen where you can select another drug.

If you select **Yes** (Alt Y) and wish to continue to prescribe the drug, despite the Drug Sensitivity Warning, you will be prompted with *Please enter your reason for overriding this warning:*
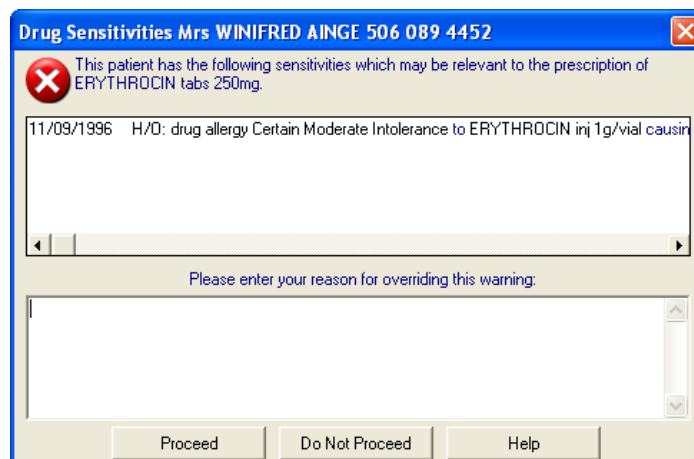
You have the option of entering free text to record why you are prescribing a drug to which the patient has an allergy/intolerance. You can of course choose not to enter free text but this is not advisable. Click **Proceed** (Alt P) to add the drug to the patient record or **Do Not Proceed** to be taken back to the Therapy Add where you can select another drug. An audit trail of any free text entered or whether you have bypassed the opportunity to enter free text can be found in the Event Log.

If you prescribe a drug to which the patient has an allergic severity of Severe, Very Severe or Fatal recorded, a High Level Warning will be recorded in the Event Log. In England, Wales and Northern Ireland only, if you prescribe a drug to which the patient has an allergic severity of Minimal, Mild or Moderate recorded, a Medium Level Warning log will be recorded in the Event Log. In Scotland, all allergy warnings are high level, regardless of security.
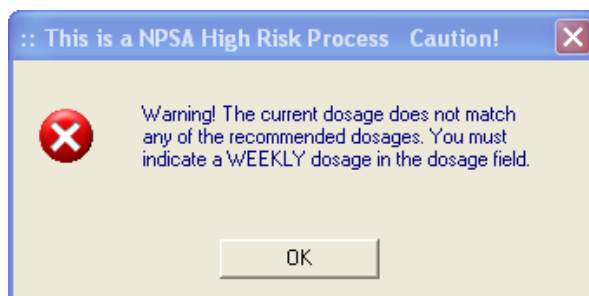
Methotrexate

Frequency Warning

If you prescribe Methotrexate with a dosage frequency that is not weekly, you will be prompted with the following warning: *Warning! The current dosage does not match any of the recommended dosages. You must indicate a WEEKLY dosage in the dosage field*.

For Scotland and Northern Ireland, Vision will not allow you to continue unless "Weekly" appears in the dosage field.

For Practices in **Scotland** and **Northern Ireland**, you will not be allowed to prescribe Methotrexate unless the word "WEEKLY" appears in the dosage text.

Methotrexate Dosage List

Methotrexate dosages can be selected from the dosage pick list in the Therapy Add screen:

Methotrexate recommended dosages

The following dosages are available for selection for 2.5mg and 10mg strengths of Methotrexate tablets.

The standard dosages are highlighted in **bold**:

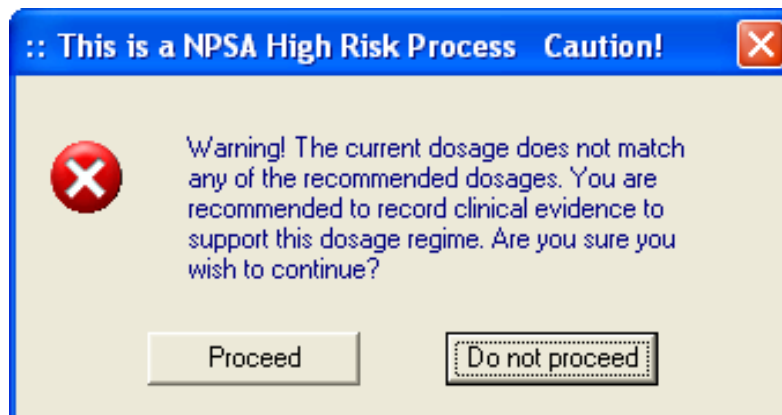| **2.5mg Methotrexate Tabs**	**10mg Methotrexate Tabs**
2.5mg (One Tablet) to be taken weekly	**10mg (One Tablet) to be taken weekly**
5mg (Two Tablets) to be taken weekly	**20mg (Two Tablets) to be taken weekly**
7.5mg (Three Tablets) to be taken weekly	*Dosages greater than 20mg will not be presented for the 10mg dose*
10mg (Four Tablets) to be taken weekly	
12.5mg (Five Tablets) to be taken weekly	
15mg (Six Tablets) to be taken weekly	
17.5mg (Seven Tablets) to be taken weekly	
20mg (Eight Tablets) to be taken weekly	
22.5mg (Nine Tablets) to be taken weekly	
25mg (Ten Tablets) to be taken weekly	

Changing Recommended Dosages

If you change the text of a recommended dosage or enter your own free text dosage, you will be prompted with the following high risk message: *Warning! The current dosage does not match any of the recommended dosages. You are recommended to record clinical evidence to support this dosage regime. Are you sure you wish to continue?*

Shaded area on prescriptions for dangerous drugs

In line with the Patient Safety Alert, Methotrexate and all other dangerous drugs will print out onto FP10s with the signature area shaded. Previously in DLM 250, the area was hatched and proved more difficult to read.

Repeat prescriptions should be retained separately for Prescriber review prior to authorising. It may help to change the printer driver software so that it shades the prescription signature space on FP10/WP10 to alert the Prescriber to this high-risk drug.

This applies to the following:

Dextropropoxyphene hydrochloride with paracetamol tabs 32.5mg + 325 mg

Co-proxamol tabs 32.5 mg +325 mg

Co-proxamol sugar-free suspension 32.5 mg +325mg

Mercaptopurine tabs 50 mg and 10 mg

Mercaptamine caps 50 mg and 150 mg

Penicillamine tabs 125 mg and 250 mg

Methotrexate tabs 2.5 mg and other methotrexate items

DISP	80	Mrs Yvonne Yvette Adams
		5 Boundary Farm Road
		Leeds LS17 5JA
11/10/1927		480 364 1978

METHOTREXATE tabs 2.5mg. Mitte (28) tablet(s).
2.5mg (one tablet) to be taken weekly

One prescription on form
X
X
X
X
X
X
X
X
X
X
X
X
X
X
X
X
X
X
X
X
X
X
X

28/01/2008

Dr Alison Hill   334123
The Health Centre
234 Ashtree Road
Leeds
Tel: 01234 567890   LS12 3RT

The Primary Care Trust   PCT code not found

Black Triangle Drugs

Black triangle products are new drugs and vaccines which are being intensively monitored in order to confirm the risk/benefit profile of the product. Such drugs have always been flagged in Vision's drug dictionary.

From now on, when you prescribe a black triangle drug, you will also see a black triangle symbol on the Therapy Add form:

See The Medicines and Healthcare products Regulatory Agency (MHRA) website for further information about black triangle drugs.
http://www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&nodeId=278

Scottish Requirements for Training, Education and Data Quality for Prescribing Safety

Requirement area	Objective	Practice Solution
Recording Pregnancy	**To ensure that the practice are informed of how to record pregnancy so that the relevant drug checks are triggered.** A full list of pregnancy Read codes recognised in the Multilex dictionary can be found in the Prescribing Safety user guide.	**To read the Prescribing Safety user guide (summarised in the DLM 260 User Guide) and ensure that all users in your practice are aware of how to record pregnancy correctly and the significance of doing so with regards to drug checks.**
Prescribing Safety Support	**Practices should be aware of the limitations and changes in the prescribing functionality of the software.** This is achieved through the availability of continual on-site and seminar training. Also DLM User Guides and integrated help files detail all functional software changes. The INPS Clinical Safety team will inform practices of any prescribing issues with the Vision software.	**To read the DLM user guides as they are released.** These are accessed from the INPS website **www.inps.co.uk** from Client Zone – DLM – Vision DLM. On-screen help can be found on the menu options under Help - Contents or Index or Search. Training should be requested when needed.
	To be trained on data quality if requested. Practices that want to organise an on site training day can speak to the training department to organise a customised training day.	**To endeavour to maintain good data quality.** Vision can only operate on the basis that data is recorded in an accurate manner. You are reminded that you should not fully rely on the prescribing safety alert system. There is a professional responsibility to manually check prescriptions before issuing them to a patient.
	Practices should be aware of any third party risk areas that are not controlled by the Vision System. For instance, uncoded information received from a laboratory or out of hours report will not be included in the drug checks.	**To monitor and tidy up any third party data that is automatically entered onto the Vision system.**
	Practices should be aware of the necessity to remove incorrect or out of date information from the	**To edit/correct or inactivate inaccurate data and understand why this must be maintained.**

	patient record to prevent unnecessary alerts to be displayed. This will be done through training, documentation and online help files.	
	Practices should be aware of the Read codes which trigger the drug interaction alerts for major disease groups and ensure that they are informed about the effects of adding free text entries with regards to drug alerts. This can be done through on site training and user help documentation.	Understand the relevance of using the correct Read codes and the consequences of using free text.
	Practices should be aware of the most effective way of recording Adverse Drug Reactions in their Vision system. This will be done through on site training and will be documented in user literature.	To request training when necessary and be prepared to look for information in user documentation.
Drug Dictionary Updates	**To provide automatic monthly drug updates to Vision customers.** Multilex Drug Dictionary changes are sent to all users on a monthly basis through DLM and are automatically installed unless higher priority tasks are scheduled.	**To regularly check that the automatic drug dictionary updates are downloaded.** This is done by checking the DLM section of the Mail Gateway. You can also check the version of the Multilex Drug Dictionary from the front screen of Vision Help - About Vision.

Event Log

The Event Log has been enhanced to allow for greater search and audit functionality:

- You are now able to search between date ranges

- It is now easier to search on Event Types through an easy to use pick list.

- You have more Event Types to select from (see below), including dismissed Prescriber Warnings.

- You can print the results of the search.

1. The Event Log is accessed from the Vision front menu from **Management Tools – Event Log**.

As required, you can select User, a From and To date range, an individual patient (or leave blank for all patients), and the Event Type(s). Then click on Search.

2. From the **User** drop down box, select the user you would like to search on or leave the setting as **All Users** if preferred. All users ever added to Vision are listed.

3. You can select an individual patient if need be using **Select Patient**. The **Deselect Patient** lets you cancel the current patient so you can move on to another patient.

4. If required, you can enter a date range for which you would like to search. The default date range is from one week ago to today. You can use date shortcuts, e.g., T (today), T-1m (one month ago), 6w (six weeks ago).

5. Next, select the **Event Type** you would like to search on (see list on page 26). This example searches for all users in the last week who have been prompted to enter Reason for Drug Warning Override.

6. You are also able to select more than one Event Type, for example, Reason for Drug Warning Override. Hold the Control key down and select the required Event Types you wish to search on. Control-click will then deselect any selections.

7. Click on **Search** to search in the audit trail.

8. The results of the search will be displayed: the date, time of the event, the user, type of event, the patient the event affects, the workstation the user was logged into and full Details of the Event.

9. Highlight a line to see details in the bottom pane.

10. You are able to print the selected Event list by clicking on the Print button at the bottom of the screen.

11. You can sort a column by clicking on the column header.

Event Types

The **Event Types** are divided into sections:

System Access : *Unsuccessful Login, Successful Login, Logout, Password Re-enter Failed, Login Aborted*. Note that unsuccessful logins should be investigated in case someone has been trying to log in on an unattended workstation.

Installations : *Drug and Read dictionary install dates, Software Installs, Prodigy Install* (Prodigy was removed in DLM 240).

Consultations : *Consultation started, Consultation ended, Patient selected, Patient deselected.*

Prescribing : *Drug Options Changed, High Level Drug Warning, Medium Level Drug Warning, Low Level Drug Warning, Drug Warnings Suppressed, Reason for Drug Warning override* (see "Drug Warnings Override Confirmation Required" on page 12).

Deleted Records : This lists any deleted records by date, deleted template letters, partnership reallocation, etc.

Other Events : *Module started, Module ended, Error message, FP10 Reprint, Over event, DA1 ReWrite failed causing duplicate records, Data Collection, Log Function usage, Login Failures cleared, Down Line Loading, GP Communicator, Report produced, Password changed, User lockout, Mail Manager message view, Screen saver invoked, Screen saver ended, Remote access dialin - INPS support, Acceptance onto caseload, Caseload self-referral, Forced Shutdown.*

New Practice events (to do with GP2GP) : *PDS Patient Trace no match found, PDS Update Failures, Patient traced on PDS success but no HCP held, Requests Sent, Negative Acknowledgements received of Type 06, Negative Acknowledgements received of Type 07, Negative Acknowledgements received of Type 08, EHR Extracts Received (Electronic health records), Failed to integrate ENR Extract, Negative Acknowledgements sent of Type 09, Negative Acknowledgements sent of Type 11, Negative Acknowledgements sent of Type 12*

Old Practice events (to do with GP2GP) : *Requests Received, Total Negative Acknowledgements sent, Attempting to send EHR to a non-current HCP, EHR Extracts Sent, Total Negative Acknowledgements received*

New/Old Practice - GNC Code to Practice Code SDS Failures

New Practice - Practice not GP2GP enabled

Edit record, Off Formulary Prescription

National Summary item edit, National Summary defer consent recording, National Summary defer initial send

Scheduled Task Failure

Electronic MED3 Doctor's Statement

Overview

A new electronic MED3 Doctor's statement is being piloted. For non-pilot practices you will be able to enter data for a MED3. In a future DLM, you will be able to print the MED3 form, and in time, transmit it electronically.

- MED3 is completed in Consultation Manager from the patient record from a new MED3 SDA (structured data area) accessed from **Add – MED3**. This is available to all practices in DLM 260.

- For pilot sites only, a copy of the MED3 can be printed and given to the patient.

- The MED3 is saved to the patient record in Consultation Manager. Existing entries can be filtered in the Miscellaneous section of the Navigation Pane.

- For pilot sites only. At regular intervals Vision will run a process to produce an audit of MED3 information that will be electronically transmitted to the Department of Work and Pensions.

Partial functionality will be introduced to all practices in DLM 260. The full functionality includes printing the MED 3 direct from Vision and giving it to the patient, as well as the electronic transmission of MED 3s to the Department of Work and Pensions. This is to be piloted in Wales with a view for full integration with all Vision users.

The new form, which is a mail-merged Word template, will be completed electronically in the process of a normal GP consultation from the new MED3 Structured Data Area (SDA) in Consultation Manager. This form will include all the information that is currently included on the handwritten MED 3 form that has been in use of many years, but provides all practices with a more structured method of recording MED3 data and offers greater flexibility in form design and evolution.

Switching On

You will be able to enter data on the new MED3 form upon receipt of DLM 260. Unless you are a pilot site, you will not be able to print the MED3 from Consultation Manager for the time being. Pilot practices will be given further instructions in due course.

Adding a MED3 in Vision

There is now a MED3 Structured Data area in Consultation Manager which replaces the MED3 History-Add form. To access the MED3 form:

1. From Consultation Manager, open a patient consultation.

2. First, enter data as you normally would during a consultation, or at the very least, a diagnosis or symptoms.

3. Select **Add – MED3** or enter one of the following qualifying MED3 Read codes:

   9D1 MED3 Doctor's Statement   9D13 MED3 not issued to patient

   9D11 MED3 issued to patient   9D14 MED3 issued – back to work

   9D12 MED3 duplicate issued   9D1Z MED3 NOS
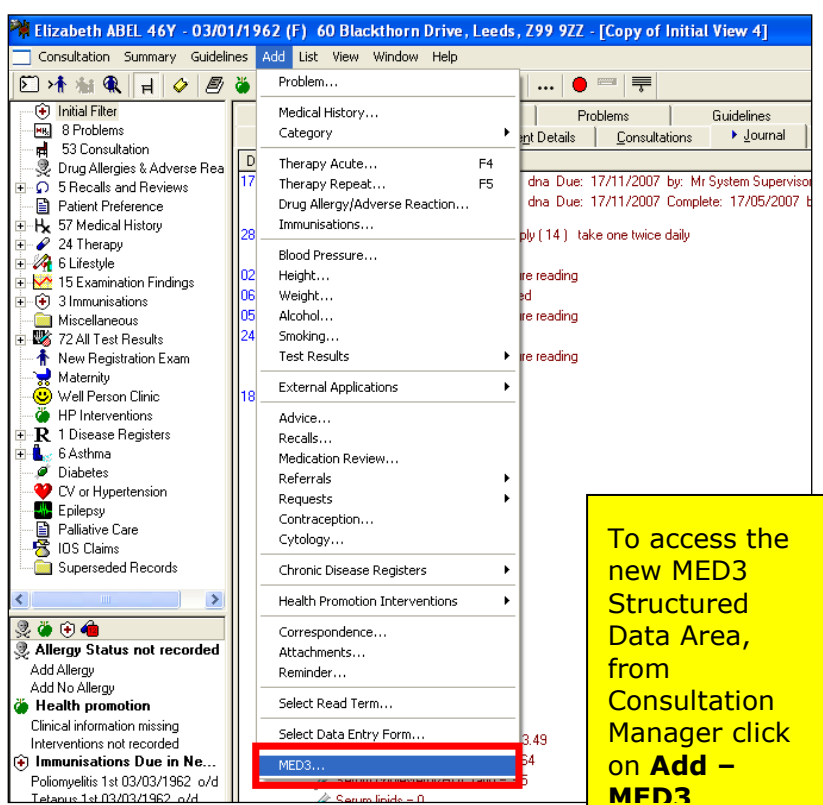
Add- MED3 in Consultation Manager

4. The MED3 form appears for completion. Fill in the appropriate boxes.

New MED3 SDA

The MED3 Doctor's Statement form is arranged into the following three sections:

Standard Information

This is the Vision standard information such as date, clinician and initial Read Term.

Date of Recording - Defaults to today. Vision will allow you to back date the Date of Recording but you cannot print a MED3 which is dated more than one day in the past.
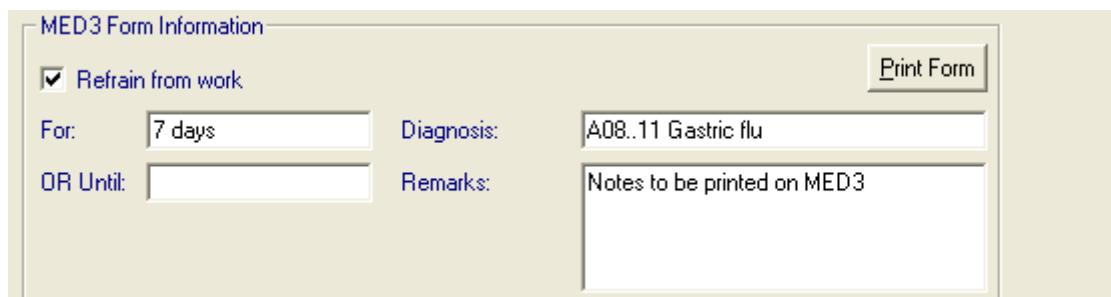
Clinician - The clinician authorising the MED3.

- **Private and In Practice flags -** These can be selected/deselected to record the place of the recording and/or whether the certificate or patient is private.

- **Read term -** Select the appropriate MED3 Read Term from the picklist. The options are:

    9D1MED3 – doctor's statement

    9D11.MED3 issued to patient

    9D12.MED3 duplicate issued

    9D13. MED3 Not Issued to patient *

    9D14.MED3 issued – back to work

    9D1Z.MED3 - NOS Clinically Appropriate - New

* Note that selecting 9D13 MED3 Not issued to patient disables the Print button.

MED3 Information

For pilot practices only, data added to the MED3 Information section will print on the MED3 form. Practices not participating in the pilot are still able to fill in these details but the Print button will remain inactive.

Refrain from Work Is ticked by default. The For and OR Until boxes, see below, become active once this is selected. Fill in one or the other.

For In the **For** box, you can enter the period the patient should refrain from work and it is stored like that. You can use the abbreviated date format, for example, type 7d (7 days), 1w (1 week) or 1m (1 month).

OR Until In the **OR Until** box, the date is displayed - you can either enter the exact date the patient should refrain from work, or you can enter t+1w, for example, for Vision to calculate the date.

Note you must enter a date or duration into **For** or **OR Until** boxes if you want to print the MED3. You are only permitted to fill in one of these boxes, so typing into either of the boxes will blank out the other.
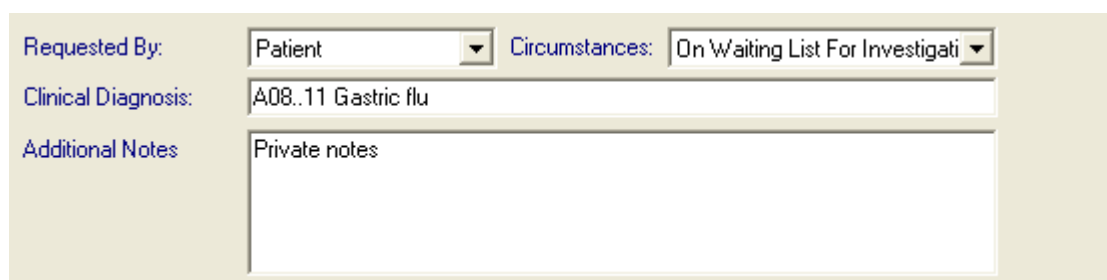
Diagnosis Allows you to enter a preliminary Read code or free text for diagnosis and offers full Read search functionality. Type the keyword or the Read Code and press enter to search for a Read code. For free text you can simply type in the Diagnosis box but you have a limit of 60 characters. Diagnosis is a mandatory field if you are intending to print the MED3. If you enter a clinical diagnosis on the Additional information area before entering it here, the Read term from the clinical diagnosis will copy into this field.

Remarks You can optionally enter free text in the Remarks box, up to 30 characters of free text - this limitation is due to the amount of space on the MED3 form.

Additional Information

Additional information will not print on the MED3 form and can be added after the MED3 has been printed.

- **Requested By** is optional to printing the MED3 but mandatory to saving the data entry form, This allows you to record who the MED3 was requested by. You have the choice of either requested By Patient, By GP or Both.

- **Circumstances** is an optional field which allows you to record information which is relevant both when a MED3 has and has not been issued. The picklist choices are:

> Clinically Appropriate - New
>
> Clinically Appropriate - Existing Illness
>
> On Waiting List For Investigation / Procedure / Op
>
> Should Have Been Hospital Generated - Post Op / OPD
>
> Should Have Been Hospital Generated - Trauma
>
> Social Reasons - E.G. Bereavement, Family Illness
>
> Addiction Problems - E.G. Alcohol, Substance Misuse
>
> Long Term Illness - E.G. Learning Difficulty, Blindness
>
> Patient Records Not Available - E.G. Temporary Resident
>
> Employer Pressure - E.G. Denial Of Sick Pay
>
> Patient Pressure - Include Threats Of Some Kind
>
> Clinically Inappropriate
>
> Within First 7 Days Of Illness So SSC1 (Self Certification)
>
> Social Problems (Not Medical) So Sickness Absence N/A
>
> No Clinical Evidence For Patient Request
>
> Clinical Diagnoses

- **Clinical Diagnosis** is an optional field which is automatically populated with the diagnosis Read code from the current open problem. If there is no current open problem, the clinical diagnosis field is populated with the diagnosis Read code from the current consultation. Where neither of these exist, or there are multiple qualifying diagnoses, the form will not be populated and you are free to enter a Read code or keyword as desired.

- **Additional Notes** is an optional field where you can enter further free text which will not print on the MED3 form.

Printing the MED3 – Pilot Practices Only

Note - At the moment, only pilot practices are able to print the MED3 form from Vision. For all other practices, the Print button is inactive.

1. Once you have filled in the required fields on the MED3 data entry form. Click the **Print Form** button. Upon selection, Vision opens the relevant MED3 template in Word and the MED3 information displays as a merged form.

2. Select **File - Print** to print the MED 3. You will notice that Vision prints a 2D Barcode on the MED3 printout which contains a unique ID containing the practice code,

patient ID and date and time of the creation of the MED3. This is also stored in Vision.

The print button is inactive active if:

- You have NOT been configured as a pilot practice.
- The Date of Recording is more than one day on the past and the form has not been previously printed.
- If you have chosen the Read code **9D13 MED3 not issued to patient**.
- There is no diagnosis and/OR Refrain from Work is checked with no date.

3. Once you have printed the MED3, select **File – Close**. If prompted to save any changes select Yes. Vision allocates the MED3 it's own file name Give the printed MED3 form to the patient

4. You are taken back to the MED3 Doctor's Statement entry form. Once you have finished, Click OK to save.

5. The entry is saved in the Journal in Consultation Manager.

MED3 data entries can be filtered on the journal by selecting Miscellaneous in the Navigation Pane.

Reprinting

Vision recognises when you have printed the MED3 and when editing a MED3 form and pressing **Print Form** you will be asked if you want to:

- **Reprint** i.e. the patient has not been given the previous printed copy of the MED3 form. If this is selected Vision will assume that this is the first time that the MED3 has been printed.
- **Duplicate** i.e. you want to print a duplicate copy of the MED3. If this is selected a different template is used which has Duplicate stamped as a watermark. Also a the Read code 9D12 MED3 duplicate issued is automatically selected as the MED3 Read term.

Note If the Read term 9D12 MED3 duplicate issued is already selected, the MED3 template will automatically print with a duplicate watermark.

Cancelling the MED3 Data Entry Form

If you cancel the MED3 from after it has been printed, the following message appears:

If this data entry form is cancelled there will be no record of the printing of the MED3 form and all printed forms should be destroyed. Do you wish to cancel the data entry?
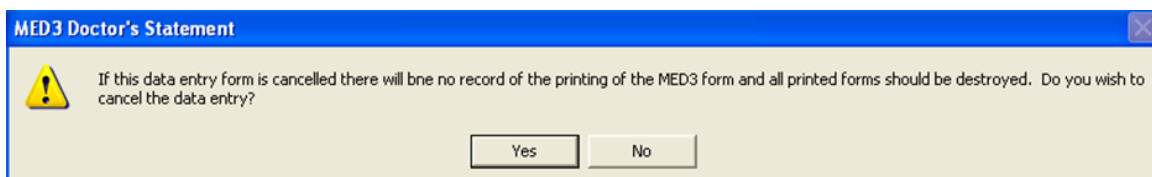
Select Yes to cancel. Vision will cancel the MED3 data entry without recording any information. Select No to be taken back to the MED3 data entry form.

Other Consultation Manager Changes

Confirmation of Deselection

You will be warned in Consultation Manager if you have a current form open, such as History, Therapy or BP and you try and deselect the patient.

On the warning message, **Save Form** will save the open form in its current state. **Cancel** will return you to the open form for you to add or edit further before clicking OK. **Discard Changes** closes the form without saving anything.
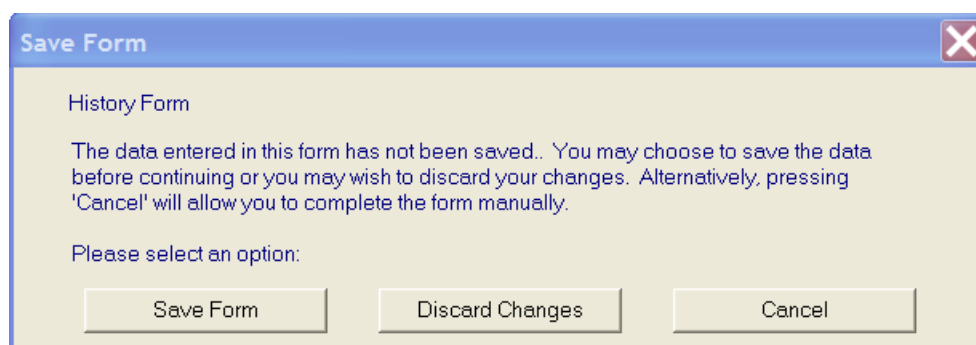
This applies to deselection of a patient by any of the following methods:

- Deselecting a patient by selecting another patient, whichever patient selection method is used
- Deselecting a patient by closing a consultation (if Consultation - Options - Setup - Consultation - Deselect the Patient Automatically When a Consultation is closed is ticked)
- Manually choosing Deselect the patient from the Consultation menu
- Selecting the next patient in a group of patients
- Exiting from Consultation Manager

Predicted Peak Flow for Children

Due to issues with clinical safety, the **Predicted Peak Flow** calculation has been disabled for **children** under 16.

Hepatitis A Viatim

If you add a vaccination for Hepatitis A and Typhoid (Viatim), the next Hepatitis A vaccination is shown as a 6 months interval, but the due date for the next Typhoid vaccination is left blank, as this is only given on a 'need' basis.

Opening Tif files from Choose and Book or GP2GP

The Problem

When an attempt is made to open a .TIF or .TIFF attachment from a Choose and Book referral or from a GP2GP message, the following error has been seen by some users:

> *Unable to open the file "C:\local settings\Temporary Internet files\ABC.TIF. Check file name and permissions.*

The file could, however, be saved and viewed.

The Remedy
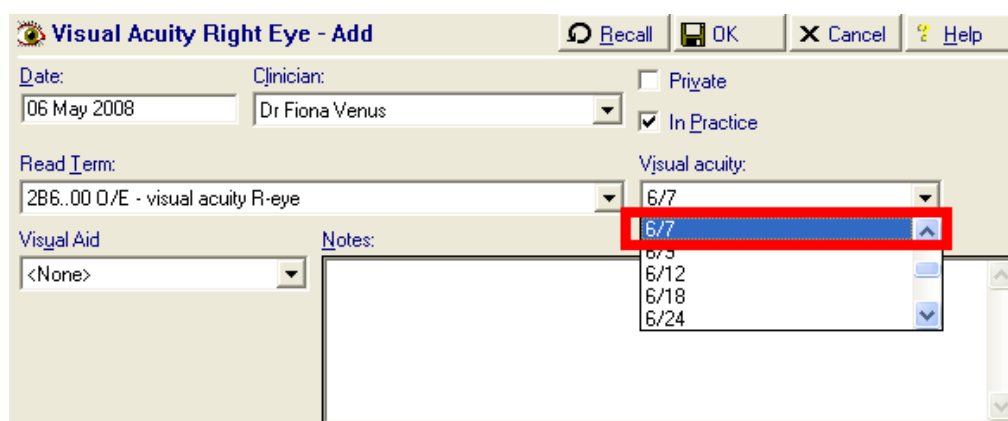
There is a simple workaround to this issue which is to associate the file extension manually with your chosen viewer. It should then work immediately in Vision.

To remedy this (you may find you have to do this with both a .tif and a .tiff if you use both file types):

1. Right click on any .tif file.
2. Choose **Open with...** and then select **Choose program...**
3. Choose the application in which you wish to view tif files, for example, we would suggest Microsoft Office Document Imaging.
4. Ensure you check the box **Always use the selected program to open this kind of file**.

Visual Acuity

You are now able to select 6/7 as a value from the Visual Acuity Right Eye and Visual Acuity Left Eye Structured Data Areas.

Nurse Prescriber changes

Two types of Nurse Prescribers

There are currently two forms of nurse prescribers:

- **Community Practitioner Nurse Prescribers** who can only prescribe dressings, appliances and licensed medicines listed in the Nurse Prescribers Formulary for Nurse Practitioners, known as the Nurse Formulary in Vision.

- **Independent/Supplementary Prescribers** (abbreviated to IPs and SPs) - From May 2006 supplementary prescribers and independent prescribers are no longer different types of prescribers. They are now both known as Independent/Supplementary Prescribers. The need for prescribing from the extended nurse formulary is no longer relevant as Independent/Supplementary Prescribers can prescribe any drug other than controlled drugs.

In Control Panel - File Maintenance - Staff, under one of the permitted roles, e.g. Practice Nurse, an independent prescriber is marked by ticking the Independent Prescriber box and a supplementary prescriber by ticking the Supplementary Prescriber box. See "Training Tip - How to Set up Nurse Prescribers" on page 43.

The method of selecting drug items and adding a therapy, be it acute or repeat, is the same for nurses as it is for any other member of staff. If you are a nurse Independent/Supplementary Prescriber, you have access to the full drug list. If you are signed into Vision as a Community Practitioner Nurse Prescriber, drug selection can only be made from the items in the nurse formulary, with no option of switching to the full drug dictionary.

See "Training Tip - How to Set up Nurse Prescribers" on page 43.

Note - Pharmacist as prescribers are still either Independent or more usually, Supplementary. There is no joint qualification for pharmacists at the moment.

Further information on nurse prescribing can be found at
http://www.dhsspsni.gov.uk/non-medical-prescribing

Changes in Nurse Prescribing for Vision in DLM 260

For regional differences, see the following pages.

The following changes made to nurse prescribing include:

- Northern Ireland HPSS have now issued cut sheet prescriptions for Community Practitioner Nurse Prescribers and Independent/Supplementary Prescribers.

- For England and Northern Ireland, Community Practitioner Nurse Prescribers and Independent/Supplementary Prescribers are permitted to print Batch Repeat Prescriptions.

- In Wales, Independent Prescribers are now permitted to print Batch Repeat Prescriptions.

- In Wales, Independent Prescribers are now permitted to issue private prescriptions under their own name in Vision.

- Independent/Supplementary prescribers in Northern Ireland are eligible to print private controlled drug prescriptions in Vision. This does not include Pharmacist Prescribers who are not permitted to prescribe any controlled drug.

- If a private drug is selected and a Community Practitioner Nurse Prescriber is selected as the authorising signatory, then the following warning is shown and the private controlled drugs is deselected. *"Nurse and Nurse Independent/Supplementary prescribers are not eligible to print private, discontinued or non-NHS drugs or drugs for private patients."*

Private prescriptions and Non-FP10 items

For England, Northern Ireland and Wales, Independent prescribers and Supplementary prescribers are able to issue private prescriptions in Vision.

Note that a nurse can make an FP10 drug into a private prescription by ticking the Private box on Therapy Add. If, however, a non-FP10 drug is selected in order to print a private prescription, then the following message is shown:

It is not possible for a practice nurse to prescribe non-NHS drugs.

If a nurse as signatory, tries to print a non-NHS drug (for example, possibly created by a GP) then the following message is displayed:

Nurse, Supplementary and Independent prescribers are not eligible to print discontinued or non-NHS drugs.

If you change the signatory to a GP, printing will be allowed under the GP's name.

Private controlled drug prescriptions

For private controlled drug prescriptions to be printed by nurses, the private controlled drug code (PCD code in England; or in Wales the IPC code) must be added in **Control Panel - File Maintenance - Staff - [edit user] - Identifiers - Add - Identifier Type.** This will then allow Independent/Supplementary prescribers to be able to issue Private Controlled Drug prescriptions.

The PCD code has the format 6AAAAA (eg 6ABCDE) in England and the IPC format is PNNNNNN in Wales, eg P123456.

If the code is not entered, then the following message is displayed when a nurse tries to print a private CD prescription:

- The authorised signatory selected to sign these prescriptions does not have a valid private prescriber code. Either:

- 1. Deselect all private controlled drugs

- 2. Select a different authorising signatory, or

- 3. Add a PCD code for the staff member using control Panel.

England - Current Nurse and Pharmacist Prescribing Rights within Vision

The table below show the current nurse and pharmacist prescribing rights within Vision.

Therapy Function	Community Practitioner Nurse Prescriber	Nurse Supplementary Prescriber SP	Nurse Independent/ Supplementary Prescriber IP	Pharmacist Supplementary Prescriber	Pharmacist Independent Prescriber
Create Prescription under own name	✓	✓	✓	✓	✓
Print Prescription under own name	✓	✓	✓	✓	✓
Create Private Prescription under own name	X	✓	✓	✓	✓
Print Private Prescription under own name	X	✓	✓	✓	✓
Repeat Dispensing*	✓	✓	✓	✓	✓
Print Controlled Drugs under own name	✓	✓	✓	✓	X
Private CD**	X	✓	✓	✓	X

* Repeat Dispensing for nurses in England

Community Practitioner Nurse Prescribers and Independent/Supplementary Prescribers are permitted to print Batch Repeat Prescriptions. This will need enabling per user - see "Repeat Dispensing for Nurse Independent/Supplementary Prescribers" on page 47.

** Private CD Scripts for nurses in England

Both Independent and Supplementary Prescribers can print private CD prescriptions but there must first be a relevant PCD code entered in Control Panel - File Maintenance - Staff - [nurse] - Edit user - Identifiers Add (see "Training Tip - How to Set up Nurse Prescribers" on page 43). The format is 6AAAAA, eg 6ABCDE

Wales - Current Nurse and Pharmacist Prescribing Rights within Vision

The table below shows the current nurse and pharmacist prescribing rights within Vision.

Therapy Function	Community Practitioner Nurse Prescriber	Nurse Supplementary Prescriber	Nurse Independent/ Supplementary Prescriber	Pharmacist Supplementary Prescriber	Pharmacist Independent Prescriber
Create Prescription under own name	✔	✔	✔	✔	✔
Print Prescription under own name	✔	✔	✔	✔	✔
Create Private Prescription under own name	X	X	✔	✔	X
Print Private Prescription under own name	X	X	✔	✔	✔
Repeat Dispensing *	X	X	✔	X	X
Print Controlled Drugs under own name	X	✔	✔	X	X
Private CD	X	X	✔	✔	X

- In Wales, Independent Prescribers are now permitted to print Batch Repeat Prescriptions.
- When either a GP or an independent prescriber are batch prescribing, the acronyms "RA" will now print on the prescription for the batch prescription master and "RD" for issues of Repeat Dispensed masters.
- Independent prescribers are able to issue private prescriptions under their own name in Vision.
- Independent prescribers can prescribe private controlled drugs. The IPC code must beforehand have been entered in Control Panel - File Maintenance - Staff - [nurse] - Edit user - Identifiers Add. The format is PNNNNNN, eg P123456.
- Note that supplementary prescribers cannot issue private prescriptions nor batch prescriptions.

Note - 2D Barcoding for prescriptions in Wales will NOT be enabled in DLM 260.

Scotland - Current Nurse and Pharmacist Prescribing Rights within Vision

The table below shows the current nurse and pharmacist prescribing rights within Vision

Therapy Function	Community Practitioner Nurse Prescriber	Nurse Supplementary Prescriber	Nurse Independent/ Supplementary Prescriber	Pharmacist Supplementary Prescriber	Pharmacist Independent Prescriber
Create Prescription under own name	✓	✓	✓	✓	✓
Print Prescription under own name	✓	✓	✓	✓	✓
Create Private Prescription under own name	X	X	X	X	X
Print Private Prescription under own name	X	X	X	X	X
Repeat Dispensing *	X	X	X	X	X
Print Controlled Drugs under own name **	X	X	X	X	X
Private CD	X	X	X	X	X

- Repeat dispensing is not enabled in Scotland *
- Nurse independent/supplementary prescribers cannot issue private prescriptions under their own name
- Nurse independent/supplementary prescribers can prescribe controlled drugs but must handwrite the prescription **
- Nurse independent/supplementary prescribers cannot issue private CD prescriptions

Northern Ireland - Current Nurse and Pharmacist Prescribing Rights within Vision

The table below shows the current nurse and pharmacist prescribing rights within Vision

Therapy Function	Community Practitioner Nurse Prescriber	Nurse Supplementary Prescriber	Nurse Independent/ Supplementary Prescriber	Pharmacist Supplementary Prescriber	Pharmacist Independent Prescriber
Create Prescription under own name	✔	✔	✔	✔	✔
Print Prescription under own name	✔	✔	✔	✔	✔
Create Private Prescription under own name	X	✔	✔	✔	✔
Print Private Prescription under own name	X	✔	✔	✔	✔
Repeat Dispensing	✔	✔	✔	✔	✔
Print Controlled Drugs under own name	✔	✔	✔	✔	X
Private CD	X	✔	✔	✔	X

Northern Ireland – Nurse and Independent/Supplementary Prescribing

Northern Ireland HPSS have now issued cut sheet prescriptions for Community Practitioner Nurse Prescribers and Independent/Supplementary Prescribers.
For paper prescriptions, doctors use form type HS21, nurses HS21N and Extended Nurses HS21X.

Community Practitioner Nurse Prescribers and Independent/Supplementary Prescribers (including Pharmacists) in GP practices who have access to the GP's computer will use the same blank prescription forms as GPs in order to avoid the need to switch paper in the printer. Community Practitioner Nurse Prescribers and Independent/Supplementary Prescribers employed by the PCT can print scripts, if they are working in the practice; excluded are those who are not working in practices who therefore have no access to a clinical system.

On nurse prescriber prescriptions:

- A banner at the top of the drug items section will be displayed as either Community Practitioner Nurse Prescriber, or Nurse Independent Supplementary Prescriber.

- The nurse's 4 digit cipher code will be printed on the right-hand side of the form.

- The nurse's name (title, initials and surname) will be printed under the stamp together with the practice address and postcode (if employed by the practice), or the Trust name, address and postcode (if employed by the Trust).

- The 2D barcode will be displayed as it is for GP prescriptions.

- In Northern Ireland, Community Practitioner Nurse Prescribers and Independent/Supplementary Prescribers are permitted to print Batch Repeat Prescriptions.

- In Northern Ireland, Independent/Supplementary prescribers are able to issue private prescriptions in Vision.

- Independent/Supplementary prescribers in Northern Ireland are eligible to print private controlled drug prescriptions in Vision. This does not include Pharmacist Prescribers who are not permitted to prescribe any controlled drug.

Training Tip - How to Set up Nurse Prescribers

Editing the prescriber's staff file

1. The **Professional** tab on the Staff form (**Control Panel - File Maintenance**) allows a staff member to be given Community Practitioner Nurse Prescriber or Nurse Independent/Supplementary Prescriber privileges. Right click on the nurse name under Staff and select Edit user, or for a new nurse, right click and Add User.

2. Select one of the following roles, which will enable Prescribing number entry: Practice Nurse, Health Visitor, Community Nurse, Midwife, Community Psychiatric Nurse, Hospital Nurse, School Nurse, Mental Handicap Nurse, Pharmacist.

Control Panel - File Maintenance - Staff - [edit nurse] - Professional

Prescribing numbers

3. Enter the Prescribing number in the Prescribing Number box.

- In Northern Ireland, this is a four digit number (pricing numbers).

- In Scotland, the prescribing number is a 5 character alphabetic field (Health Board cipher followed by unique identifier for the nurse, and the last two digits identify the practice. Enter in either upper or lower case - it is converted to upper case for the record.

- In England and Wales, the prescribing number is an 8 character alphanumeric field with the format NNANNNNA where N is a number and A

is a letter, e.g. 12A3456B. This too can be entered in either upper or lower case and is converted to upper case for the record.

- Pharmacists who are Supplementary Prescribers need to enter their RPSGP code and tick the box Supplementary Prescriber

4. The next step depends on the prescribing status of the nurse prescriber or pharmacist:

Community Nurse Practitioner Prescribers

- The Extended Nurse Formulary is no longer relevant for nurse prescribing. However, if you are adding a Community Nurse Practitioner Prescriber who uses a nursing formulary, once a Prescribing Number has been entered and suitably validated, **tab** across to Formulary where the pick list gives two options. Select **Nurse Formulary** which is the default. This nurse will only be able to select items from the Formulary on Therapy Add.

Nurse Independent/Supplementary Prescriber

- If you are adding an Independent/Supplementary Prescriber, once a Prescribing Number has been entered and suitably validated, tick the Independent Prescriber box. Do not select a formulary. Refer back to the relevant country tables to see what functions are permitted in Vision for Independent (IP) or Supplementary (SP) nurse prescribers.

Pharmacists

- Pharmacists who are Independent Prescribers (IPs) need to enter their RPSGP code and also tick the Independent Prescriber box. If the pharmacist is a Supplementary Prescriber (SP), tick the Supplementary box.

Pharmacists should select either the Supplementary or Independent prescriber box

Employed by Practice

5. This is ticked by default to signify the prescriber is employed by the practice. If the prescriber is employed elsewhere, then untick this box and select the organisation or HB for which they work in **Employer**. This organisation or HB should previously have been entered in Control Panel - File Maintenance - Organisation.

6. **Private Controlled Drug code.** If the nurse is permitted to print private controlled drug prescriptions, you should enter a PCD code (England) or IPC code (Wales) in **Identifiers - Add - Identifier Type.** The code has the format 6AAAAA (eg 6ABCDE) in England and PNNNNNN for the IPC code in Wales, eg P123456. This includes nurse IPs and SPs in England, IPs in Wales, and SPs and IPs in Northern Ireland. Nurses in Scotland are not permitted.

7. Click **OK.**

Nurse Prescribing and Advanced Printing

In order to be able to print Nurse prescribing in Vision, you must be using Advanced Printing. To check that you have Advanced Printing enabled:

1. On the front screen of Vision click on the **Options** menu, if there is a tick next to the **Use Advanced Printing** then you currently have Advanced Printing switched on.

If the Advanced Printing menu is not ticked, please see on screen help (search for Advanced Printing) or the Vision Training Manual for further instructions on setting up Advanced Printing.

> **Note** If your practice is using the Barcoded Prescription functionality, Advanced Printing should already be enabled. Note that barcoding on Welsh prescriptions is not yet available.

Nurse Prescriptions and Signer Selection

With Community Practitioner Nurse Prescribers and Nurse Independent / Supplementary Prescribers being able to print prescriptions, the way that Vision manages the signer of prescriptions has changed.

When a Community Practitioner Nurse Prescriber elects items for printing which include items they can and cannot sign, Prescription Manager will sort the items onto two prescriptions; one prescription for the nurse to sign and one prescription for the authorised GP to sign.

In the same way, when a GP elects to print items that have been added by an Independent/Supplementary Nurse Prescriber or a Community Practitioner Nurse Prescriber, the items will print on one prescription for the GP to sign.

Prescriber	Selected Drugs	Signer
Community Practitioner Nurse Prescriber	Nurse Formulary Drugs	Community Practitioner Nurse Prescriber to sign
	Drugs outside of the Nurse Formulary	GP to sign
Independent/ Supplementary Prescriber	Any drug (excluding certain specific controlled drugs).	Independent/Supplementary Prescriber to sign
	Specific controlled drugs. See http://**www.dhsspsni.gov.uk/patients_accsess.pdf** page 41 for further information on controlled drugs for Independent/Supplementary prescribers. **Note** Pharmacists who are Independent **OR** Supplementary prescribers are not permitted to prescribe any controlled drug.	GP to sign
GP	Any drug by any prescriber.	GP to sign

Note that there are regional variations in what prescriptions are permitted to be printed for some nurse independent or supplementary prescribers (refer back to the tables on the previous pages).

In a situation where a nurse has prescribed but is not permitted to print the prescription, the Authorised signatory could be changed to that of a GP in order to print.

Repeat Dispensing

Repeat Dispensing for Nurse Independent/Supplementary Prescribers

- In **Wales**, Nurse Independent Prescribers are now permitted to print Batch Repeat Prescriptions. Supplementary Prescribers and Community Practitioner Nurse prescribers are not.

- For **England** and **Northern Ireland**, Community Practitioner Nurse Prescribers and Independent/Supplementary Prescribers are permitted to print Batch Repeat Prescriptions under their own names.

- If the selected prescriber is a Community Practitioner Nurse Prescriber or an Supplementary Prescriber in **Scotland**, the Batch box is unavailable. An error message is shown if the Batch box becomes the focus - *Nurse prescribers may not authorise batch prescriptions*

-

To enable Repeat Dispensing:

1. Log in to Vision as the Independent/Supplementary Prescriber .
2. In Consultation Manager select **Consultation - Options – Setup**
3. Click on the **Therapy** tab.
4. Tick the box **Enable Repeat Dispensing**.

Repeats Interval allows you to set the default period for Repeat Dispensing batches

5. **Repeats Interval:** You can set your own default period for repeat dispensing batches. This defaults to 28 days. If you prefer, you can alter this, for example, to change to thirty days, overtype 30D and press Enter.
6. Click OK.

See on-screen help for further instructions on printing and editing Batch Repeat Prescriptions (Con Manager - Help - Therapy - Repeat Dispensing).

Add a batch prescription for Repeat Dispensing

To add a batch prescription:

1. In Consultation Manager, select the patient and open a consultation.

2. On the Repeat Therapy Add screen, select the required drug and enter quantity, dosage etc as required.

3. Tick the **Batch** box to turn the repeat into a new batch prescription.

Tick the Batch box if you want to create a new batch prescription. This enables an Interval box, defaulting to 28 days.

- An **Interval** box appears in place of Days Between Issues Min/Max. This denotes the interval between issues. The default is 1 month, but you can alter it if you like, using the abbreviated format - e.g. 2M (two months), 6W (six weeks) etc.

- The **Repeats** box defaults to 6. This number of repeats can also be amended, though you cannot exceed one year (Interval x Repeats).

With Repeats at 6, and the interval set at 1 month, this is a repeat master - a batch prescription - with a batch of six issues, one month between issues.

All Schedule 1, 2 and 3 Controlled Drugs and buprenorphine are excluded, where these are used in the treatment of drug misuse and dependence. If the drug is a controlled drug, the Batch box will be unchecked and disabled. If you do try and save a prescription with a controlled drug selected, an error message is shown: *[drug name] is a controlled drug and cannot be provided as a batch prescription.*

The Repeats box default to 6, ie six months of issues. The Repeat Until Date window shows the date that the batch prescriptions expire, eg, 6 months in the future.

4. Click OK. Read and deal with any drug warnings. The Batch Repeat prescription is added to the Repeat Master list.

    -   Notice that on Therapy Add, the Repeat Until Date becomes read only, showing a date that corresponds to the Interval/Repeats. If the Interval is set to 1 month and Repeats to 6 and today is, for example, 21st June, then Repeat Until Date is six months' in the future (Interval x Repeats), e.g. 21st December.

    -   If you uncheck the Batch box, the batch instructions disappear and it reverts to a normal Therapy Add screen.

    -   If the drug is changed, then all data is cleared.

    -   The duration of the batch prescription cannot exceed one year, for example, if you set the interval to 2 months and the repeat to 9, interval x repeats = 18 months. You will see an error message: *The total duration of this batch prescription may not exceed one year.*

See : Print Batch Prescription.

Print Batch Prescription

To print a repeat batch prescription:

1. Click on the required repeat batch prescription from the Repeats list.

2. Print the batch prescription in the same way you would print any other repeat, 🖨 or F9.

- On the Print Therapy screen, all the batch issues are created at the same time, regardless of whether this is practice administered or dispensed. For example, a batch of six issues will show six issue lines ✐, and a seventh batch prescription line 🗇, the master.

- By default all the lines are selected with ticks. You may uncheck one or more of the later issues if you do not want to print all at this time. However, all the issues will be marked as "issued" on the Scripts tab - this always happens as a result of the first F9 or 🖨 .

- The event date of each issue is the date of issue plus the interval date in succession, for example, if today is 22nd June, then the first issue is dated 22nd June, the second 22nd July, the third 22nd August and so on, up to 22nd November 2004.

Note Once the batch has been printed, the master batch prescription (Repeat Authorisation) listed under Repeats tab immediately becomes expired 📄 and will need reauthorising before further issues.

Signing the Repeat Authorisation Batch Prescription

Once the batch prescription and issues are printed, the batch prescription *master* is then signed by the prescriber. This is the legal prescription form, needed by the dispenser (or pharmacist) at each dispensing episode.

The batch issues are not signed (as they are not a prescription); these are used for reimbursement purposes.

Prescription Print Layout

When either a GP or a nurse independent/supplementary prescriber are batch prescribing, the acronyms "RA" will print on the prescription for the batch prescription master and "RD" for issues of Repeat Dispensed masters.

Repeat Authorisation (R.A.)

- The Repeat Authorisation or batch prescription master is printed first. This is the one that is signed by the prescriber and is the legal prescription.

- The following text is printed before the drug details on a batch prescription (where N is the maximum number of repeats):

  GP AUTHORISING REPEAT

  Authorising no. of issues = N

- R.A. is printed near the drugs and near the signature box on the Repeat Authorisation.

- The RA batch prescription contains the right-hand reorder form. If the reorder form is of length it will continue to print onto the right hand side of the issues.

- More than one batch drug can be printed on the same prescription, providing this is permitted by the existing printing rules (for instance, oxygen is printed separately).

Repeat Dispensing batch issues (R.D.)

- The Repeat Dispensing batch issues are printed after the Repeat Authorisation.

- On a printed batch issue script, the Prescriber signature box is overwritten with (where n is the maximum number of Repeats):

  Repeat Dispensing: 1 of n

  Repeat Dispensing: 2 of n etc

- The following text is printed before the drug details on a batch issue:

- GP REPEAT DISPENSING

- R.D. (Repeat Dispensing) is printed near the drugs and near the signature box on every repeat dispensing issue.

- More than one batch issue drug can be printed on the same page providing this is permitted by the existing printing rules, with the additional requirement that they have the same issue number and total number of issues.

- All issues are printed with the same date, i.e. the date of printing of the batch repeat master, enabling a pharmacist to issue an earlier supply in the event of a patient holiday. The Journal and Scripts views list the issues with an Event date of their issuing date (the calculated future date), at 28 days' interval (or whatever Repeats Interval has been set) consecutively from the date of printing.

Repeat Dispensing Process for patient and pharmacist

What the patient does

The patient takes the signed batch prescription/Repeat Authorisation and the batch issues/R.D.s to the pharmacist. The pharmacist retains the prescription, and the patient either keeps the remaining batch issues or asks the pharmacist to keep them on their behalf.

If the patient changes address mid-way through a batch, they will need to contact their GP for a further repeat prescription to take to their new pharmacy.

What the dispenser or pharmacist does

The dispenser processes the batch issues/R.D.s and forwards them to the PPA monthly, as now. The batch prescription is sent to the PPA once all issues have been dispensed, or, if the patient does not collect all, on expiry, for the PPA to carry out its usual processing and compliance checks.

Preferred Pharmacy

Remember that you can record a patient's preferred pharmacy in **Consultation Manager - Patient Details** 🔍 **- Preferences.** Click on **Change** and select from the picklist of pharmacies. If there are none, then you need to add each pharmacy likely to be used by patients in **File Maintenance - Organisations** - with a category of Pharmacy. This will be printed on the prescription.
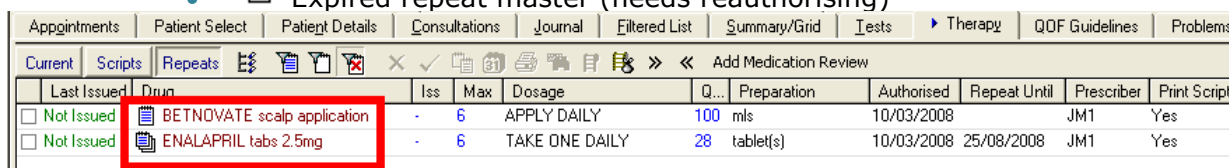
Differences between normal and batch repeats

Distinguish between normal repeat master and batch master/repeat authorisation on Therapy list

It is easy to see by the icons which medications are on repeat issue:

- 📑 Batch prescription (a Repeat Master with a batch setup as defined by Interval and number of Repeats).

- 📑 Issued batch prescription (needs reauthorising)

- 📋 A normal repeat master

- 👆 Ordinary repeat issue

- ☐ Expired repeat master (needs reauthorising)

	Last Issued	Drug	Iss	Max	Dosage	Q...	Preparation	Authorised	Repeat Until	Prescriber	Print Script
☐	Not Issued	📋 BETNOVATE scalp application	-	6	APPLY DAILY	100	mls	10/03/2008		JM1	Yes
☐	Not Issued	📑 ENALAPRIL tabs 2.5mg	-	6	TAKE ONE DAILY	28	tablet(s)	10/03/2008	25/08/2008	JM1	Yes

In both these screenshots, Betnovate is the "normal" repeat master; Enalapril is the repeat batch master

Distinguish between normal repeat issue and batch repeat issue/authorisation on Print Therapy screen

 Batch issue, *Ordinary repeat issue,* *Batch repeat master issued*

Distinguish between normal repeat issue and batch repeat issue on Journal or Scripts view

- Batch issue - one of the issues printed from a batch prescription

The Betnovate issue in this screenshot is an ordinary repeat issue - the Enalapril issues are batch issues

Editing batch, reauthorise, change from batch to normal

Editing a batch

If the batch issues have not been printed, it is possible to edit the R.D. batch prescription.

Reauthorise

Reauthorisation of a batch prescription is the same as a repeat master. Once a batch prescription has been printed and all its issues, it becomes expired ▯ .

Before re-issuing again, under the Repeats tab, click on the batch prescription master/R.A. line to select it with a tick, then click on the Reauthorise icon 🗐 . The Reauthorise Add screen will retain the batch details - the Batch box will be ticked, and the Interval and number of Repeats remain the same as the old batch master. Click OK.

Post Date

You cannot post date batch prescriptions.

Copy

You cannot copy a batch issue.

Changing from batch to normal repeats

If a batch master/R.A. has been set up, you can change it to a normal repeat master, before printing, by editing and removing the tick in Batch.

Once a batch master has been issued and has expired 🗐, you can remove the tick in Batch when reauthorising in order to revert to a normal repeat master.

Reprinting batch issues

1. On the Scripts tab of Therapy, highlight the issue you want to reprint.

2. Click on the Reprint icon 🖨 .

3. If you click Yes to answer: *This item is a batch issue, do you want to reprint all batch issues?* then all the batch issues will be reprinted in step 6. If you answer No, you will be asked if you want to reprint other drugs prescribed for this patient on the same day (if any), and only the issue highlighted in step 1 will be reprinted (*Other drugs were prescribed for this patient on the same day as this drug. Do you wish to re-print these items as well?*).

Consultation Manager

⚠ This item is a batch issue, do you want to reprint all batch issues?

Yes   No

Consultation Manager

Help

❓ Other drugs were prescribed for this patient on the same day as this drug. Do you wish to re-print these items as well?

Notes >>

Yes   No
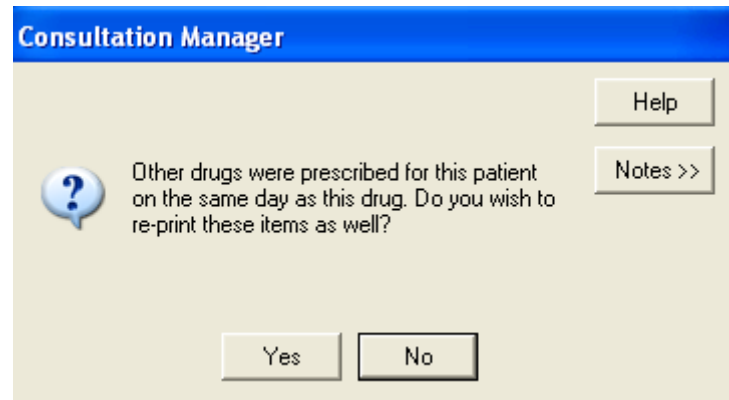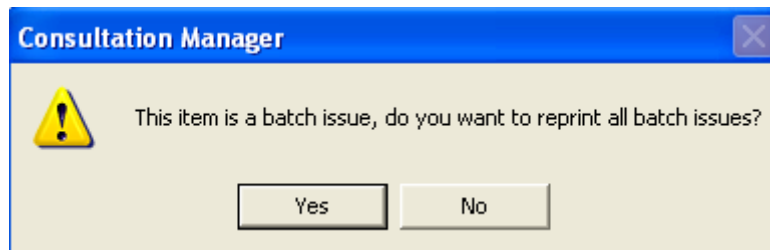
4. Complete the Event Log to explain the reason for the reprint.

5. On the Print Therapy screen, you can remove the ticks from the issues you do not want to print.

6. The issues are reprinted.

Deleting a batch

To delete batch issues, go to the Scripts tab, right click on the first issue, and select Delete with a left click.

You are warned: *Warning! This is a batch issue. All other issues in this batch will also be deleted. Do you wish to continue?*

Consultation Manager

Help

❌ Warning! This is a batch issue. All other issues in this batch will also be deleted. Do you wish to continue?

Notes >>

Yes   No
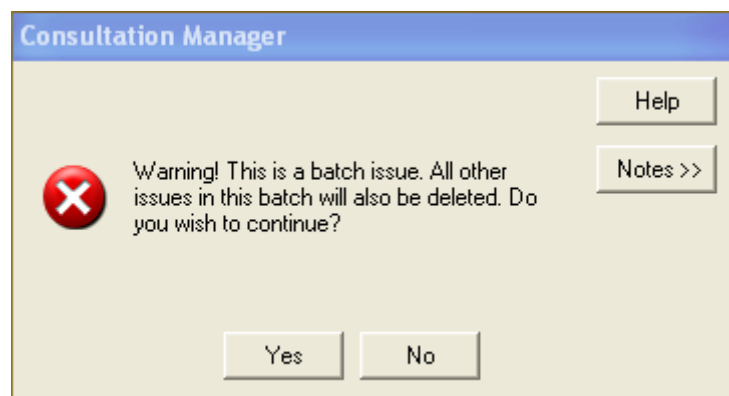
If you answer No, the deletion is cancelled. If you answer Yes, and if you have printed any of the batch, then you will see a message: *[Number of printed issues] of these issues have been printed. Are you sure you wish to delete them?*
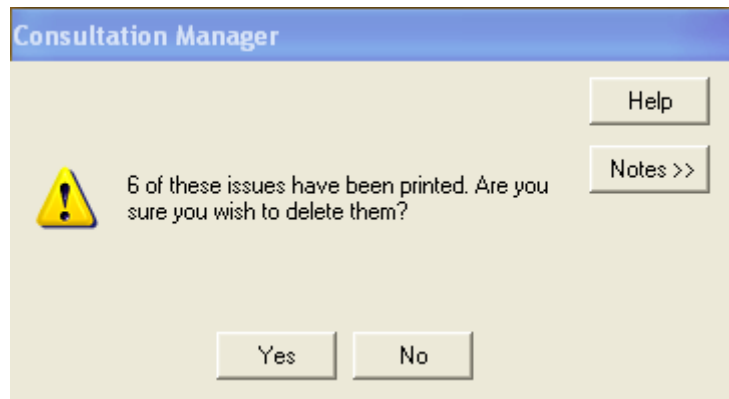
If you answer Yes, you are prompted once to enter a reason for the deletion. This reason text applies to all the issues being deleted.

The number of issues returns to zero and the Last Issue date becomes blank.

Deleting batch issues without having to delete the whole batch

You can delete batch issues without having to delete the whole batch.

1. On the Scripts tab, highlight the issue to be deleted, right click, select Delete. You will be warned: *This is a batch issue. All later issues in this batch will also be deleted. Do you wish to continue?*
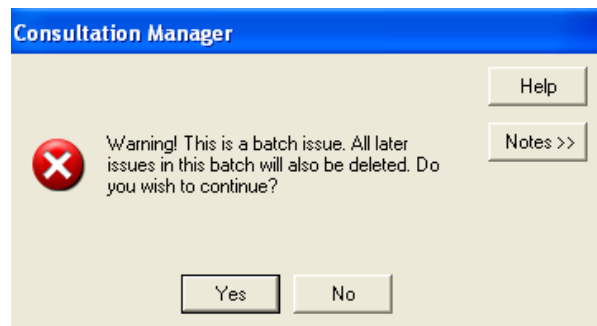
2. It then reminds you how many issues have been printed and asks if you are sure you want to delete them.
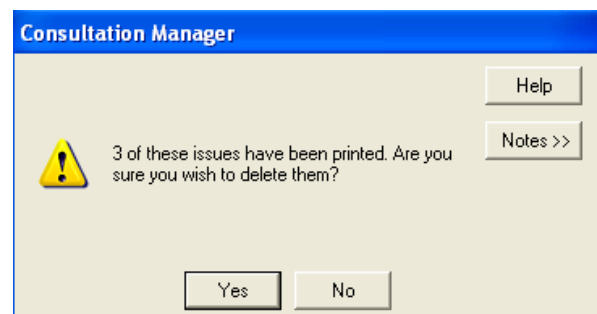
3. Confirm with Yes for the confirmation to delete.
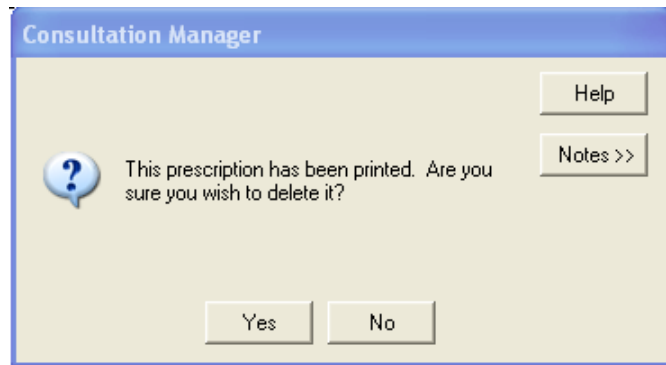
4. Complete the Event Log to explain the deletion.
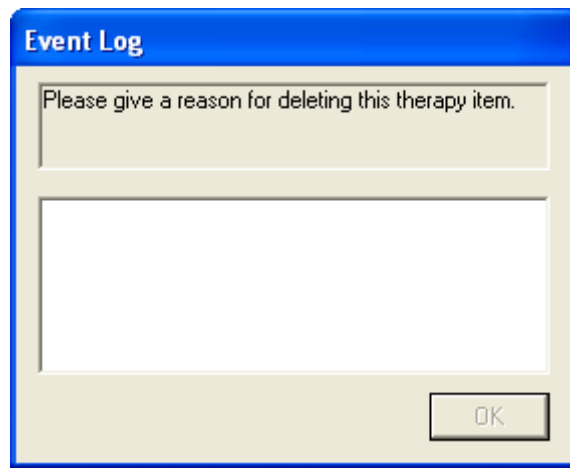
5. All issues later than the one you highlighted will be deleted.

Mail Manager

Keep Mail Gateway open

To allow for National Programme messages to be sent and received efficiently, please remember to keep the Mail Gateway open at all times if you are a LAN practice, and during working hours if you are on the Managed Service/VES.

In England, no longer necessary to keep Mail Manager open all the time

In DLM 237, we advised you to keep Mail Manager open whilst using Vision in order to maximise messaging performance and avoid messaging errors. Due to changes in the message spooler, which collects incoming and outgoing messages, you are no longer obliged to do this. The message spooler now periodically collects messages whether Mail Manager is open or not.

In Scotland, must keep Mail Manager open all the time

In order to maximise the performance of the Vision system, all users in Scotland MUST on the auto refresh facility in Mail Manager by following these steps:

1. Login to Vision using your smartcard.
2. Open Mail Manager (found in the Messaging section of the main menu).
3. Select Tools - Options.
4. Ensure the Refresh tickbox is checked and the interval set to 10 minutes. Also check the "Process messages when refresh selected" option. Click OK.

Then leave Mail Manager minimised at the bottom of the screen while working in other parts of Vision. It is important that this is done. This will ensure the message queues are up-to-date, highlight any errors and make sure the queues are running efficiently.

Message Allocation to Usual GP

On receiving DLM 260, all future incoming XML messages will be automatically assigned to the **Usual GP** Mailbox rather than the **Registered GP** Mailbox.

Mail Manager Workflow

Processing New Results - Administration

Allocate result(s) from the unallocated mailbox if necessary

↓

Assign unmatched result(s) to a patient if asterisked

↓

File result(s) or Mark Filing as Complete

↓

Result(s) can now be Actioned by the Clinician

Processing New Results - Clinician

View your unread results from your folder in the **Staff Tab**

↓

Mark the result(s) as **Read**

↓

Action Result(s) and add any necessary free text

↓

The result is copied to the selected member of staff who can now process and complete the action

Completing Allocated Actions - All users

Find Actions allocated to you or your group from the Actions tab

↓

Select the result, read and add any necessary free text

↓

Carry out the action and **Mark the Action(s) as Complete** and/or **add another action** and/or **update the action status**

↓

The Action is now complete and the copied result is deleted from your Action View.

A N D / O R

Giving Results to Patients - All users

Find the patient in Mail Manager or Consultation Manager

↓

Select the result, read and add any necessary free text

↓

Carry out the action and **Mark the Action(s) as Complete** and/or **add another action** and/or **update the action status**

↓

The Action is now complete.

Actioning Multiple Messages

Within Mail Manager you are now able to action messages en masse.

> **Note You should use the bulk action facility with caution and restrict it to messages that have been read. Adding a bulk action does NOT itself mark a message as read. There is a clinical risk of actioning items that have not even been viewed, let alone, read.**

The quickest way to action multiple messages is to tick the required messages and then use **Actions – Ticked - [action message].** An alternative is to use File - Ticked - Actions - [action message].

1. Select the required messages to action by ticking the select boxes next to them or using the Tick icon to tick all.

2. Click on **Actions – Ticked** and select the required action from the menu or select **Add Action**… to select from Additional Actions.

Note You cannot action multiple messages from the right click menu which is only used for the currently *highlighted* message. If you do multi-tick messages then right click and select a function, Mail Manager will only action the first selected message.
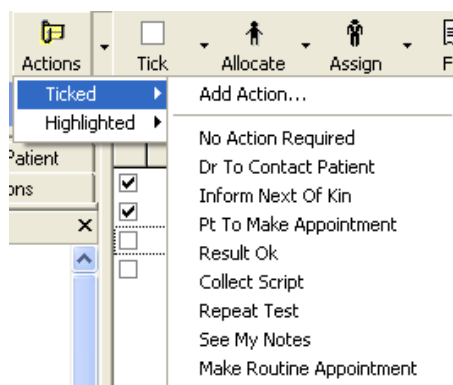
3. Fill in the **Add Action** dialogue. The date for the action to be completed by is optional but you must make a selection from the **Action By** list (see Mail Manager Training Tip – Default Action By on page 67).

Click OK.

4. Once the action has been applied to the ticked messages, you will be prompted with a confirmation that the process is complete - *Ticked - Action completed.*
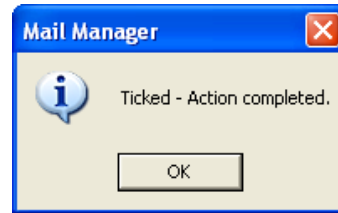
On clicking OK, the ticked messages will then be refreshed to display the selected action.

			Status	Type	Read	Date ▽	Staff	Patient	Action/Subject
☑	♥		Availab...	Citrate	☐	18/10/2007 ...		*Editestpatient...	No Action Required
☑			Availab...	Serum	☐	18/10/2007 ...		*Haddock, Zoe	No Action Required

The Audit trail for the bulk action will display in the same way as non-bulk actioned results.

Note - You are able to add a bulk action at any stage of the message process. Adding a bulk action does NOT mark the message as Read.

Default options when double clicking a message

Double clicking on a message in Mail Manager takes you through a whole pathway of functions - filing, marking the message as read, adding an action, completing an action, etc. For only one of these functions, such as marking a message as read, the quicker option is to use the right click menu.

However, for those who prefer to double click on the message, there is a new option in Tools - Options - Message which can be set per user.
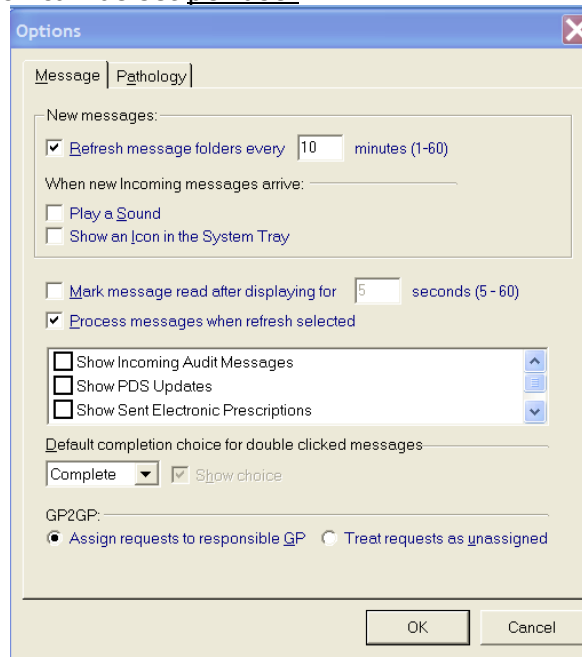
When double clicking on a message, you can now decide whether the Complete (a message) button or Add an action is the default.

An additional Show Choice tick box allows the user the option to swap from their usual choice to the alternative when double clicking on the message.

Default completion choice for double clicked messages:

Complete ▼ ☑ Show choice
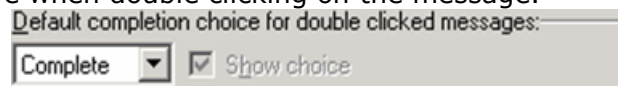
- Selecting **Complete** means the default focus will be on the Complete button...

Mail Manager

? Do you wish to mark this message as complete or add an action?

Complete   Add Action   Cancel
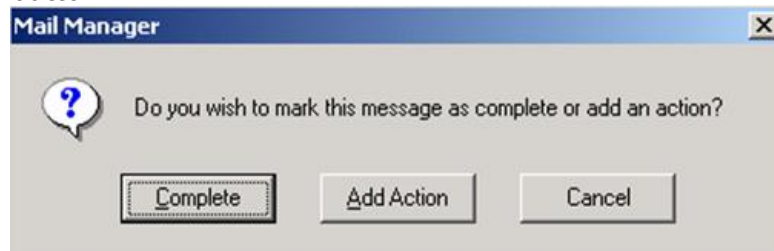
- Selecting **Add Action**, with **Show Choice** ticked ...

Default completion choice for double clicked messages:

Add Action ▼ ☑ Show choice
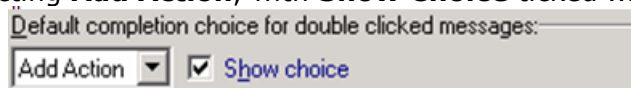
shows focus on the Add Action button:

Mail Manager

? Do you wish to mark this message as complete or add an action?

Complete   Add Action   Cancel
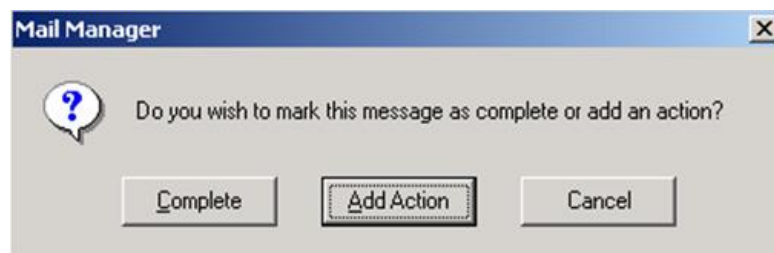
- Selecting **Add Action**, with Show Choice unticked ...

Default completion choice for double clicked messages:

Add Action ▼ ☐ Show choice
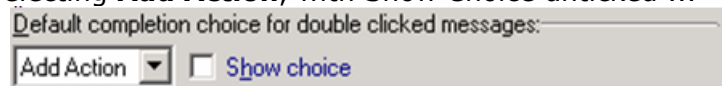
...goes straight to the Add Action screen.

Add Action

Contact details:
Patient: Campbell, Sanjay
Address: 56 Ceres Road, Wetherby, W Yorkshire, LS22 4JX
Contact Numbers:

Add:
Set by: Mr System Supervisor   25/10/2007
Date:
Code: ▼   Patient specific: ☐
Text:

Action by: ▼   Confidential: ☐
Status: To Be Reviewed By Gp   ▼   Complete: ☐

OK   Cancel
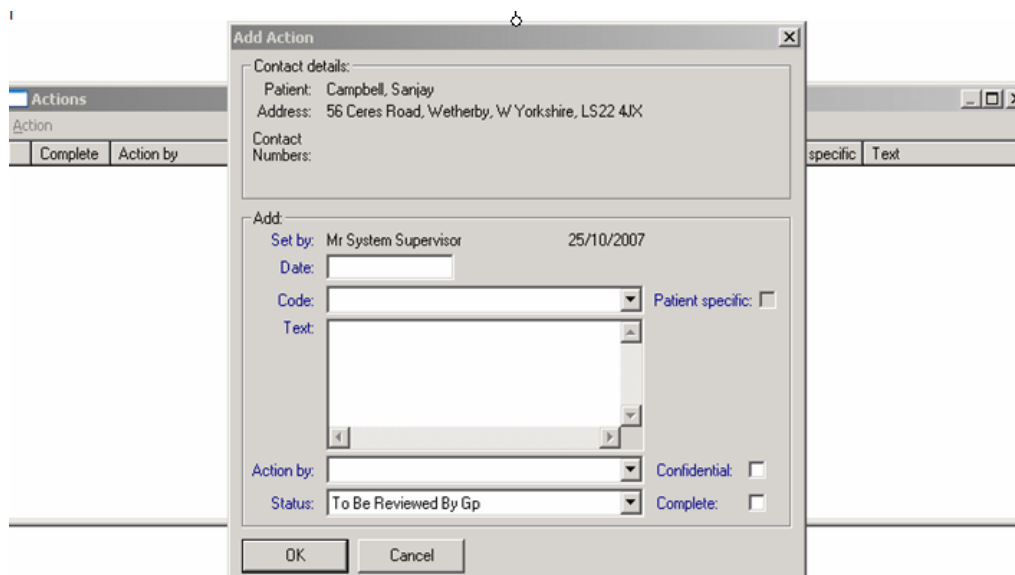
Bulk Mark as Read

You can now also bulk Mark as Read for selected messages in Mail Manager.

> **Note** In line with PMIP requirements, for pathology results, you cannot bulk Mark as Read until the individual pathology message has been fully viewed. This means viewing *each* tab of a multi-tabbed result. You also cannot mark as read any unassigned message (this applies to English pathology messages only), or any message already marked as read.

1. Select the required messages to be Marked as Read by ticking the select boxes next to them or using the Tick icon

2. Click on either **File – Ticked – Mark as Read,** or click on the

Mark as Read icon then **Ticked**.
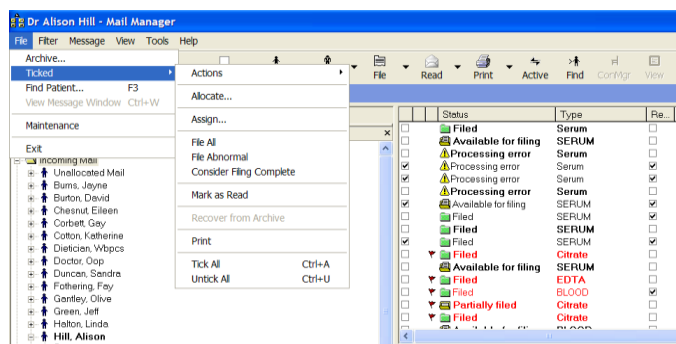
3. Once the messages have been Marked as Read you will be prompted with the following message: *Ticked – Mark as Read completed*.
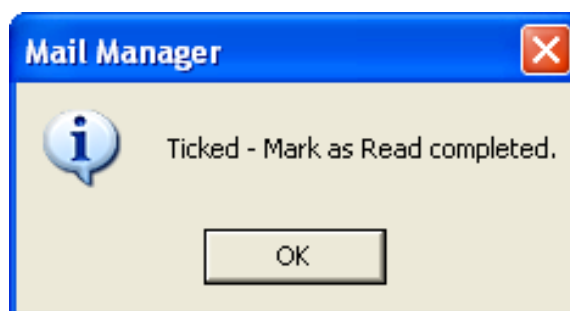
4. If some of the ticked messages have not been Marked as Read as part of the bulk process, you will see the following prompt: *Ticked – Marked as Read completed. Some messages were not Marked as Read*.

Remember the whole of a Pathology message must be viewed before it can be Marked as Read - view each tab of multi-tabbed results. You also cannot mark unassigned messages as read.
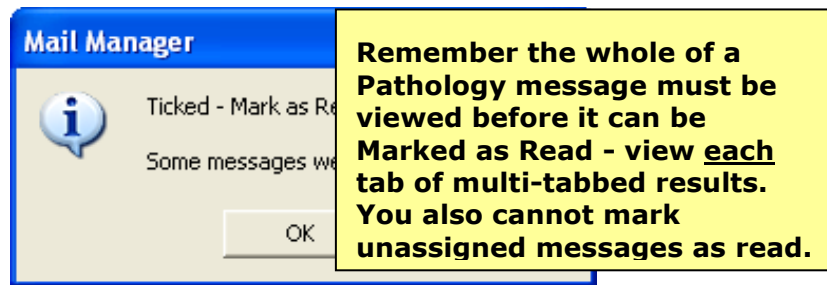
5. The messages that have been Marked as Read will show a tick in the Read column. The Audit tab will also reflect that the message(s) have been Marked as Read.

Note - For technical reasons you cannot Mark as Read for multiple messages from the *right click* menu. If you do select Mark as Read from the right click menu, Mail Manager will only mark the first selected message as read.

File All, File Abnormal and File Tab for multi-specimen messages

Multi-specimen pathology messages have more than one tab for each specimen taken.

- **Each tab must be viewed** before the message can be marked as Read. The tab clearly says "Unread" but when you select the next tab, "Unread" changes to "Read".

- **File All** and **File Abnormal** file <u>all</u> tabs of a multi-specimen message.

- To file results from only one tab of a multi-specimen message, right click within the result pane on that tab and select **File Tab** - this will file the results on the currently displayed tab only.

Mail Manager Automatic Archive – England

For practices that are connected to the Spine, on receiving DLM 260, Mail Manager will start to automatically archive the following message types:

- ETP Messages

- Choose and Book/E-booking Messages

- PDS Update Messages

- GP Summary Messages

These messages will only be automatically archived if they have been successfully acknowledged (i.e. have a status of ✉ **Sent** or ✉ **Complete**). Any rejected messages or messages in error will remain in the incoming/outgoing folder for your attention.

> **Note** - The first time that you open Mail Manager after receiving DLM 260, the automatic archive process will start. This might take some time if you have not already been manually archiving messages on a regular basis. You are able to exit Mail Manager whilst the automatic archive process is initially running as it will recommence when Mail Manager is next started.

Archived messages can still be viewed from the archive view from **View – Archive View** where you can enter a date range for the archived messages you would like to view.

Mail Manager Training Tip – Default Action By

You can set up Mail Manager Actions with a default Action By for an individual or group. This saves the need to select who is to carry out the action each time an action is chosen.

To set a default action go to **Control Panel – Mail Maintenance – Actions**. You can either edit an existing or add a new action to set the Default Staff/Group.
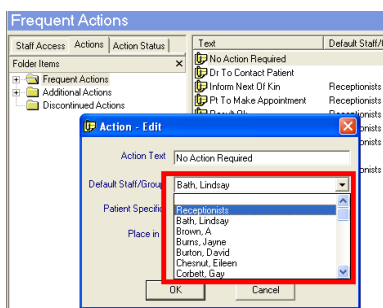
Reminder - Staff groups are set-up in **Control Panel – File Maintenance – Staff Groups**.

Some practices using Mail Manager feel that it is more advantageous to nominate an individual in Action By rather than a group. With a group, it is possible that while everyone receives the action message, nobody acts on it! Nominating an individual gives ownership for that action. Another suggestion is for staff to act on a buddy system - for example, two receptionists may act as buddies for each other, and when one is away, the other steps in.

Mail Manager Training Tip - Viewing completed messages

If you mark a message as complete, it may "disappear" from view unless you have the All

icon selected, rather than the Active icon .

When the Active icon is shown on the toolbar, this is displaying only active messages, i.e. Active only aims to remove from view any messages that have been fully processed (read, filed, actions completed / marked as completed) and these can only be shown by using the All icon.

A message remains active when:

- It is not allocated to a staff member
- It is not assigned to a patient
- It has not been read
- It has not been filed (if filing is appropriate)
- It has not been actioned or at least one action is still outstanding.

However, if not actioned and the above has been met, you have the option of marking the message as complete with the right click menu.

Mail Manager Training Tip - Remove Mailbox from Mail Manager View

You can remove other users' Mailboxes from your Mail Manager view by removing your rights to view their Mailbox in Control Panel. This would be useful if the member of staff has left the practice and been made inactive.

1. Go to the front screen of Vision and select **Management Tools – Control Panel**.

2. From the list at the side, select **Mail Maintenance – Staff Access.**

3. Click on the users Mailbox folder which should display all the Mailboxes they currently have rights to see in Mail Manager.

4. To remove Lindsay Bath so that her Mailbox no longer appears in the Mail Manager screen for Katherine Cotton, right click on her name and select Remove.
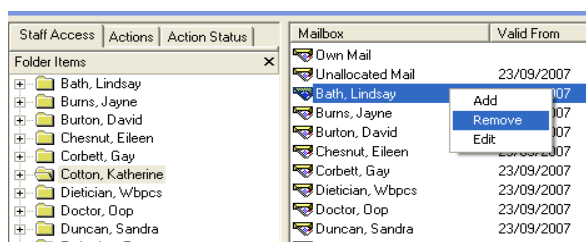
In this example, Katherine Cotton is removing her rights to view Lindsay Bath's messages.

5. You will be prompted with the following message: *Do you really want to remove mail access rights to [Mrs Lyndsay Bath]?* Select Yes to remove.

Mail Manager Training Tip - Allow Temporary Access to Mailboxes

You are able to enter date ranges to allow temporary access to a persons' Mailbox i.e. when a member of staff is on holiday. This is done from **Management Tools - Control Panel – Mail Maintenance – Staff Access.**

1. In **Staff Access**, right click on your folder from the Staff list and select **Add**.

2. From the drop down list select the Mailbox that you would like to have access to. You can also give access rights to a group of users.

3. Next, fill in the Valid Until date If you do not fill in he Valid Until date, you will have unlimited access to this Mailbox. The valid from will default to today but this can be changed to a date in the future if required.
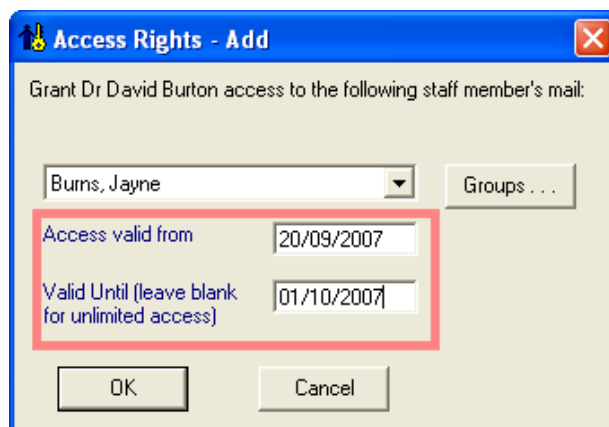
4. Click OK to save. You will see the date range that the user will be able to access the Mailbox.

View Mail for Patient - Results with Multiple Actions

Previously in Consultation Manager - Mail for Patient , to view multiple actions for a single result you would have to select the result, click on View Result and click on the Actions tab, which is a lengthy process.

From now on, if a result has more than one action, you will see each action as a separate action copy in the View Mail for Patient screen.

These action copies will need to be completed individually if doing so from Consultation Manager. In the example below, there are two actions for the same result:
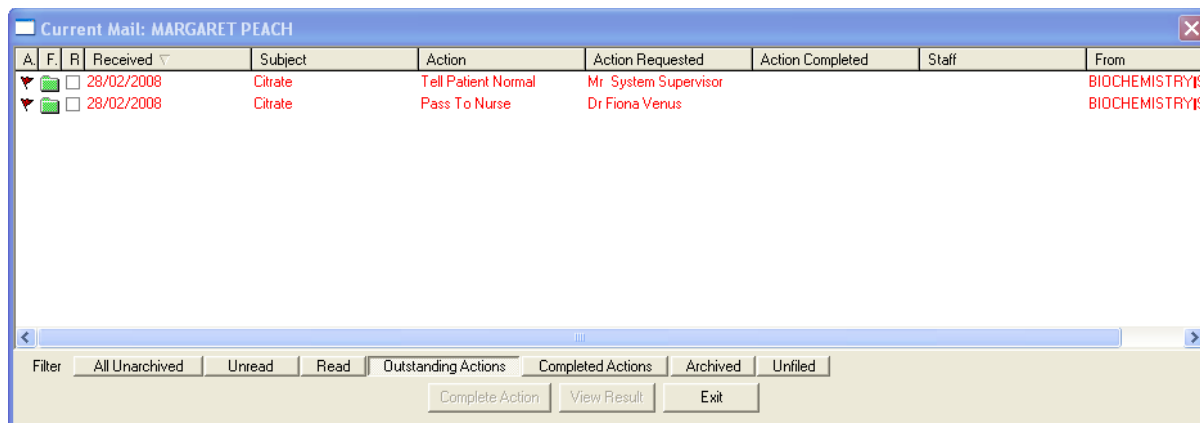
You can complete more than one action for a single result whilst viewing the result in Mail Manager from the Actions tab.

> **Note** - Clicking on the **Complete Action** button will complete any action on the currently highlighted result; if you select this you will be unable to read any extra free text that the person setting the action might have added. This text can only be read by looking at the full result (View Result).

GP2GP

Staff details from incoming GP2GP messages are automatically added to the Staff section in Vision File Maintenance as inactive staff, and a mailbox is created in Mail Manager. Mail for such staff in Mail Manager will be unallocated and can be reallocated or processed by your practice.

Display of these inactive staff will be completely hidden from DLM 280 and in the meantime, make sure any Display Inactive or Active Only options are selected accordingly when searching for current active clinicians in your practice.

For example, if you are doing an ad-hoc search, and using Clinician as one of your selection criteria, you can ignore these inactive clinicians by making sure the box **Display Inactive** is <u>unticked</u> in the Criteria Select screen.
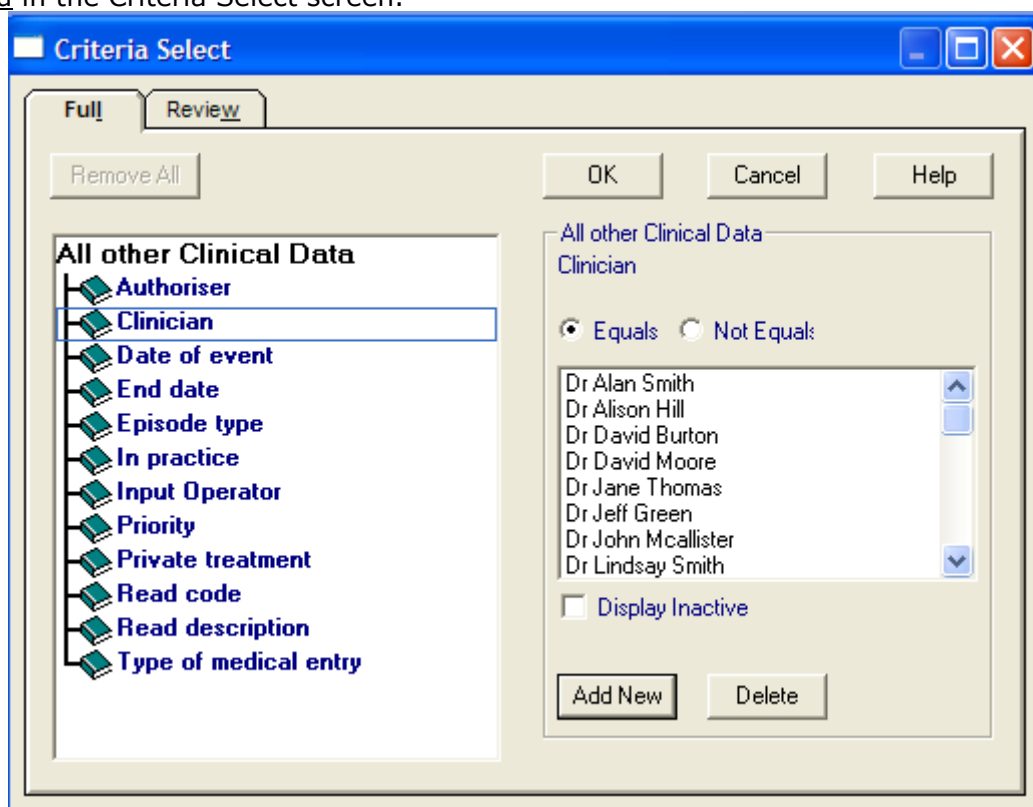
Clinical Audit

Until now, problems have been shown undated in Clinical Audit.

From DLM 260, problems will now be displayed with their start date and a description of a problem. To check this, go to the Month/Year tab in Clinical audit, select a patient with a problem (there is a Data Quality audit - Pts reported with ONLY problems) and double click on the patient's name to show the clinical problem details in the right-hand pane.

Registration Links

Many machines no longer have a floppy disk drive, so changes have been made to the Quarterly Archive in Registration Links. If drive A for floppy disks does not exist, then the archive will be saved to a network drive, usually P:\archive.

Summary Care Record Changes

Training Tip - Recording Patient Preferences

For practices in England, patient preferences relating to the GP Summary Care Record are recorded in Consultation Manager under Patient Details - Preferences. Note that the Change button is greyed out unless you have started a face-to-face consultation. with one of the following:
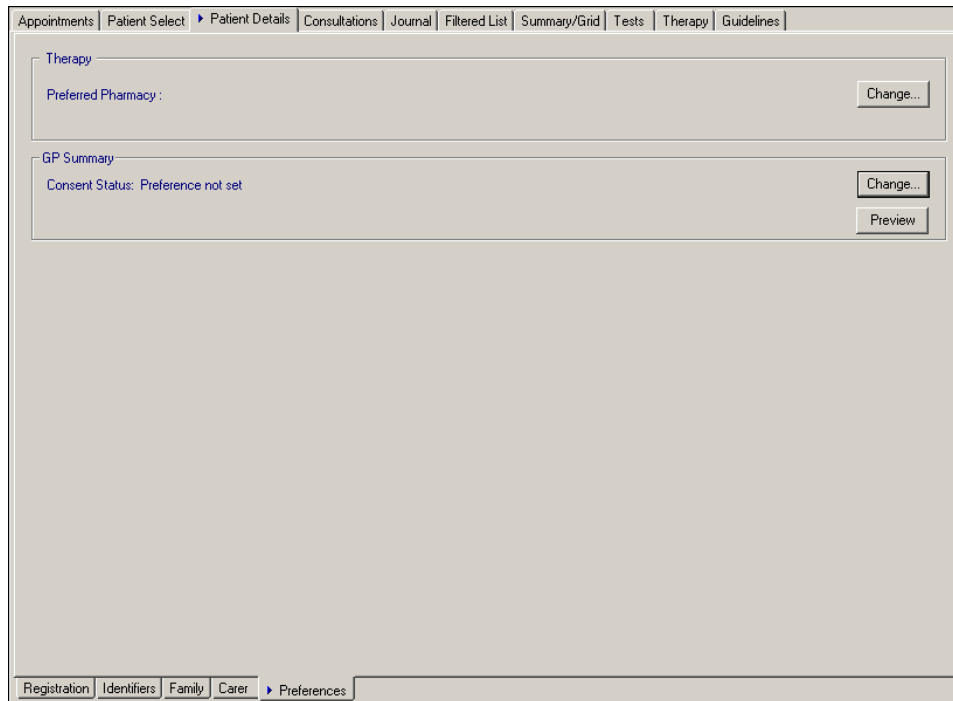
The Change button remains inactive unless you open one of the consultation types listed below

Acute visit	Night visit local rota
Casualty attendance	Night visit practice
Children's home visit	Night visit, deputising service
Clinic	Nursing home visit
Co-op home visit	Out of hours, non-practice
Co-op surgery consultation	Out of hours, practice
Co-op telephone advice	Residential home visit
Emergency consultation	Surgery Consultation
Follow-up/routine visit	Telephone call to a patient
Home visit	Telephone Consultation call from a patient
Hotel visit	
Mail from patient	Telephone Consultations
Minor injury service	Triage
Night visit	Twilight visit
	Walk-in centre

Running the Initial Upload on VES

If you are running the Initial Upload on a VES system, it is imperative that you do not end the session on the machine that is running the Initial Upload until it has completed. **Ending the session during this time will cause the Initial Upload to fail.**

SCR Status – No Preference with Supplementary Data

If you do not add a patient preference, yet add and save supplementary data to the National Summary pane (either manually or through Management Options), the status of the summary will remain as outstanding even if you have successfully sent critical data to the spine. This is because supplementary data cannot be sent without recording express consent.
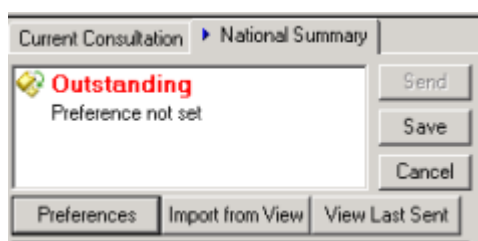
Outstanding Status on National Summary
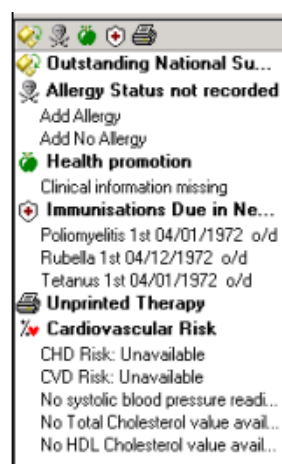
Outstanding Status on Alerts Pane

Multiple Summaries

If a patient's previous practice send a summary to the Spine subsequent to a summary being sent from Vision, thus creating a more recent summary **OR** if the most recent local summary in Consultation is lost for any reason, when you try to send a new summary to the Spine, you will be prompted with the following message: *Warning: The last summary this practice sent is out of sync with the one on the National Summary Care Record, can you confirm this update is the most recent update? Yes No Cancel.*
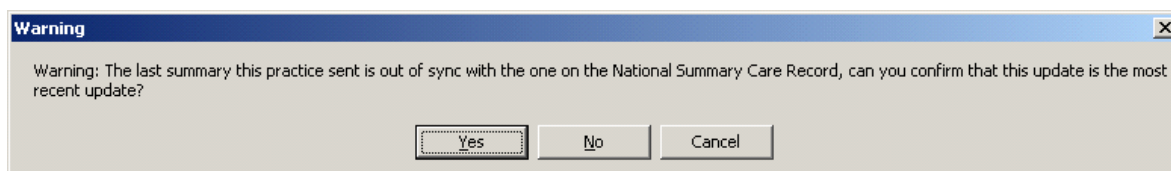
Select Yes to replace the summary, No to retrieve the summary which is on the Spine. If you select Cancel, this will return you to the patient record. From here you can look at the PSIS tab which displays the Summary updates that the Spine holds for the selected patient. Viewing the contents of the PSIS tab will help you decide which is the most up to date Summary.
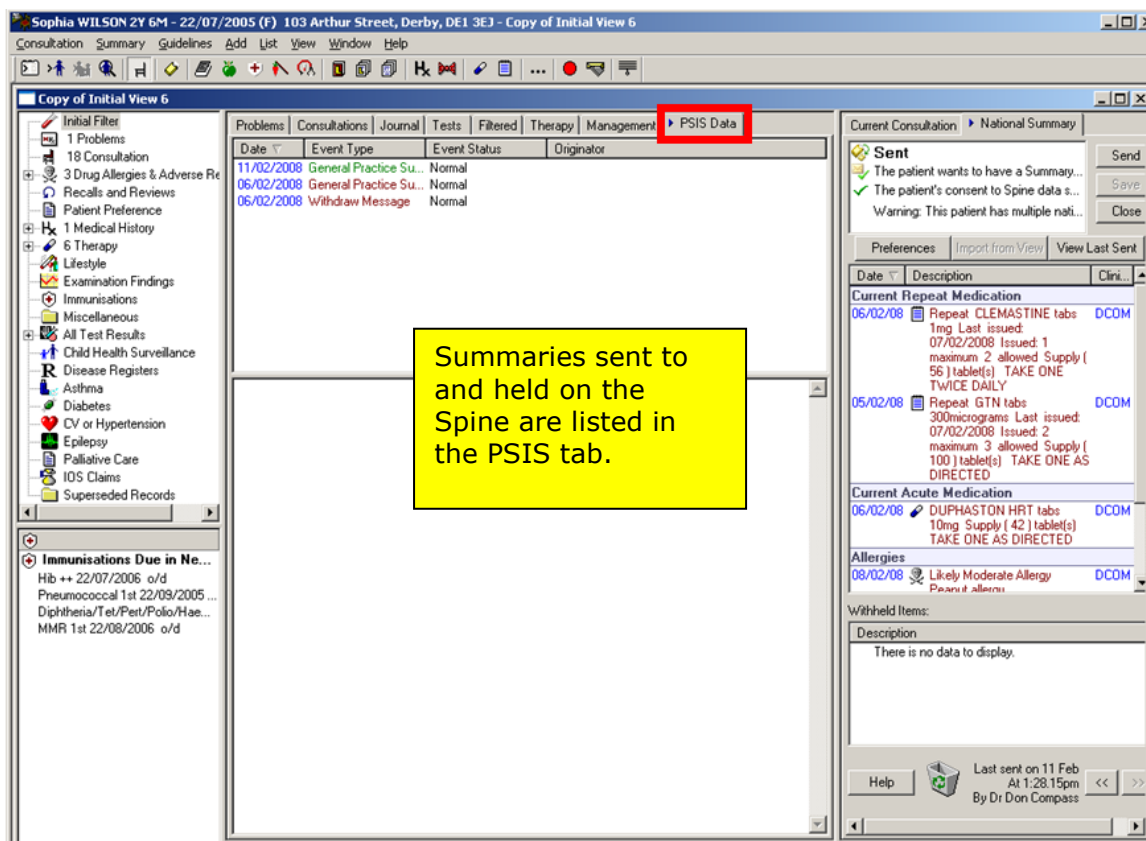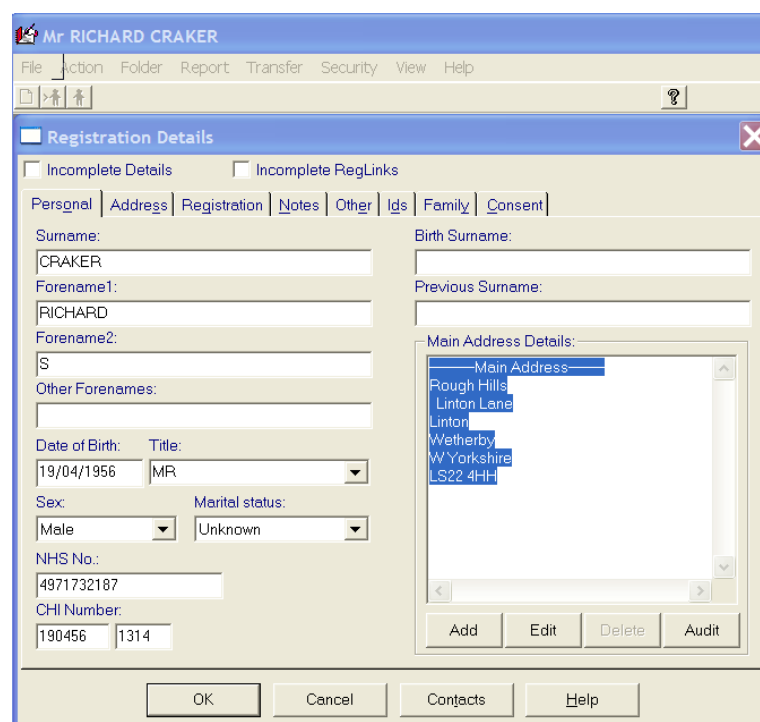
Contacts (carers and next of kin)

Contacts refers to Carers and Next of Kin and you may well want to enter both for patients, particularly those undergoing palliative care (see Gold Standard Framework Scotland - Palliative Care on page 78).

The previously named Carers tab in both Registration and Patient Details (Consultation Manager) has been renamed **Contacts**.
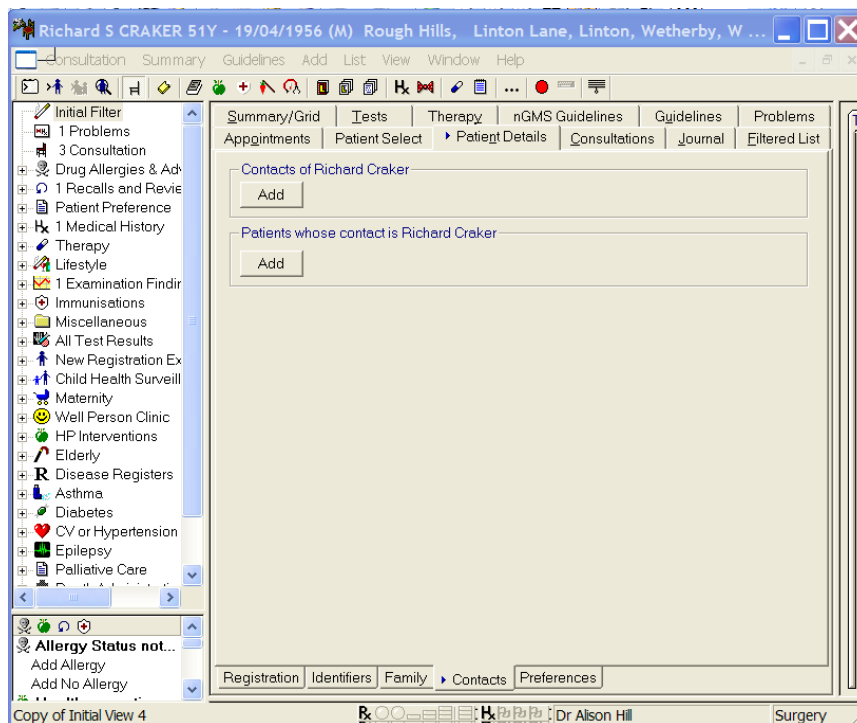
If you click on the **Contacts** tab in **Registration**, you will immediately see the **Add** contacts buttons.
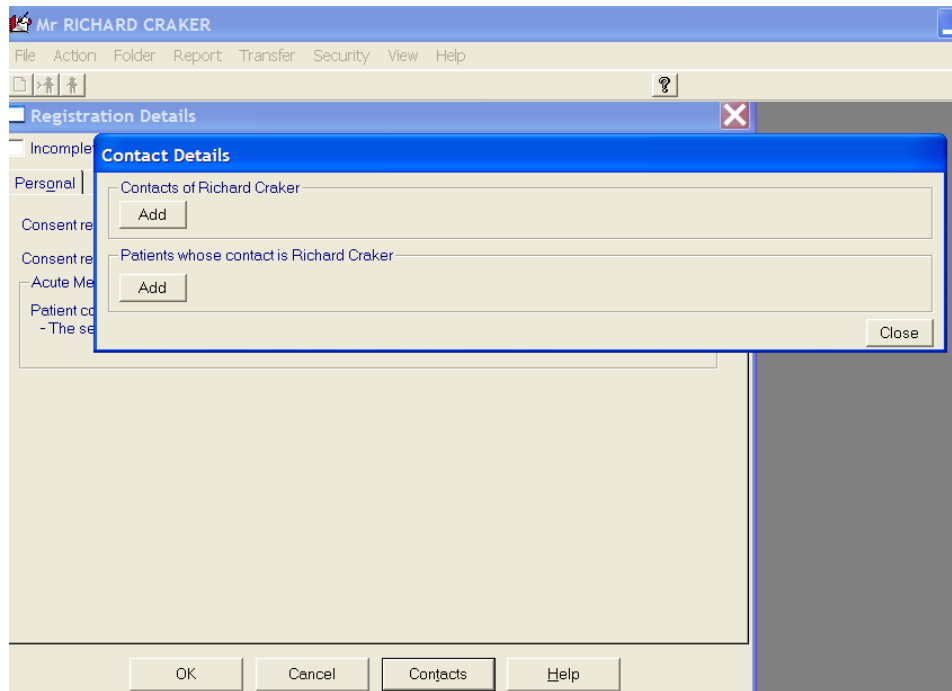
This works in exactly the same way as the previous Carers tab, except that the **Contact Relationship Add** screen now has a tick box for Next of Kin as well as Carer.

Selecting one of these will enter the word **Carer** or **Next of Kin** in the **Relationship to Patient** window and you can then add further free text to define the relationship, e.g. Sister, by placing your cursor to the right of the word Next of Kin and typing.

On the previous Person Add screen, if you have selected a contact who is NOT on the Vision database, you can record up to three telephone numbers for each contact.

MOST IMPORTANT on Person Add is the Date Entry Permission Date. In the case of contacts who are not patients registered with the practice, enter the date on which they gave permission for this information to be entered. This defaults to today's date. Although not mandatory and you can complete the screen without this date, the Data Protection Act requires you to obtain this permission.

Gold Standard Framework Scotland - Palliative Care

Introduction to GSFS

The following is an edited extract from the NHS Scotland / Macmillan Cancer Support document entitled Gold Standard Framework Scotland (GSFS) - A programme to support cancer and palliative care in the community, which is downloadable from the NHS Scotland website:

Gold Standard Framework Scotland (GSFS) is a practice based system to improve and optimise the organisation of palliative care for cancer patients.

People in the last stages of life are a special group of patients. Firstly, they are some of our most needy and vulnerable patients. Secondly, we in primary care can make a real difference to their care and their quality of life, both for patients and also for their carers, families and broader communities.

> At the time of going to press, the following has become available relating to English practices
> **http://www.goldstandardsframework.nhs.uk/gp_contract.php**

What is delivered in DLM 260

DLM 260 has the following which can be used by all countries and not just Scotland:

1. **Palliative Care guideline** (mnemonic *GSFS1). All countries can use this guideline to enter palliative care data. Some of the guideline entries trigger the creation of a *GSFS1 problem, and in Scotland, this problem is essential for the GSFS Messaging via ECS. There is no need for this GSFS problem to be created if you are in England, Wales or Northern Ireland.

2. **Palliative Care Plan** (as either a Management Plan, Summary Form or Data Grid) available from navigation pane in Consultation Manager, and can be used by all countries.

3. **In Scotland only, Palliative Care Reports** with three reports (from Reporting menu from Vision front screen):
   - Out of Hours Summary Report - This is sent in the message.
   - Palliative Care Review Report - this is for practice use
   - MDT Meetings Report - this is for practice use

In Scotland, you will have access to all these once DLM 260 is installed. In England, Wales and Northern Ireland, you will be able to use the Palliative Care guideline and the Palliative Care Plan.

Switching on GSFS messaging in Scotland

What DLM 260 does NOT do is switch on the messaging for GSFS in Scotland. This is done separately and Scottish practices will be advised later in the year when this is likely to be. The GSFS message goes via the Emergency Care Summary (ECS) messages. Only practices using ECS will also send GSFS data. In the meantime, you should continue with existing methods of communications with OOH services, as before, until GSFS messaging is working.

To switch on messaging at the appropriate time, Scottish practices should tick the Palliative Care Extract box in Options - Setup from the Vision front menu. This can be done on any workstation and it is a global setting. If on the GPC machine, exit Vision and go in again to effect the change.
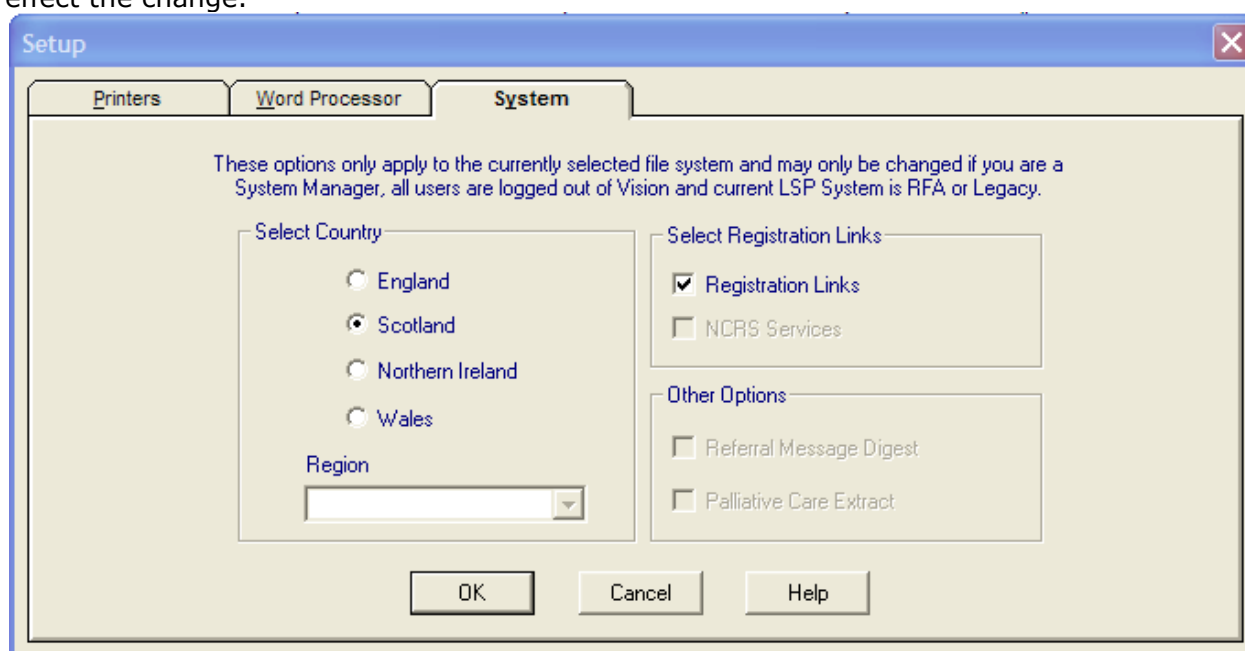
What this section covers

- Setting up patient consent for GSFS in Registration (necessary for Scotland) - see "Registration - Consent to ECS and PC (Scotland only)" on page 84

- Entering contacts in the form of carers and next of kin in either Registration or Consultation Manager - see "Contacts (carers and next of kin)" on page 75

- In Scotland only, setting up for problem generation - see "Initial Setup in Consultation Manager" on page 85

- The Palliative Care Guideline - see "Palliative Care Guideline display and data entry" on page 89.

- In Scotland only, creating the Palliative Care *GSFS1 problem - see "** Refer care to Community Palliative Care Team and create the *GSFS1

problem" on page 92, and "On palliative care - creating the GSFS problem" on page 95

- The Palliative Care Plan - see "Terminal Phase" on page 102.

- "Palliative Care Reports (Scotland only)" on page 113.

- GSFS messaging via ECS (Scottish practices only) - see "Palliative Care Messaging" on page 130.

-

Outline of how to use the software

- The patient becomes eligible for palliative care.

- Make sure the patient's contacts in the form of carers and next of kin are entered (see "Contacts (carers and next of kin)" on page 75).

- Make use of the Palliative Care guideline (or Palliative Care Management Plan) in Consultation Manager to enter data from the multi-disciplinary team involved in palliative care.

In Scotland Only:

- In Scotland (only), set up patient consent for GSFS in Registration - see "Registration - Consent to ECS and PC (Scotland only)" on page 84.

- Tick the box Palliative Care Extract from Options - Setup from the Vision front menu.

- By entering certain Read codes to do with palliative care, you trigger the creation of a palliative care problem called *GSFS1. This is essential in Scotland but not in England, Wales and Northern Ireland. This problem will contain the diagnosis information and any other relevant data to do with the patient's palliative care, including the original diagnosis. See "** Refer care to Community Palliative Care Team and create the *GSFS1 problem" on page 92, and "On palliative care - creating the GSFS problem" on page 95

- For Scottish practices only, the data within the problem is "picked up" from the Out of Hours Summary Report and will be relayed in nightly messages via the Emergency Care Summary pathway, via GPC, when the GSFS messaging is switched on. Any out-of-hours service is thus up-to-date. In Scotland only, run the Palliative Care Reports. You can schedule two of these to run automatically (see "Scheduling the MDT and PC Review Reports" on page 124)

Quick Reference to using GSFS Palliative Care software (Scotland)

1. The patient becomes eligible for palliative care.

Quick Reference Setting Up

2. Make sure the patient's contacts in the form of **carers and next of kin** are entered in either Consultation Manager - Patient Details - Contacts - contacts of [patient name], or in Registration - Contacts. See Contacts (carers and next of kin).

3. Set up **patient consent for GSFS** in Registration on the Consent tab - untick Consent refused to data sharing for emergency care; tick Consent given for palliative care data sharing. See Registration - Consent to ECS and PC (Scotland only).

4. In Scotland, when you are advised that GSFS messaging is starting, tick the box **Palliative Care Extract,** reached from Options - Setup from the Vision front menu.

5. Add the Palliative Care Guideline to your Local Guideline Index. See Adding the Palliative Care guideline to the Local Guideline Index on page 85.

6. Add a Problems tab to your patient record if not already there. See Adding a Problems tab to your Patient Record on page 87.

7. In Consultation Manager - Consultation - Options - Setup, on the Management tab, check semi-automatic generation under Problem Generation; and Passive Triggering under Automatic Triggering. See Checking triggering and problem generation on page 88.

Quick Reference Day to day use of GSFS guideline

1. Make use of the Palliative Care guideline in Consultation Manager to enter data from the multi-disciplinary team involved in palliative care. Access the guideline either from the Local Guideline Index, or from Guidelines - Select Guidelines, untick Centrally Issued, and type the mnemonic *GSFS1.

2. In summary, note the following:
   Patient Details- Warns in red if you have not completed the consent in Registration.

   Carer / Next of Kin Details - Check in Patient Details - Contacts that the carer and next of kin details are up-to-date. Information in Contacts is NOT displayed in the guideline.

   Key professionals - Under the care of: Details of any of these: Practice Nurse, District Nurse, Community Palliative Care Team, Macmillan Nurse, Multidisciplinary Team.

   Key professional - Refer Care to: If you make a referral to the **Community Palliative Care Team**, or on entering data in **On palliative Care**, you trigger the creation of a palliative care problem called *GSFS1 (as long as semi-automatic problem generation is switched on, and if not, create the problem manually). This problem is essential for messaging purposes. Do not alter the Short name *GSFS1. This problem should contain all the data to do with the patient's palliative care, including the original diagnosis. See ** Refer care to Community Palliative Care Team and create the *GSFS1 problem

   Key Professionals - Refer Care to - the other buttons: also Social Services, Voluntary Services, Arrange care by relative, Arrange care attender

   Access Information - Change Type of Note to Access Information. Put access text, eg *Key with neighbour,* in Note section.

On palliative care - creating the GSFS problem - Also triggers creation of *GSFS1 problem (see above). If already created from referral to Community PCT, select Cancel.

Diagnosis information - Picked up by OOH summary report.

- Palliative care issues - Remember to change Type of Note to Palliative Care Issues. type text, eg *Tingling in fingers*, in Note.

- Aware of Diagnosis, Informing of Prognosis **-** only latest record is shown.

Terminal Phase - Care Plan - You can also reach the Palliative Care Plan - Add from the navigation pane under Palliative care. Note that completing the Care Plan is essential in order to run the OOH Summary Report for Scottish practices.

- **Date of Agreement** must be entered.

- **Last ECS Upload data** - Automatically shows last successful ECS (Emergency Care Service) message transition in which GSFS message is included.

- **GP to sign death certi -** Only tick if true and enter text in Note, eg *If patient dies between 8am and 8 pm*.

- **Date resus status agreed** - Only enter a date is this is true.

- **Resus date notes**, eg Discussed with patient and family.

- **GSFS Review Date** - Enter future review date, eg T+2W (two weeks from today). Free text in Note, eg *Family review*. When the review is overdue, it will show in the Alerts pane. You can search for patients with expired or imminent review dates in the Palliative Care Review Report.

Add for Resuscitation / Not for Resuscitation(**Terminal Phase)** - only latest record is shown.

DS1500 form(**Terminal Phase) -** Clicking on Add Form Completed records the DS1500 form has been completed.

Note that Scottish practices currently do not have Read code 9EB5 *DS1500 Disability living* in their Scottish Read dictionary, but this code will be included the Qtr 3 version of the dictionary this autumn.

- Treatment - Add Cancer Review, Add Radiotherapy, Add chemotherapy, Add Palliative Treatment (type drug name in comment field).

- Current Rx in last 3 months - Current therapy in last three months. To prescribe, use the Therapy tab in the usual way.

- Allergies- Shows any recorded allergies. Use Add-Allergy/Adverse Reaction to add new ones.

Palliative Care medical data - Display only section, builds up from entries elsewhere. Medical History records are picked up from chapter A-U of the Read dictionary.

OOH Information - We recommend that you make entries in OOH Information.

Additional OOH Information - Note pad entry, change Type of Note to OOH Information. Free text in Note, eg *Review medication*.

Care at home:

- Extra drugs Available at home, e.g., *diamorph 5 mg*

- **Catheter Products at home**, e.g., *drainage bags x 5*

- Moving/Handling Equip at Home, e.g., *bath hoist*

- **Notes** - this is optional, e.g. *drugs in top drawer*

Syringe driver use- All records of commenced/discontinued use are displayed.

Preferred Place of Care - Preferred place of death. Make sure to select General History and NOT the selected SDA if asked.

3. Viewing the GSFS problem and its data in Problem tab. All data in the GSFS problem (whether entered from the GSFS guideline or moved into the guideline manually) will be sent in the palliative care data extract.

Quick Reference Palliative Care reports

1. For Scottish practices only, use the three GSFS Palliative Care Reports (Scotland only) which can be accessed from the Reporting menu of Vision, or Modules - Palliative Care Reports.

2. The data within the *GSFS1 problem is "picked up" from the Out of Hours Summary Report and relayed in nightly messages which run automatically via the Emergency Care Summary pathway, via GPC, when the GSFS messaging is switched on. Any out-of-hours service is thus up-to-date. You can also use the OOH Summary report to produce two types of reports: one for an individual patient, and one for groups of patients according to selected criteria. It summarises the entries on the GSFS guideline

3. MDT Meetings Reports(Multi-disciplinary team) finds patients according to specific criteria - the Read codes that trigger the Palliative Care guideline and the patients' registration status, eg all active patients with a Read code of 8CM1 *On gold standards palliative care framework*. The report is not sent in the messaging in Scotland and is for practice use. Click on New, select the Read codes you want to report on, and click on Search. You can then File - Print or Save. If you select Save, a filename is offered - there is NO NEED to enter a file extension. You can view and load existing reports (changing the date range is necessary).

4. Palliative Care Review Reports - This finds patients near to or overdue for a palliative care review. It is not sent in the messaging in Scotland and is for practice use. The review date is entered in GSFS Review Date on the Palliative Care Plan - part of the GSFS guideline

5. You can schedule the MDT Meetings and Palliative Care Review reports to run automatically using Windows Scheduler (see Scheduling the MDT and PC Review Reports).

Quick Reference Messaging and GPC

Look regularly in Mail Gateway to make sure the most recent ECS message has been successful. You should ring the Helpline if you see that the most recent ECS message has failed.

The palliative care data will initially be sent in full, and thereafter, incrementally with any data added since the last send.

Registration - Consent to ECS and PC (Scotland only)

Scottish practices will need to record patient consent to data sharing for the purposes of both Emergency Care (ECS for Emergency Care Summary) and Palliative Care (PC). This can be recorded in Registration (there is no direct access to the consent screen within Consultation Manager).

> **Note** - You can record consent in Registration for both ECS and Palliative Care once you have received DLM 260

Go into **Registration**, select the patient and click on the **Consent** tab.

Consent refused to data sharing for emergency care. The default is unticked, i.e. the patient consents to share data.

Consent given for palliative care data sharing - The default is unticked. Tick this if the patient consents to share data for palliative care. Note that you can only record consent for palliative care data sharing if the patient consents first to ECS data sharing, i.e. if the ECS consent is not refused and is given (i.e. unticked), then you can tick the palliative care option. ECS consent can be given on its own without palliative care being ticked.

If patient changes consent and you change the tick status, then you get a warning messages, for example:

Consent to Palliative Care and Consent to Emergency Care Summary

⚠ You have marked MARY HADDOCK as consenting to data sharing of Palliative care.

Consenting will also result in the consent of data sharing of Emergency Care Summary.

Click Yes to confirm your request. Click No to cancel.

[Yes]   [No]
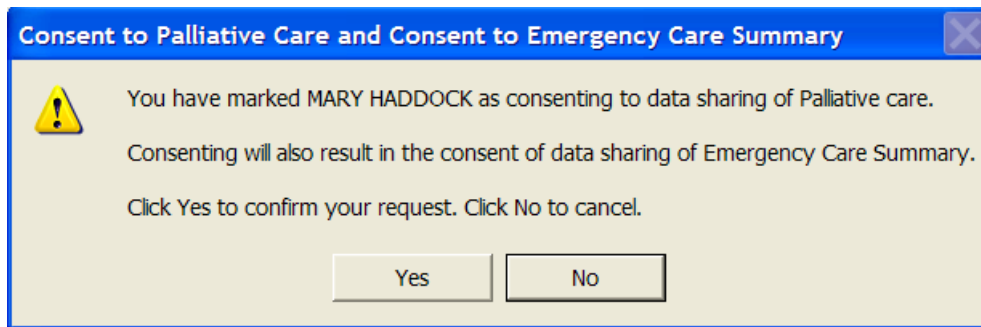
Initial Setup in Consultation Manager

One of the key elements of the Gold Standards (GSFS) software in DLM 260 is the **Gold Standards Framework Scotland - Palliative Care Guideline**.   This has been designed to ease the recording of data relating to a patient's Palliative care.   Note that the guideline is locked and cannot be edited.

We recommend that Scottish practices set up the following before starting to record GSFS data:

- Add the Gold Standards guideline to the Local Guideline Index - see "Adding the Palliative Care guideline to the Local Guideline Index" on page 85

- In Scotland, check your current Patient Record view displays a Problem tab (and this will need adding if not already there) - see "Adding a Problems tab to your Patient Record" on page 87

- In Scotland, check that Disable Triggering is not switched on and that preferably check that semi-automatic Problem Generation is selected - see "Checking triggering and problem generation" on page 88

- In England, Wales and Northern Ireland, you can use manual problem generation, if you prefer, as there is no need to generate a problem.

Adding the Palliative Care guideline to the Local Guideline Index

1. Click on the Local Guideline Index icon 🔲 .
2. Click on the Maintenance icon 📝 to display the floating toolbar.
3. Decide where you want the Palliative Care guideline to appear in your index. Click and highlight with two framing lines the line ABOVE where the guideline should appear.
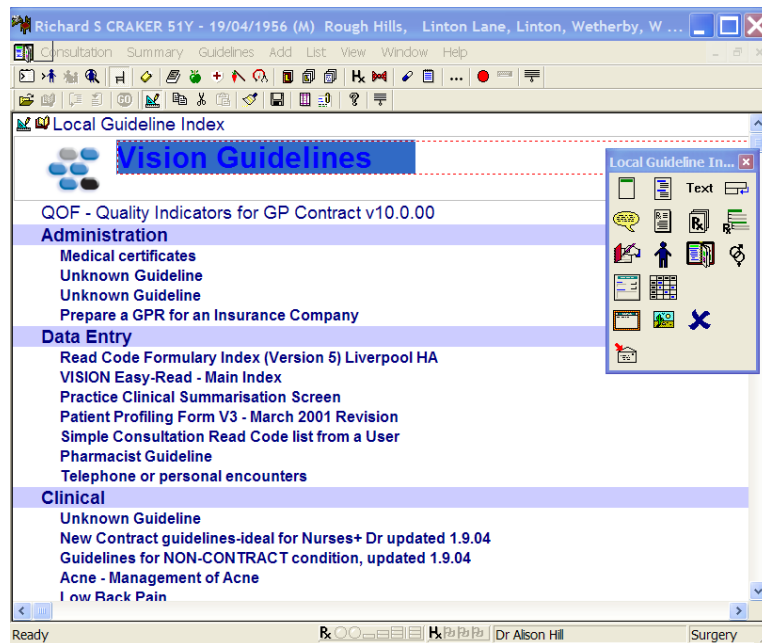
4. Then click on the Embedded Guideline icon from the floating toolbar .

5. Type *g in the Select Mnemonic window and press Enter. This should display the Gold Standards Framework guideline
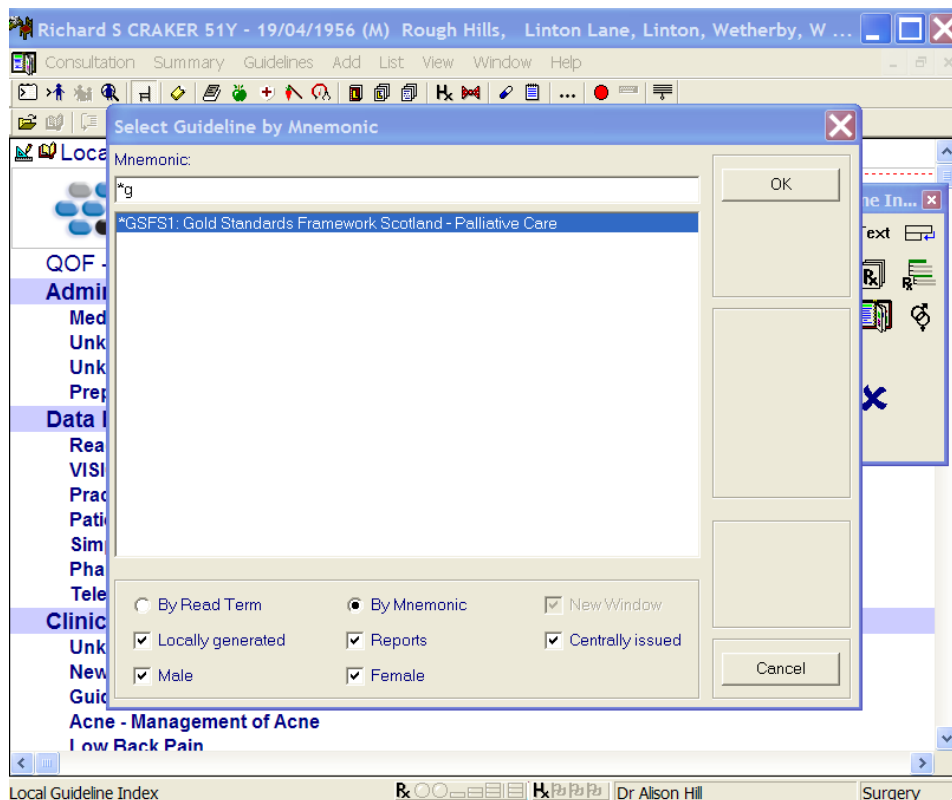
6. Click **OK**.

7. The Gold Standards guideline should now appear on your Local Guideline Index list.
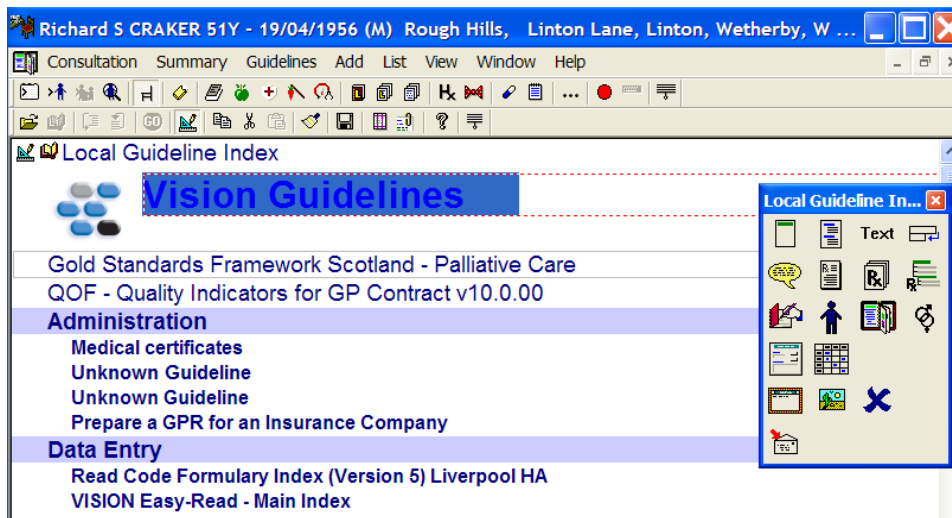
8. Finally, click on the Design Maintenance icon again to save.

Adding a Problems tab to your Patient Record

In Scotland particularly, check that your current Patient Record view displays a Problem tab. If it does not, this will need adding.

> Data from the GSFS Palliative Care guideline is collected together into one problem and, in Scotland, is relayed in the ECS messaging. A *GSFS1 problem MUST be created for this to happen and will do so once you enter certain triggering Read codes. You may want to review the data included in the Problem so will need a Problems tab.

1. Right click on any one of the tab headings on the Patient Record, e.g. Journal, or Therapy.

2. Select **Organise Tabs**.

3. Click on **Add**.

4. Select **Problems List** and click OK.

5. Highlight **Problems** and click on **Move Up** (the Guidelines tab prefers to be on the extreme right).

6. Click OK.

7. Click OK again to the Refresh message.

8. Click on the **Problems** tab. You will see three lines, if the patient has no problems yet - a blue **All Problems** line, a **Currently Relevant** problem, and a green line called **New Problem**. The GSFS problem you will create later will appear under the All or Active Problems line.
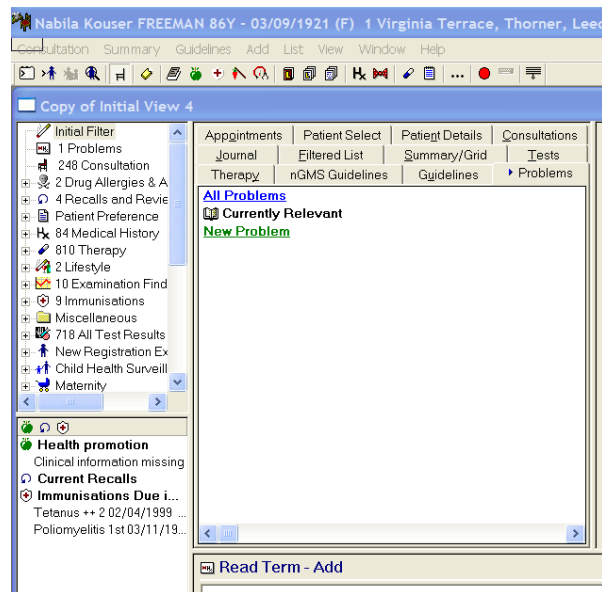
Checking triggering and problem generation

In **Consultation - Options - Setup** under the **Management** tab, check that you have selected the following, depending on whether you are in Scotland and need to generate the Palliative Care problem, or in England, Wales or Northern Ireland where you can choose not to.

- either **Active Triggering** or **Passive Triggering** in Scotland. In England, Wales or Northern Ireland, you can choose either.

- and that in Scotland, under Problem Generation, **Semi-Automatic** is selected. If you choose Manual Problem Generation, you will need to follow the instructions of creating the GSFS problem manually - otherwise no messaging for GSFS will take place. See "Manually create the GSFS problem" on page 96.

- In England, Wales or Northern Ireland, where there is no need to generate a problem, you can choose either Manual Problem Generation or Semi-Automatic Problem Generation.
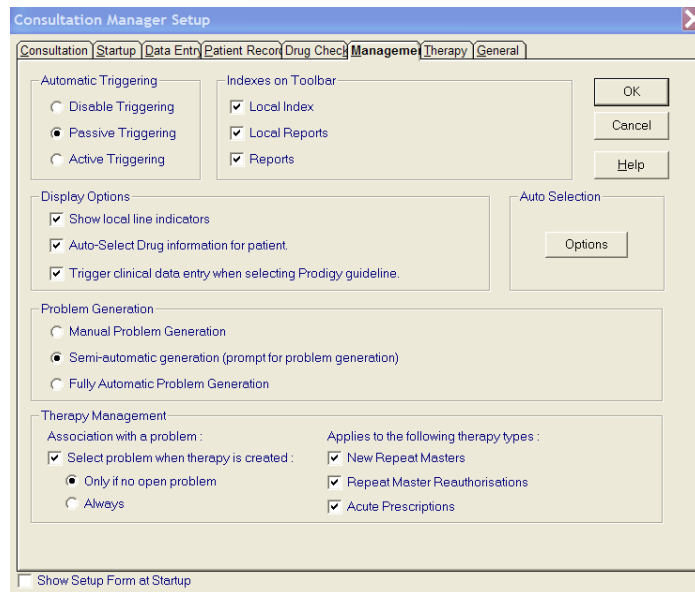
Palliative Care Guideline display and data entry

Accessing the Palliative Care Guideline

- Two ways to access the guideline:

  - Either click on the Local Guideline Index icon ![icon] (see "Adding the Palliative Care guideline to the Local Guideline Index" on page 85); then double click on the Gold Standards Framework Scotland - Palliative Care.

  - Otherwise select from Guidelines - Select Guidelines, untick Centrally Issued, and type the mnemonic *GSFS1, then highlight the *GSFS1 line and select View.
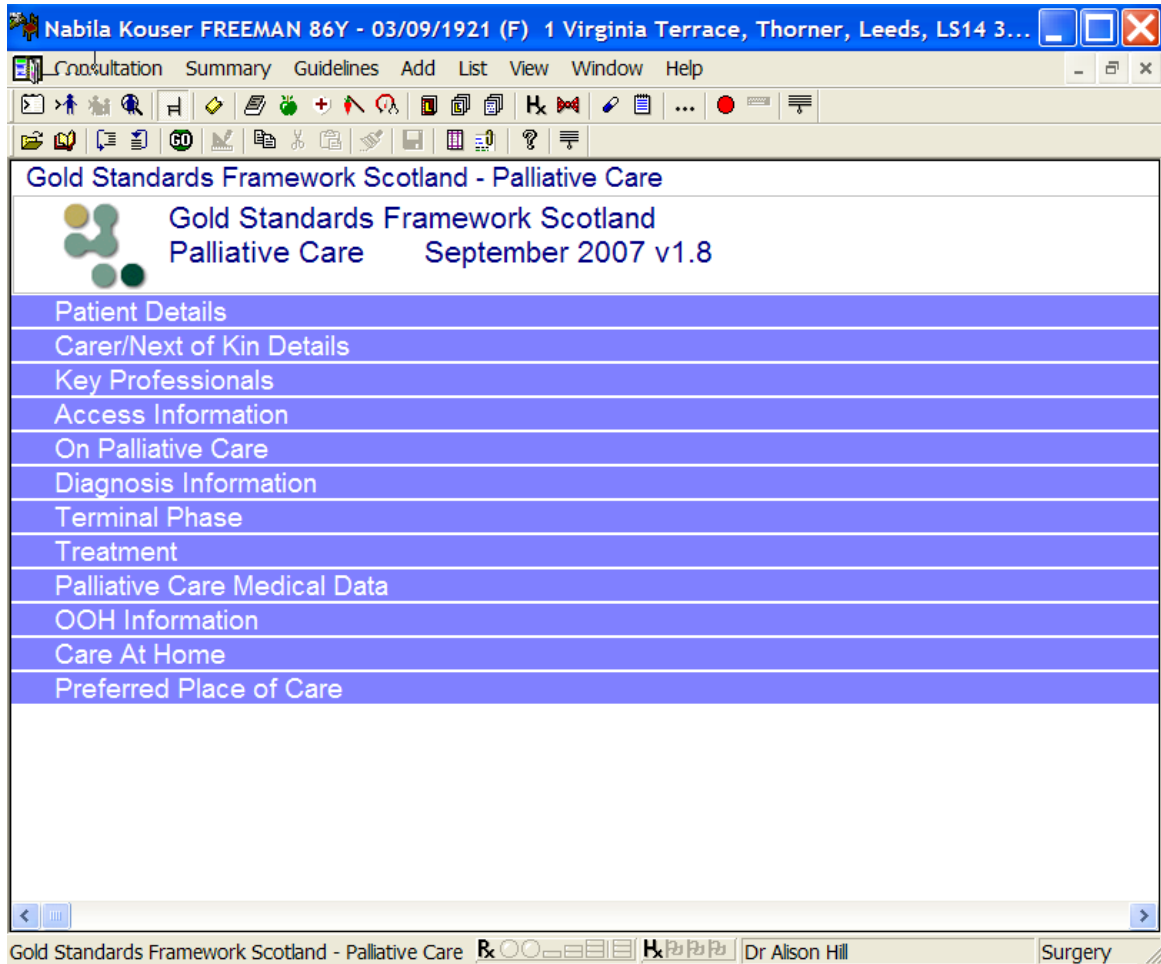
The date and version number of the guideline on your system may be later than that shown in this screenshot

The blue headings are expandable lines. Click once on a blue line in order to expand it.

Patient Details

Display only of patient's name, dob, sex, NHS and CHI numbers and address and telephone numbers.

You will be warned by a line in red if you have not yet completed the Consent in Registration (see "Registration - Consent to ECS and PC (Scotland only)" on page 84). This only applies to Scottish practices.

Carer / Next of Kin Details

It is unfortunately not possible to pick up details in this guideline of any contacts (carer or next of kin) entered in Contacts. The message in red directs you to *Select the Patient Details/Contacts tab to ensure that Carer/Next of Kin details are up-to-date*.

Without closing the guideline, click on the Patient Details icon 🔍 then the Contacts tab to see details of any contacts already entered.

To return to the GSFS guideline, click on Window on the menu then select Gold Standards Framework.

You may also want to add a Read-coded History record for carers: 918F Has a carer
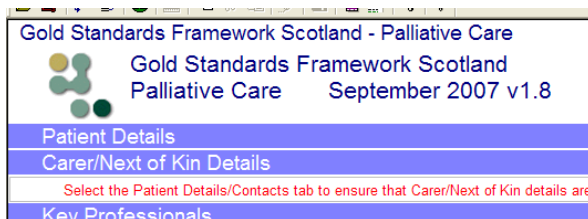
Key professionals
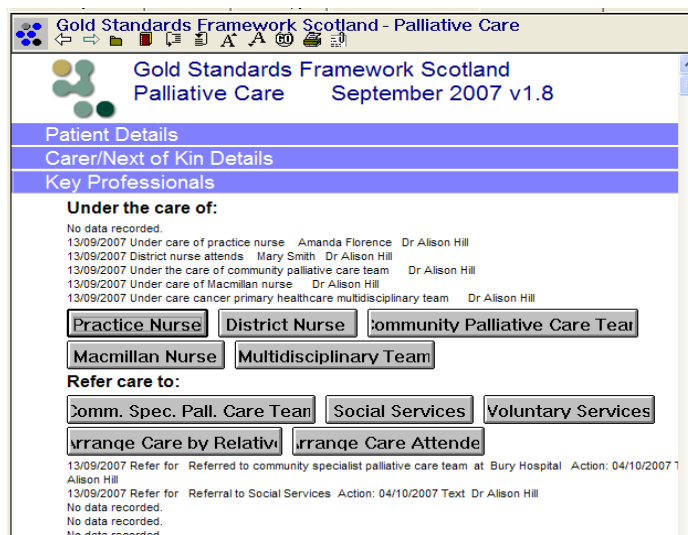
Under the care of

This is where you can record members of the team looking after this patient. Clicking on any of these buttons gives a <u>History</u> entry with a relevant Read Code.

You can add the person's name in the Comments field. On the Palliative Care Reports (Scotland only), the role will be shown, e.g. Practice Nurse, but not the name.

Practice Nurse - 9NNA Under care of practice nurse

District Nurse - 13G1 District nurse attends

Community Palliative Care Team ** - 9Nh0 Under the care of community palliative care team

McMillan Nurse - 9NNS Under care of Macmillan nurse

Multi-disciplinary team - 9Nh1 Under care cancer primary healthcare multidisciplinary team

** Refer care to Community Palliative Care Team and create the *GSFS1 problem

In Scotland, when you enter a referral to the Community Palliative Care Team or enter data in On Palliative Care, you should trigger creation of the **Gold Standards Framework Scotland - Palliative Care problem (*GSFS1 problem),** which is essential for GSFS messaging in Scotland (provided you have semi-automatic problem generation switched on, and if not, you must create the problem manually).

> Note that in England, Wales and Northern Ireland, there is no need for you to create this problem but you may if you want to.

Creation of the GSFS1 problem is triggered:

- either making a referral for the first time to the Community Palliative Care Team button (see "** Refer care to Community Palliative Care Team and create the *GSFS1 problem" on page 92)

- OR making an entry under the section On palliative care (see "On palliative care - creating the GSFS problem" on page 95)

> In Scotland, you MUST create this problem the first time you are asked to do so, and its SHORT NAME (MNEMONIC) MUST REMAIN AS *GSFS1. If later you enter a second triggering Read code in the **On Palliative Care** section and you are asked once again if you want to create the Gold Standard Problem, this time you can answer No if the problem has already been created.

1. Click on the **Comm. Spec. Pall. Care Team** button under **Refer Care to.**

2. On the **Referral Add** screen, the Read code is entered automatically. Complete the provider if relevant. Note that for Provider to be included, it must already be in the Organisation list in Control Panel - File Maintenance.

3. When you click OK on Referral Add, you will be asked if you want to **Create Problem** called Gold Standards Framework Scotland - Palliative Care.

- In Scotland, YOU MUST CLICK ON CREATE.
- In England, Wales and Northern Ireland, you can click on Cancel so a problem is not created - this is up to you.
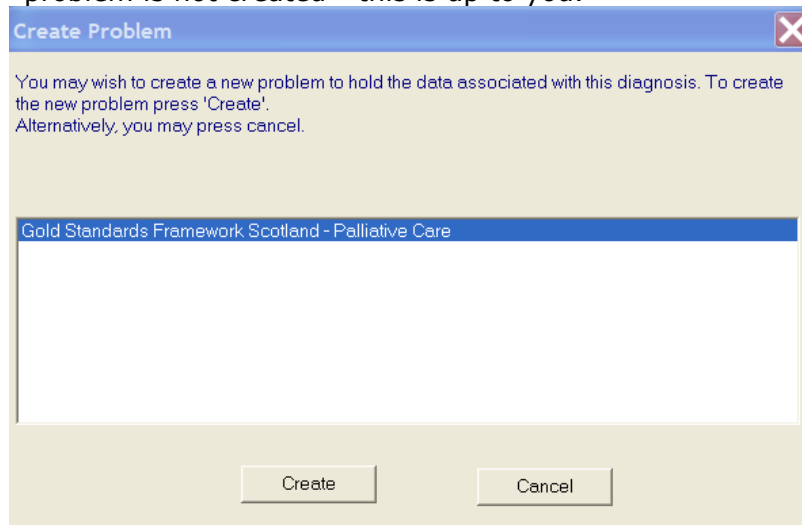
4. When the Problem Add screen is displayed, **DO NOT ALTER ANYTHING ON THIS SCREEN. THE SHORT NAME MUST REMAIN AS *GSFS1**. Click OK.
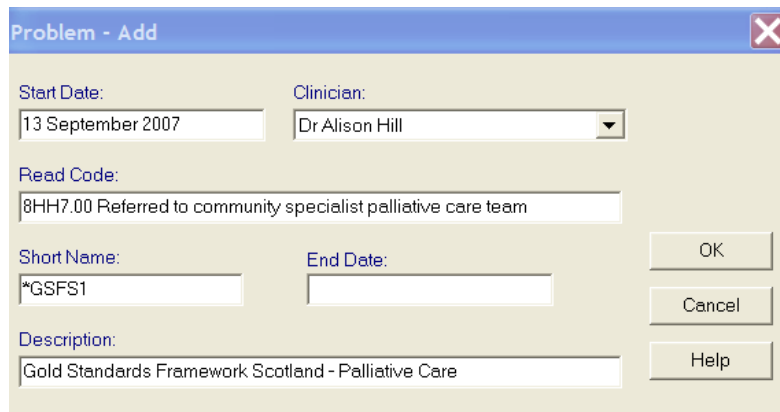
5. Without closing the guideline, go to Window and select Copy of Initial View or whatever your patient record view is titled.

6. Click on the Problems tab (how to add a Problems tab is explained on page 87). You should see the GSFS problem, open , with the referral you have just added listed.
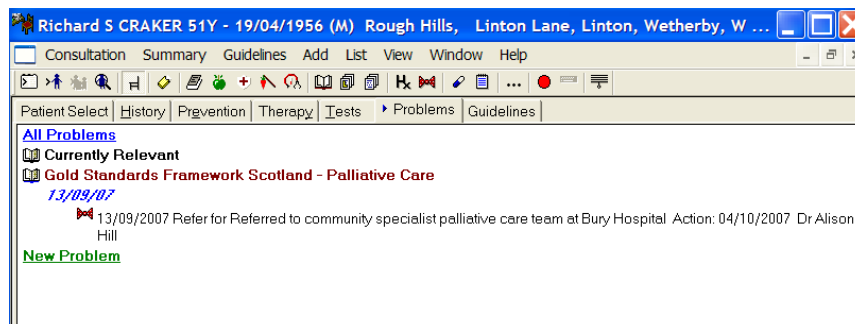
7. As long this problem remains open, any other data added in the guideline, and this consultation, will go into the GSFS problem.

8. Use the Window menu option to return to the GSFS guideline.

9. If you make another referral under Refer Care to, you will not create a second GSFS Problem.

But entering a referral for the Community Spec Palliative Care Team, the *GSFS1 problem is created and remains open (open book icon). Any data subsequently entered in this guideline during this consultation will be listed under the *GSFS1 problem (as long as you do not close the problem manually (closed book icon), or open or add another problem which will close the previously open problem).

In Scotland, all data within the * GSFS1 problem will be picked up by the GSFS / ECS messaging. You can move data in and out of the problem list.

Refer Care to - the other buttons

The following buttons under **Refer Care to** do <u>not</u> act as a trigger for *GSFS problem creation. Use the Comments field to add extra text if necessary:

Social Services - 8HHB Referral to Social Services - Referral

Voluntary Services - 8HHN Referral to voluntary service - Referral

Arrange Care by Relative - 8HH0 Arrange care by relative - History entry

Arrange Care Attender - 8HH4 Arrange care attender - History entry - this refers to someone supplied by a local authority, care agency, or private.

Access Information
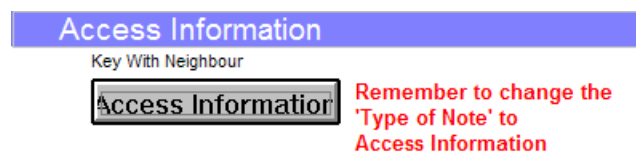
When you click on **Access Information**, a Notepad screen is displayed.

Change **Type of Note** to **Access Information**.

Any text entered in **Subject of Note**, e.g. "Key with neighbour", or in Note, is displayed in the guideline (and Palliative Care report in Scotland only).

On palliative care - creating the GSFS problem

In Scotland, making any entry under **On Palliative Care** will generate the creation of the Gold Standard Framework Scotland Palliative Care problem (GSFS) if it has not already been triggered by your making an earlier referral to the Community Spec Palliative Care team (see "** Refer care to Community Palliative Care Team and create the *GSFS1 problem" on page 92).

If the GSFS1 problem has already been created by referral to the Community Palliative Care Team and you are asked when entering an On Palliative Care Read code to create the problem again, you can Cancel.

If you prefer to create the GSFS problem manually, see "Manually create the GSFS problem" on page 96.

> Note that there is no need to create the GSFS problem, unless you wish to, in England, Wales or Northern Ireland.

Triggers for creating the *GSFS problem

The green lines here are all history entries. The triggering Read codes are NOT diagnosis codes, such as Malignant neoplasm, but the following Referral and Palliative Care codes. Note that entering these elsewhere in History Add will also trigger creation of the GSFS problem if it does not yet exist.

If you have already created the GSFS problem earlier, and are prompted to do so again because you entered a second trigger, then press Cancel so the second version of the GSFS problem is not created.

- 1Z01. Terminal illness - late stage
- 8BA2. Terminal care
- 8BAP. Specialist palliative care
- 8BAS. Specialist palliative care treatment - daycare
- 8BAT. Specialist palliative care treatment -outpatient
- 8BJ1. Palliative treatment
- 8CM1. On gold standards palliative care framework
- 8H6A. Refer to terminal care consult
- 8H7g. Referral to palliative care service
- 8H7L. Refer for terminal care

- 8HH7. Referred to community specialist palliative care team
- 9EB5. DS 1500 Disability living allowance (terminal care) completed
- ZV57C [V]Palliative care

In Scotland, you can search for patients with these Read codes in the OOH Summary Report (see "Out of Hours Summary Report" on page 121) and the MDT Meetings Report (see "MDT Meetings Reports" on page 115).

Manually create the GSFS problem

Some practices are not comfortable with generating problems semi-automatically and would prefer to create the GSFS problem manually.   The option in Consultation - Options - Setup - described in "Checking triggering and problem generation" on page 88 is left at Manual Problem Generation.

To create the GSFS problem manually:

1. Once you have added an entry in On Palliative Care, right click on a data line and select **Problems**.
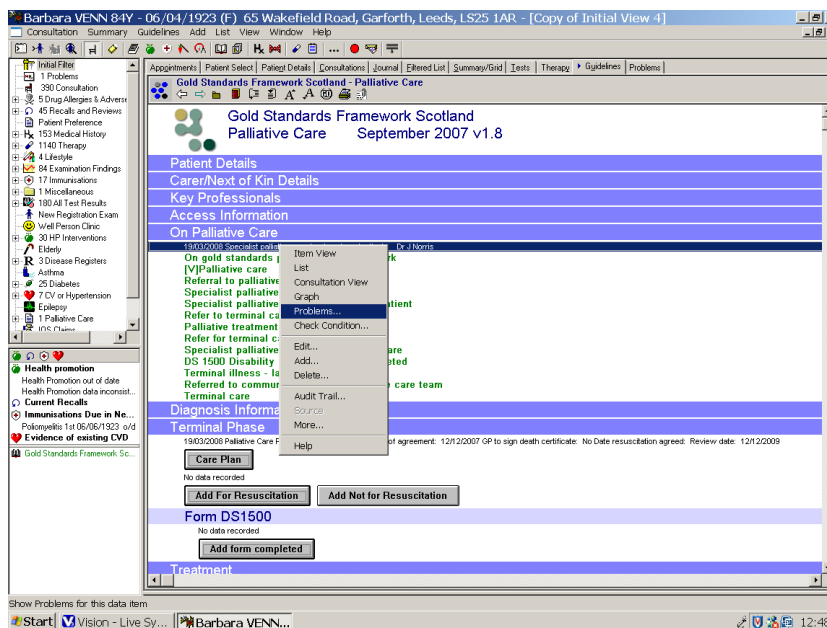
2. This displays the **Current Problems** list.
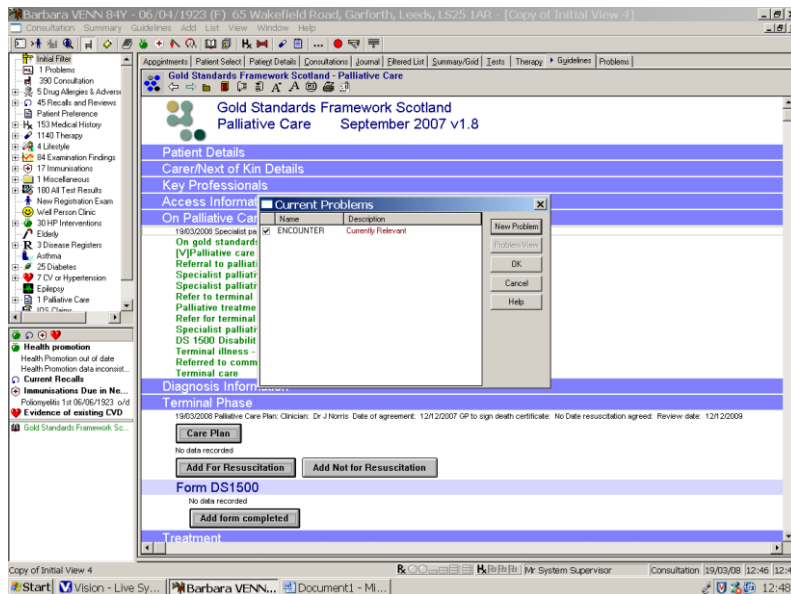
3. Select **New Problem** to display the **Problem-Add** screen.
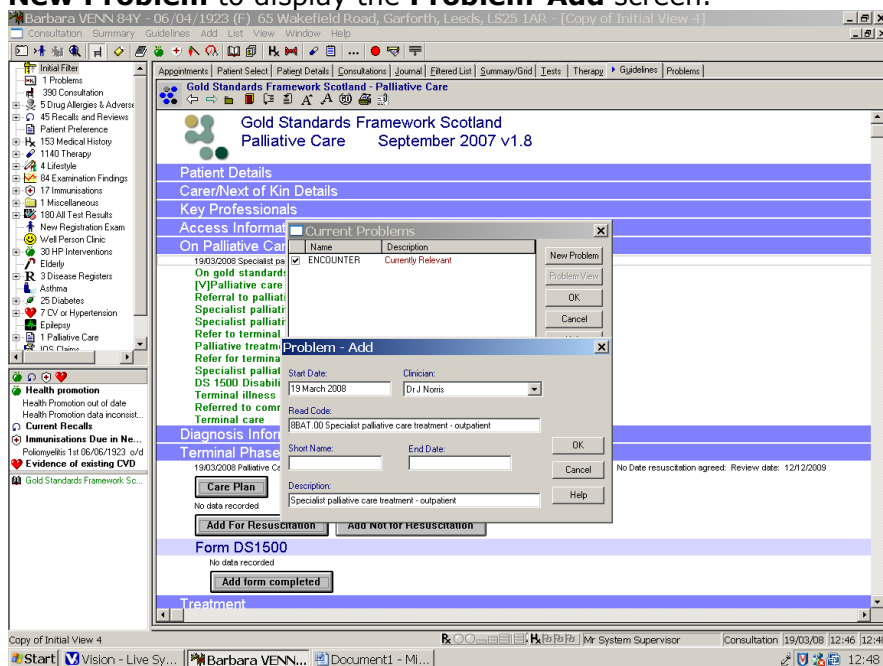
4. Change the Description to **Gold Standards Frame Work** and the Short name ***GSFS1** and click OK.
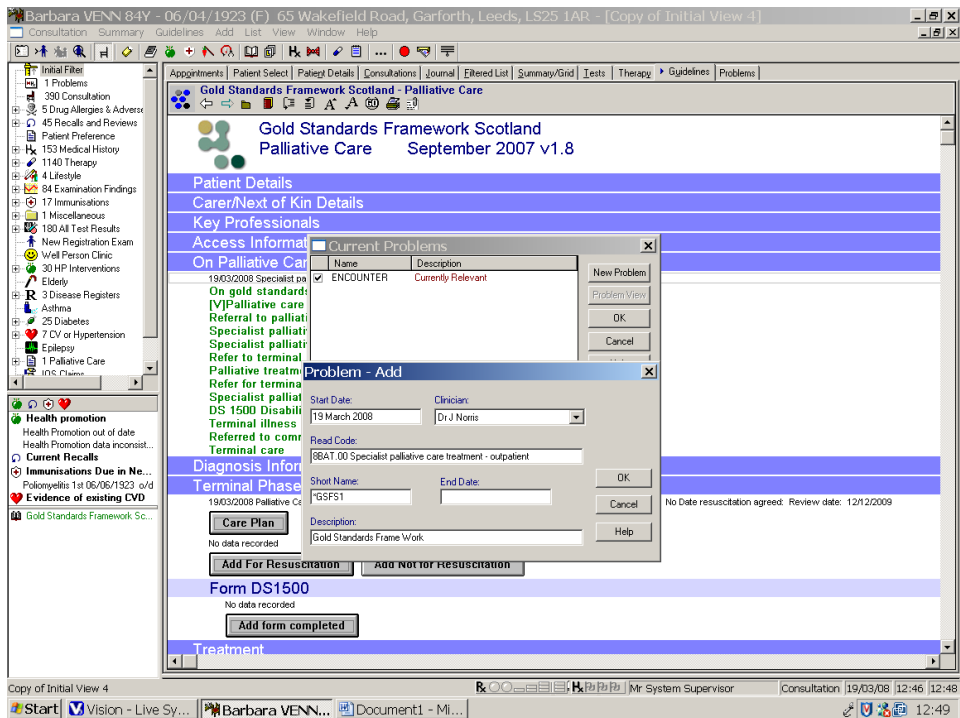
5. Highlight any Diagnostic information.

6. Right click and select **Problems**.
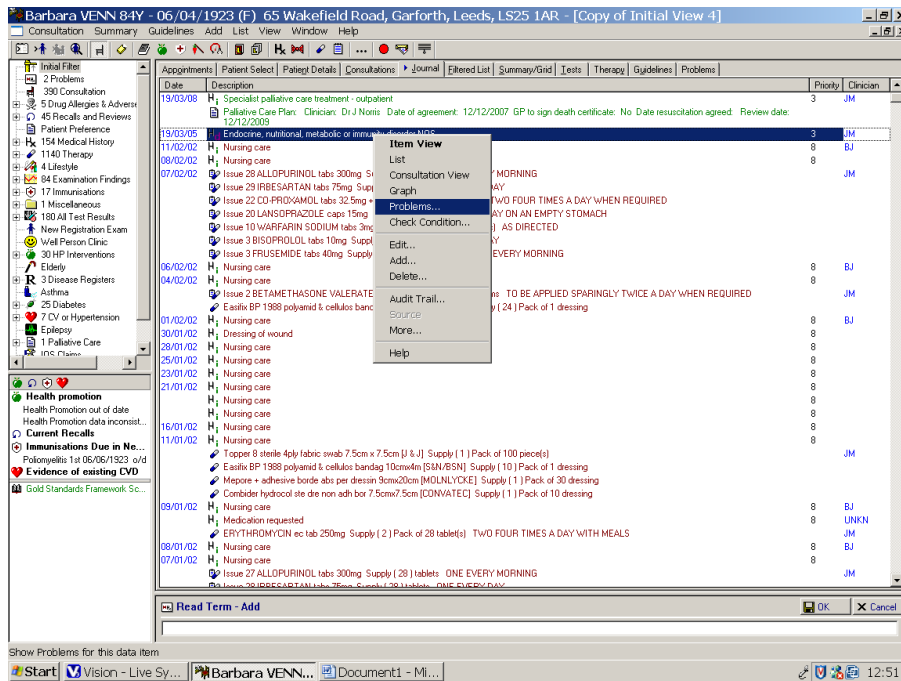
7. Add to the*GSFS1 problem by making sure that box is ticked on the Current Problems list. Click OK.
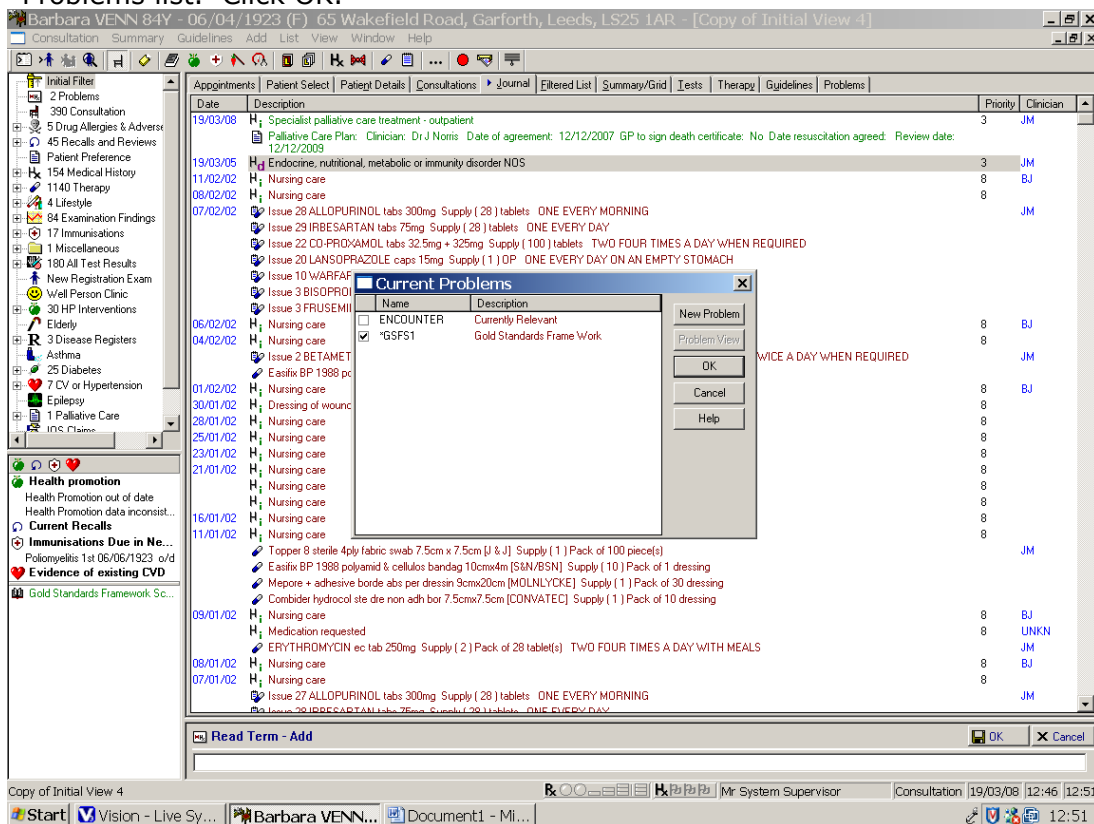
8. Click on the Problems tab. This displays the GSFS problem.
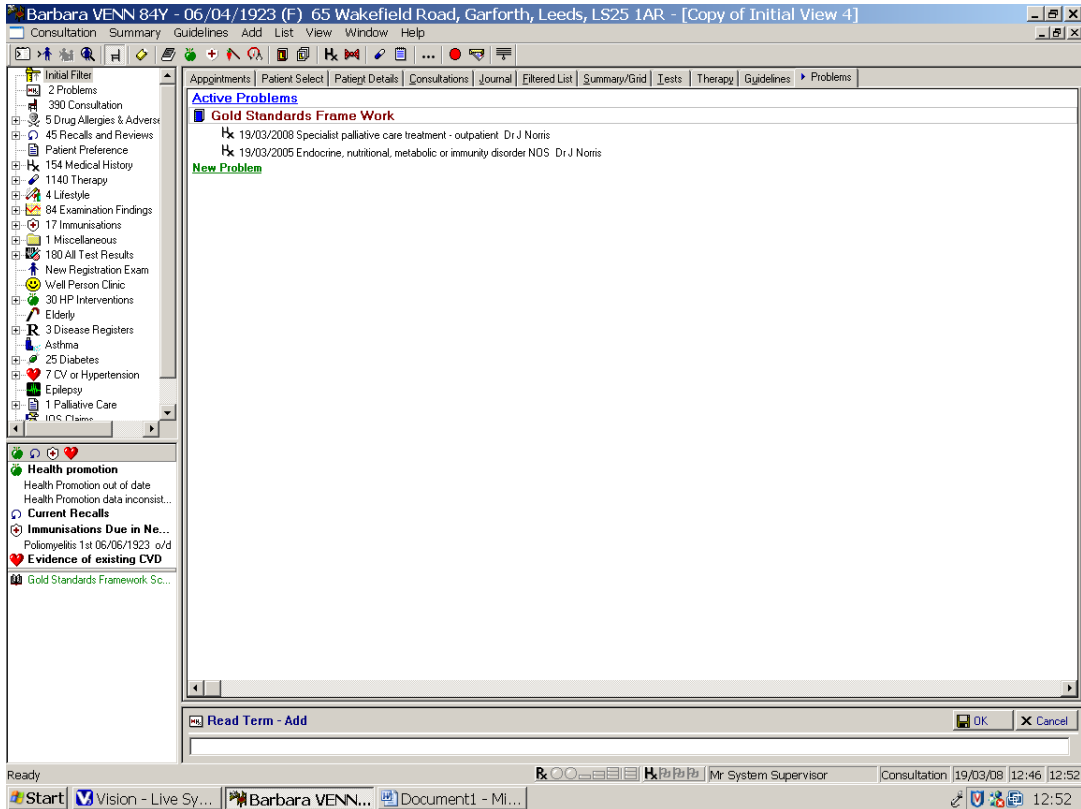
Diagnosis information

In Scotland, Diagnosis information is picked up by the OOH Summary Report.

Palliative care issues

Palliative Care Issues is a Notepad entry. Remember to change the **Type of Note** to **Palliative Care issues**.

Any text in Subject of Note, e.g. "Sore mouth, tingling in fingers", or Note, entered in free text, is displayed on the guideline (and on the Palliative Care report in Scotland only).

Aware of Diagnosis, Informing of Prognosis

Patient aware of diagnosis / Patient unaware of diagnosis
      Only the latest record of these is shown.

Family aware of diagnosis / Family unaware of diagnosis
      Only the latest record of these is shown.

Informing patient of prognosis / Informing relative of prognosis
      Only the latest record is displayed.

Terminal Phase

Care Plan

Click on the **Care Plan** button to reach **Palliative Care Plan - Add**.

> **Date of Agreement** MUST be entered. Note that completing the Care Plan is essential in order to run the OOH Summary Report for Scottish practices.

Remember that when entering dates in Vision, you can usually use date shortcuts, for example, T for today's date, or T-2 for two days ago, or T-1w for a week ago (d for days, w for week, m for month, y for year). Future dates, if permitted entry, are entered with a plus sign, e.g. T+2d

Last ECS Upload data - this is filled in automatically by Vision after successful ECS transmission.

GP to sign death cert - tick box if this statement is true. Death cert notes, e.g. If patient dies between 8am and 8 pm.

Date resus status agreed - Enter a date if this is true.

Resus date notes - If you have discussed resus, then enter free text notes, e.g. "Discussed with patient and family".

GSFS Review Date - e.g. 2 weeks in future (T+2w). A Review date note can be entered in free text, e.g. Family request. When this review date becomes overdue, it will be shown within the Alerts pane. In Scotland only, you can search for patients whose Review date has expired or is imminent in the Palliative Care Review Report (see "Palliative Care Review Reports" on page 119).

Note the similar entries on Palliative Care Plan Add can also be reached from the left-hand navigation pane, near the bottom, right click on Palliative Care and select either Management plan, Summary Form or Data Grid.
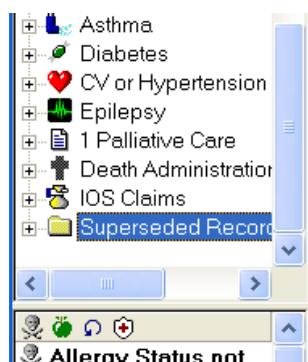
Add for Resuscitation / Not for Resuscitation

Only the latest record of these is displayed.

DS1500 form

This form relates to special care. Click on **Add Form completed** to record the DS1500 form has been completed.

Note that Scottish practices currently do not have Read code 9EB5 DS1500 Disability living in their Scottish Read dictionary, but this code will be included the Qtr 3 version of the dictionary this autumn.

Treatment

These are all History entries.

> **Add Cancer Care Review -** 8BAV Cancer Care Review.
>
> **Add Radiotherapy** - 7M37100 Radiotherapy NEC
>
> **Add Chemotherapy** - 8BAD000 Cancer chemotherapy
>
> **Add Palliative treatment** - 8BJ1 Palliative treatment, and you can enter the drug name in the comment field e.g. morphine, Zomorph nocte

Current Rx in last 3 months

Displays current therapy in the last three months. To prescribe medication, use the Therapy tab in the usual way.

Allergies

Displays any recorded allergies or adverse reactions. To record these, use the Add-Allergy/Adverse Reaction option in the usual way.

Palliative Care medical data

This is a display only section and builds up as you make entries elsewhere on the guideline - Consultations, Referrals, Medical History, Note Pad entries (Access Information, Palliative Care Issues, OOH Information), Palliative Care plan data, Palliative Care at Home, and OOH Arrangements (Palliative Care).

Under Medical History, it will pick up historical entries of a Read code from Chapters A% - U%.

OOH Information

We recommend that you make entries in OOH Information.

Click on **OOH Information** for the **OOH Arrangements (Palliative Care) - Add** screen.

Additional OOH Information

This is a Notepad entry. Change the **Type of Note** to **OOH Information**.

Free text can be entered in Subject of Note, e.g. "Review medication" or in Note, and this is displayed on guideline and, in Scotland only, the report.

In **Action Staff**, select a member of staff from the staff list.

Care at home

Click on the **Care at home** button for the **Palliative Care at Home - Add** screen.

Tick the appropriate boxes and add optional free text notes. For example:

> **Extra drugs Available at home**, e.g., diamorph 5 mg
>
> **Catheter Products at home**, e.g., drainage bags x 5
>
> **Moving/Handling Equip at Home**, e.g., bath hoist
>
> **Notes** - this is optional, e.g. drugs in top drawer.

Syringe driver use

<u>Every</u> record of syringe driver commenced / discontinued is displayed, with the latest at the top of list.

Preferred Place of Care

The Read code here is 94Z1 Preferred Place of Death.

Any of these buttons leads to a History Add entry.

When you click OK on the History screen, you will be asked whether to enter in the Selected SDA (Death Administration) or General History.

For the purposes of GSFS, DO NOT USE the selected SDA if you are asked - you MUST use the GENERAL HISTORY entry

The latest record will always be displayed.

Re-open the GSFS problem when entering data on the GSFS guideline at a later date

It is unlikely that you will complete all the entries into the Palliative Care guideline in one session as it acts as an on-going tool.

When you return to using the guideline again, and after clicking OK on your first data entry in this session, you will be asked if you want to open the GSFS problem: *There is an existing problem associated with this diagnosis. Select open to enter this diagnosis and subsequent data into this problem. Alternatively, you may press Cancel.*   Select **Open**, as this means any data added in your current session will automatically be added to the now opened GSFS problem and thus, in Scotland, be included in the regular messaging.
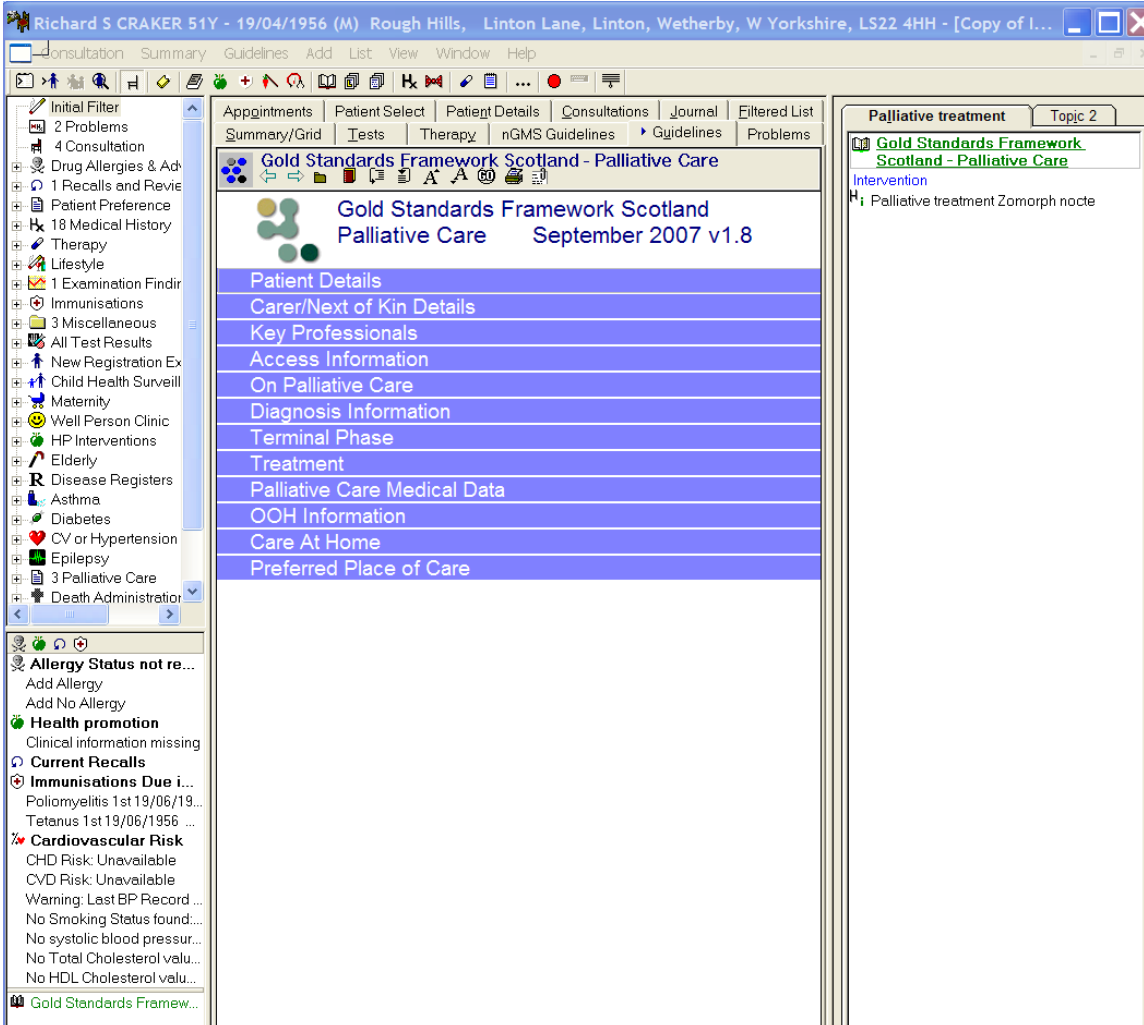
The green line represents a triggered GSFS guideline. Double click to open the guideline. This diagnosis line was entered six months previously, but has been moved into the GSFS problem

Viewing the GSFS problem and its data

You can view the GSFS problem from the Problems tab.

1. Go to the **Problems** tab.

2. Click on the **Gold Standards Framework Scotland - Palliative Care** line so that the book icon opens 📖.

3. When a problem is open, any data subsequently entered in this consultation will go into this problem automatically.

Note the triggered GSFS guideline which appears as a green line at the bottom of the Alerts. Double click on this line to open the GSFS guideline.

In this consultation, one line of data about palliative treatment has been entered into the guideline. Note how the Consultation pane on the right-hand side of the patient record has Topics tabbed, and shows the open problem for GSFS with the data added today. As the GSFS1 problem remains open (with its open book icon 📖), then all further data added today will continue to be placed under the GSFS1 problem.
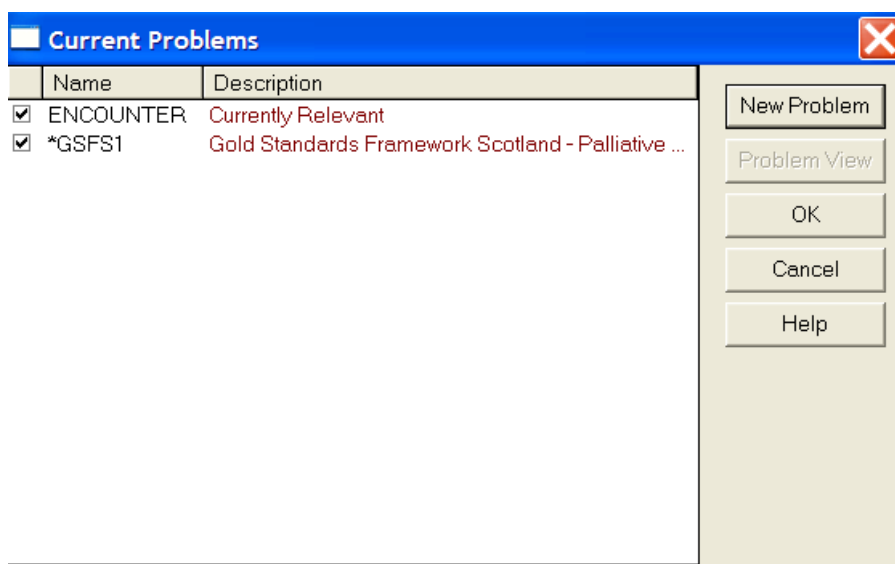
How to close the GSFS1 problem

1. Go to the Problems tab.
2. Click on the **Gold Standards Framework Scotland - Palliative Care** line so that the book icon closes.

📘 Gold Standards Framework Scotland - Palliative Care

How to move data from one place into the GSFS1 problem

1. Find the line you want to move in the Journal.
2. Right click on the line and select **Problems**...
3. Tick the GSFS1 problem.
4. Click OK.

How to remove data from the GSFS1 problem

1. Find the line you want to move in the Journal or you can do this from the list under the GSFS1 problem.
2. Right click on the line and select **Problems**...
3. Untick the GSFS1 problem.
4. Click OK.

How to copy a previously entered diagnosis into the GSFS problem

You may have some time ago made an original diagnosis entry on the patient's record which you feel would be relevant for the *GSFS problem.

To copy a diagnosis made earlier in the year into the GSFS problem:

1. Do not close the guideline but select the Window option from the top menu and select your Patient Record View.
2. Go to the Journal tab. Find the diagnosis line, e.g. Malignant Neoplasm of Upper Lip, right click on it and select Problems.

3. This displays a list of all the problems in Vision. Make sure the *GSFS1 problem is ticked (Encounter is always ticked) and untick other problems listed.

4. Click **OK.**

5. The data line from the Journal will now have been copied into the *GSFS1 problem.

6. To go back to the Palliative Care guideline, click on the Window option and click on the GSFS guideline. You may not see the diagnosis entry you added unless the guideline is refreshed (closed and re-opened).

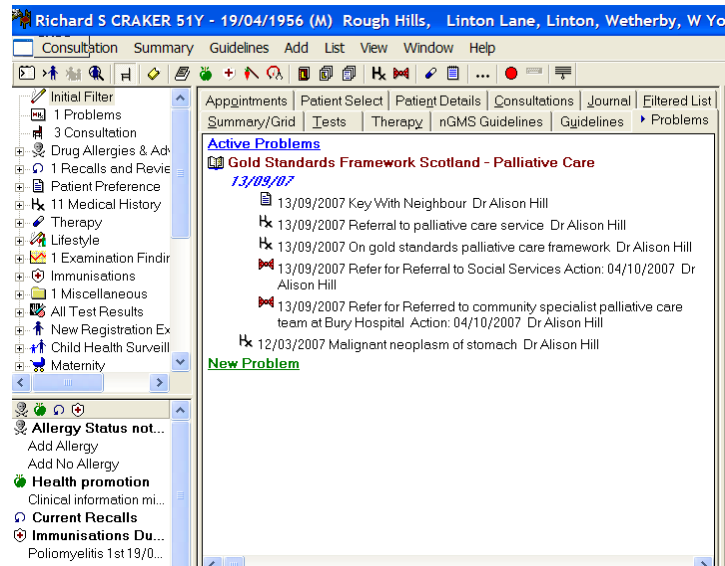
6. To go back to the Palliative Care guideline, click on the Window option and click on the GSFS guideline. You may not see the diagnosis entry you added unless the guideline is refreshed (closed and re-opened).

Palliative Care Reports (Scotland only)

Introduction and access to Palliative Care Reporting

The Gold Standards Framework Scotland (GSFS) Palliative Care guideline in Consultation Manager will help you make data entries for patients under palliative care.

For practices in Scotland, you can run Palliative Care Reports. The contents of the Palliative Care Report called the OOH Summary Report will eventually be included in GSFS messaging along with ECS (Emergency Care Summary) messages once ECS is switched on. The other two Palliative Care Reports are for use within the practice.

1. If you want to schedule the reports to run using Window Scheduling (for all countries, see Scheduling the MDT and PC Review Reports on page 124) and messaging (Scotland only), you must use the GPC workstation to run the reports. If you are just running a report for your own use, then the workstation is immaterial.
2. From the Vision front menu, select the **Reporting** option, then **Palliative Care Reports**. You can also access the reports from Modules on the Vision front menu.
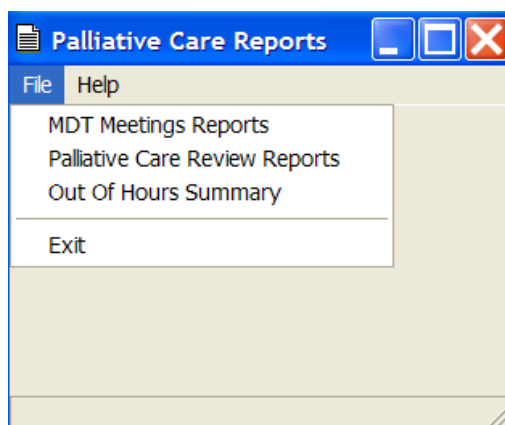
3. Click on **File** to view the three options.

- **MDT Meetings Reports** - this finds patients according to specific criteria, e.g., the Read codes that trigger the Palliative Care guideline.

- **Palliative Care Review Reports** - this finds the patients near to or overdue for a palliative care review

- **Out of Hours Summary** - this can produce two types of report: one for an individual patient, and one for groups of patients according to selected criteria. It summarises the entries on the GSFS guideline.

In Scotland only, the data from the OOH Summary report is sent with the GSFS message via the ECS (Emergency Care Summary) message and is automatically scheduled to run nightly. If you have ECS running, you do not need to do anything further.

The **MDT Meetings Report** and the **Palliative Care Review Report** are used within the practice. Both these reports can also be saved and reviewed later. You can schedule them to run regularly using Windows Scheduler (see "Scheduling the MDT and PC Review Reports on page 124").

Reports are always shown first on a Print preview screen from which you then File - Print.

MDT Meetings Reports

The Multi-disciplinary Team (MDT) Meetings Report finds patients according to specific criteria - the Read codes that trigger the Palliative Care guideline and the patients' registration status. The report is not sent in the messaging in Scotland and is for practice use.

Unless you want to visit an existing report, click on the **New** tab.
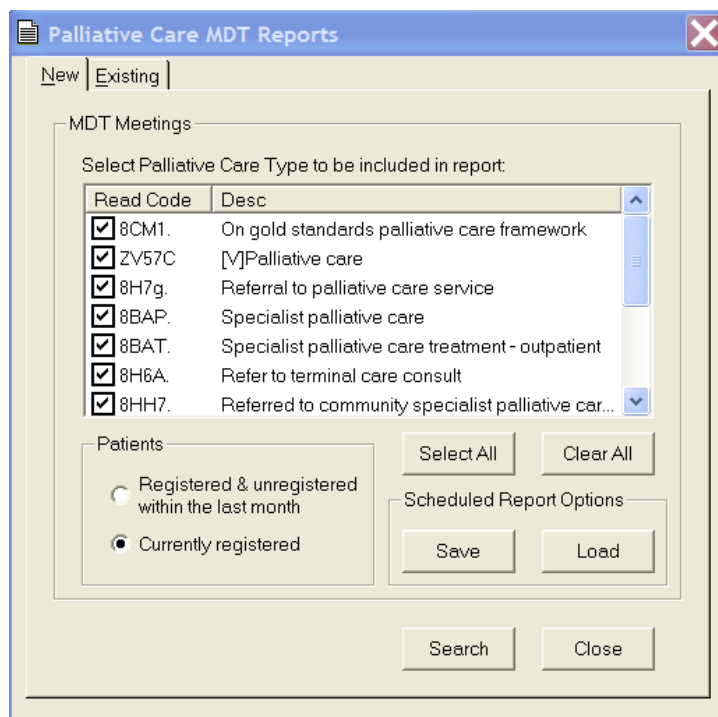
You can choose the following criteria for the report:

> **The list of palliative care Read codes** (which incidentally are triggers for the Palliative Care guideline). Use the **Select All** button to select all the boxes by the Read codes, or **Clear All** to clear all the ticks. You could use Select All, then untick one or two that you do not want; or Clear All to remove ticks then tick the one or two that you do want.

> **Registration status** - either Registered and unregistered within the last month; or currently registered. Unregistered in this context means transferred out.

Click on **Search** to search for the patients.

When the Report is displayed on screen, click on **File** to choose either **Print**, **Save** or **Exit**.
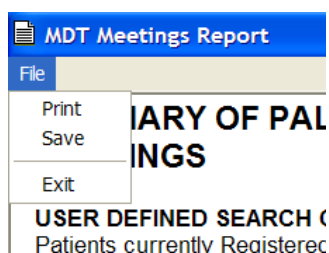
If you select Save, a filename is offered - there is NO NEED to enter a file extension.
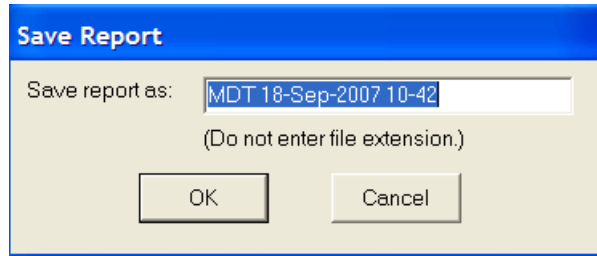
MDT Meetings Report display

The report shows a list of patients who meet the criteria, and much of the data can be entered on the GSFS guideline.   There are multiple columns headed Registration Status, Patient Surname, CHI Number, Diagnosis, Usual GP, Nurse, Carer details (name, relationship to patient), On Palliative Care, Referred to MacMillan nurse (date of referral), OOH form completed (date), Preferred Place of Care.

SUMMARY OF PALLIATIVE CARE PATIENTS FORUSE AT MULTI-DISCIPLINARY TEAM MEETINGS

18/09/2007
10:40

USER DEFINED SEARCH CRITERIA:
Patients currently Registered
8CM1. On gold standards palliative care framework
ZV57C [V]Palliative care
8H7g. Referral to palliative care service
8BAP. Specialist palliative care
8BAT. Specialist palliative care treatment - outpatient
8H6A. Refer to terminal care consult
8HH7. Referred to community specialist palliative care team
8BJ1. Palliative treatment
8BA2. Terminal care
8H7L. Refer for terminal care
8BAS. Specialist palliative care treatment - daycare
9EB5. DS 1500 Disability living allowance completed
1Z01. Terminal illness - late stage

| Regis tration Status	Patient Surname	Patient First Name	CHI Number	Diagnosis	Usual GP	Nurse	Carer details(name, relationship to patient)	On Palliative Care	Referred to Macmillian nurse	00H form completed (date)	Preferred Place of Care
Y	Ward	Ansell	3010487959		Dr John Mcallister			9EB5.00			
Y	O'Leary	Gareth	2606344650		Dr John Mcallister			ZV57C00			
Y	Craker	Richard	1904561314	Malignant neoplasm of stomach	Dr Lindsay Smith	District nurse attends, Mary Smith	Vera Drake. Carer, next door neighbour	9EB5.00 8CM1.00 8BJ1.00 - Zomorph nocte 8H7g.00	13/09/2007		Preferred place of death: home
Y	Fell	Palvinder	1402110804		Dr John Mcallister			8BA2.00			
Y	Beet	Thomas	0909501653		Dr Lindsay Smith			8BA2.00			
Y	Clark	Rosetta	0504598686		Dr John Mcallister			9EB5.00			

View Existing MDT Reports

Change to the **Existing** tab to list and view reports that have already been run. To view a report, tick the box by the line and click on **View**. You can use the **Change Range** button to change the default "in the last month" to another date range.
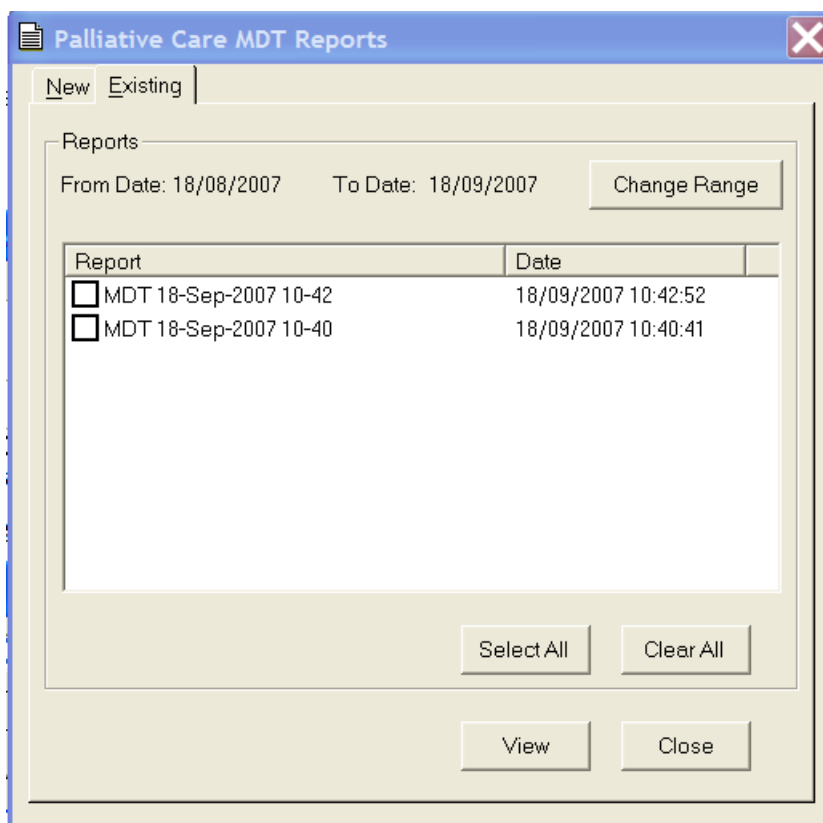
Save and Load

On the **New** tab there are two buttons - **Save** and **Load**. There is a requirement that in Scotland only, the MDT and Palliative Care review reports can be run in Silent mode, i.e. as scheduled runs without manual intervention.
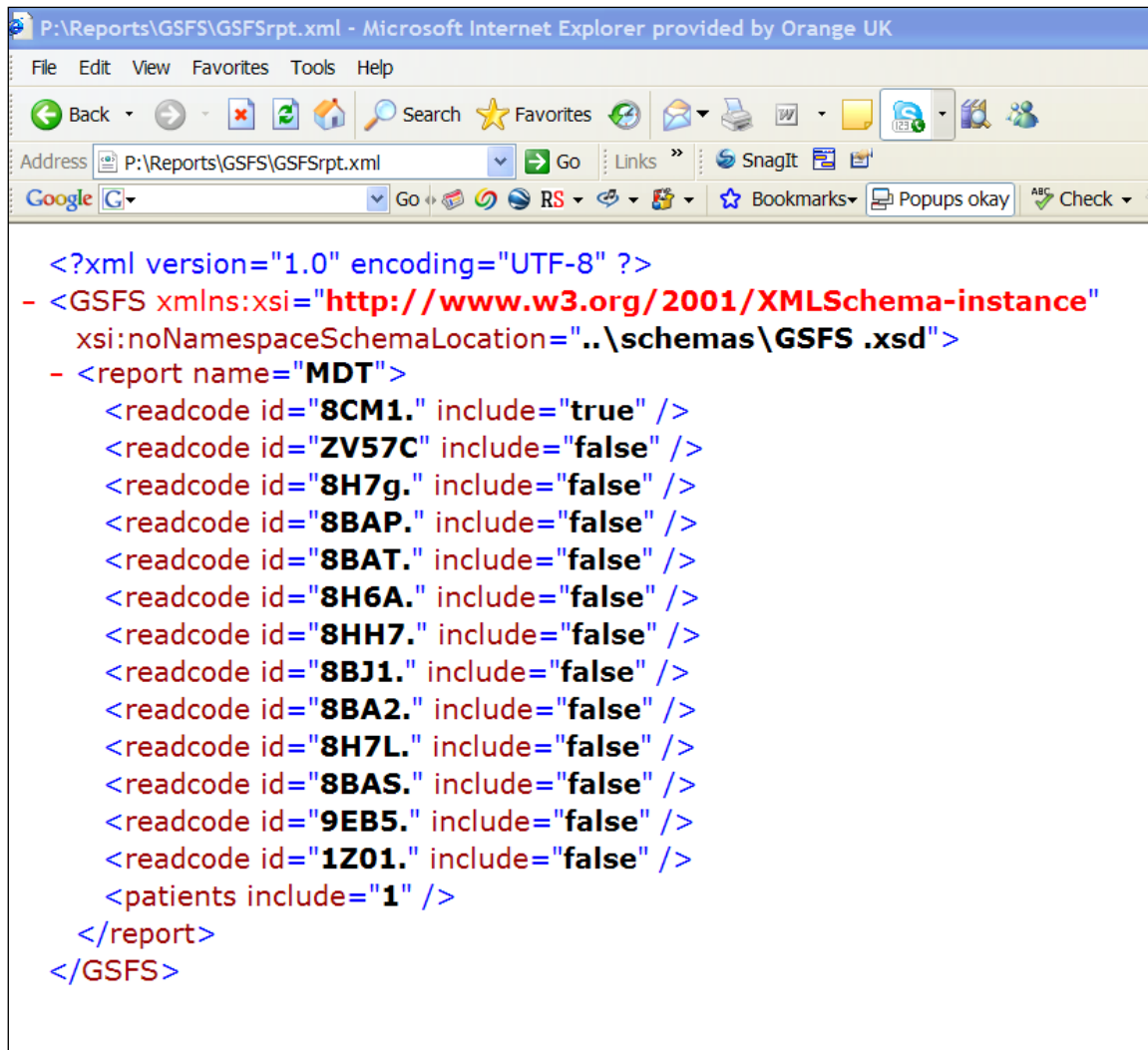
In order to set the options, select the Read codes from the list and click on **Save**. The message *Scheduled report options saved* is displayed.
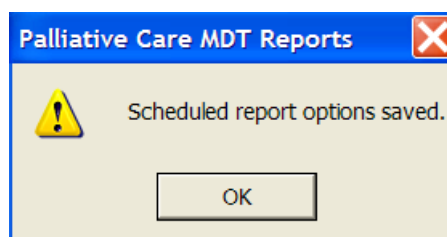
You can then use the **Load** button to load the saved scheduled options - click OK to the message *Scheduled report options loaded*.

If you want to view the options that are loaded, go to P:\Reports\GSFS\GSFSrpt.xml file for the selected Read codes - marked 'True' for the ones you selected and 'False' for the others.

```xml
<?xml version="1.0" encoding="UTF-8" ?>
- <GSFS xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
    xsi:noNamespaceSchemaLocation="..\schemas\GSFS .xsd">
  - <report name="MDT">
      <readcode id="8CM1." include="true" />
      <readcode id="ZV57C" include="false" />
      <readcode id="8H7g." include="false" />
      <readcode id="8BAP." include="false" />
      <readcode id="8BAT." include="false" />
      <readcode id="8H6A." include="false" />
      <readcode id="8HH7." include="false" />
      <readcode id="8BJ1." include="false" />
      <readcode id="8BA2." include="false" />
      <readcode id="8H7L." include="false" />
      <readcode id="8BAS." include="false" />
      <readcode id="9EB5." include="false" />
      <readcode id="1Z01." include="false" />
      <patients include="1" />
    </report>
  </GSFS>
```

In this report, only 8CM1 has been selected (true)

Palliative Care Review Reports

The Palliative Care Review Report finds the patients near to or overdue for a palliative care review. It is not sent in the messaging in Scotland and is for practice use.

The review date is entered in GSFS Review Date on the Palliative Care Plan - part of the GSFS guideline.

The first time you run this report, just click on **New Report** then **View**.

This lists all patients with a review either expired or in the near future.

The left-hand column, **Review Indicator**, uses the abbreviations of X = Review date has expired, 3 = Review Date is within the next 3 days, blank = Review Date is within the next 4 to 7 days.

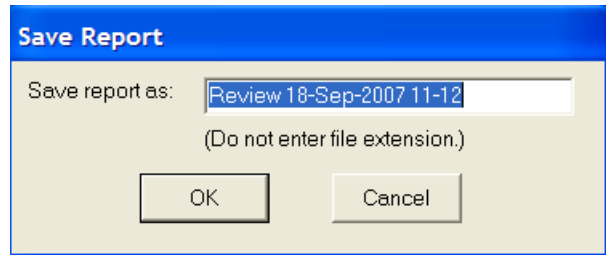Using the **File** menu, you can **Print** the report, **Save** the report or **Exit**.

If you save the report, use the offered filename and do NOT add a file extension name.

Viewing existing reports

Later, you can revisit this report or others that have been run by clicking on **Existing Reports.**   This enables the **Change Range** option if you want to alter the date range that the report searches. Then tick the report you want to view and click on **View**. The **Select All** button will select all reports and they will be showed in turn as you close the one you are currently viewing, to reveal the next. The **Clear All** button clears all ticks.
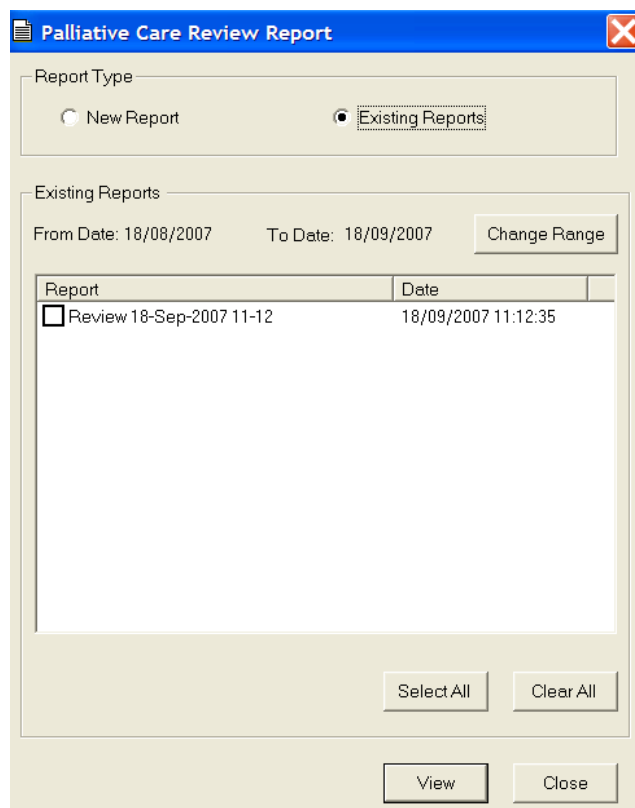
Out of Hours Summary Report

The Out of Hours (OOH) Summary report summarises the entries on the GSFS guideline. In Scotland, it will eventually be sent with the GSFS message via ECS and will automatically be scheduled to run nightly.

The Out of Hours (OOH) Summary report can produce two reports: one for an individual patient, and one for groups of patients according to selected criteria.

Run Report for a selected patient

To run the report for a single patient, make sure **Selected Patient** is selected, then click on **Search**. Select the patient at the usual **Select Patient** screen.

You can print the report from **File - Print**. There is no option to save this report.

Run Report for a group of patients

To run a report for more than one patient, select **Patients matching a criteria**.

This enables the following criteria, which you can select as required:

Review date - either within the next 7 days, expired, expired 4 weeks ago or All review dates.

Patients registration status - either Registered & unregistered within the last month, or currently registered, or All. Unregistered in this context means transferred out.

Consent - This is consent to data sharing for palliative care, recorded for Scottish practices in Registration on the Consent tab - the options are Given, Refused or Either.

Click on **Search** to run the report.

A report is shown per patient. As you select File-Exit from each report, the next patient's report is shown.

OOH Summary Report display

The report displays data entered into the Gold Standards Framework Palliative Care guideline in Consultation Manager, including the following headings:

Section 1

- Patient and Carer Details
- Patient's Own GP and Nurse
-

Section 2 - Patient Medical Condition

- Main diagnoses
- Current therapy
- Allergies / Adverse drug reactions
- Additional Drugs available at home
-

Section 3 Current Care Arrangements

- Care Arrangements (Agency Contact, On Palliative Care (Read coded)
- Syringe driver at home

- Catheter continence products at home
- Moving and handling equipment at home
-

Section 4 Patient's and Carer's Awareness of Condition

- Patient's understanding of diagnosis
- Patient's understanding of prognosis
- Carer's understanding of diagnosis
- Carer's understanding of prognosis
-

Section 5 Advice for Out of Hours Care

- Care Plan Agreed
- Preferred place of care
- Should GP be contacted out of hours?
- GP - Home Tele/Mobile/Pager
- Resuscitation Status Agreed
- Actual Resuscitation Status
- Will GP sign death certificate in normal circumstances
- Additional useful OOH information

Scheduling the MDT and PC Review Reports

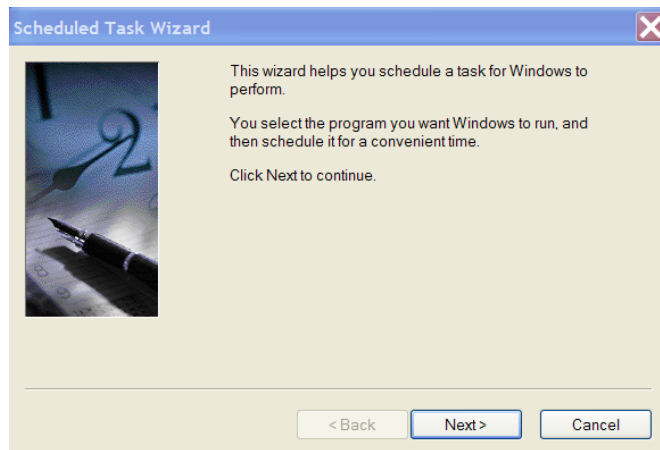You can schedule the MDT Report and PC Review Report to run regularly automatically or as a one off.

The method of scheduling is slightly different for each one.

To schedule the PC Review report:

1. **Start - Programs - Accessories - Systems Tools - Scheduled Tasks**. This displays the **Scheduled Task** screen.
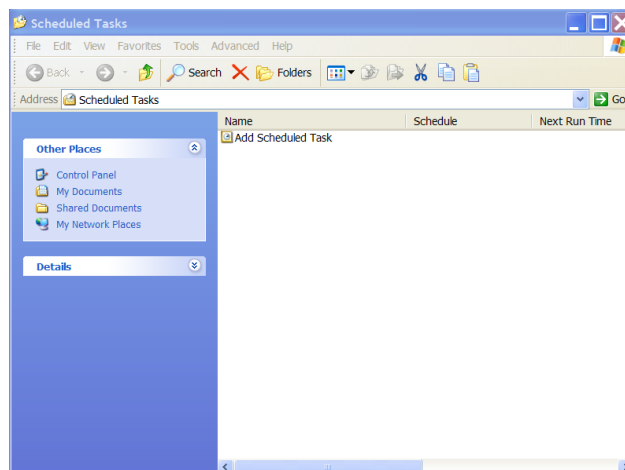
2. Double click on **Add Scheduled Task**. This displays the wizard screen.

3. Click on **Next**.
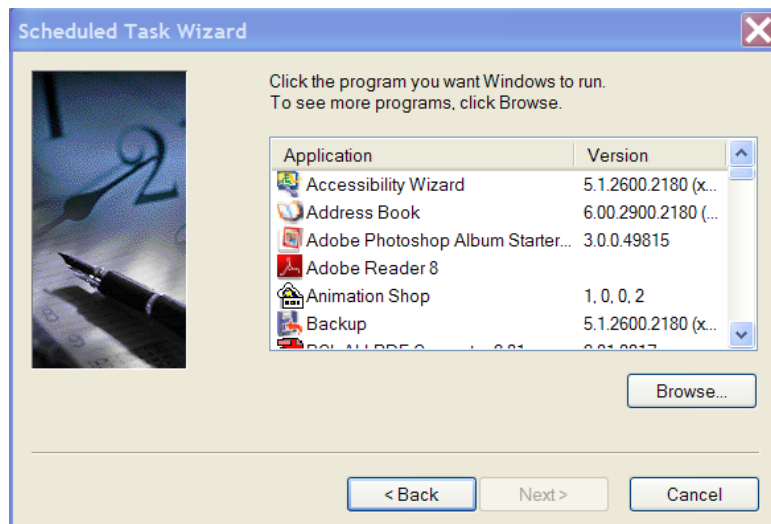
4. Click on **Browse** at the list of applications.

5. Select **O:\program\PCSReport.exe** and click on **Open**.
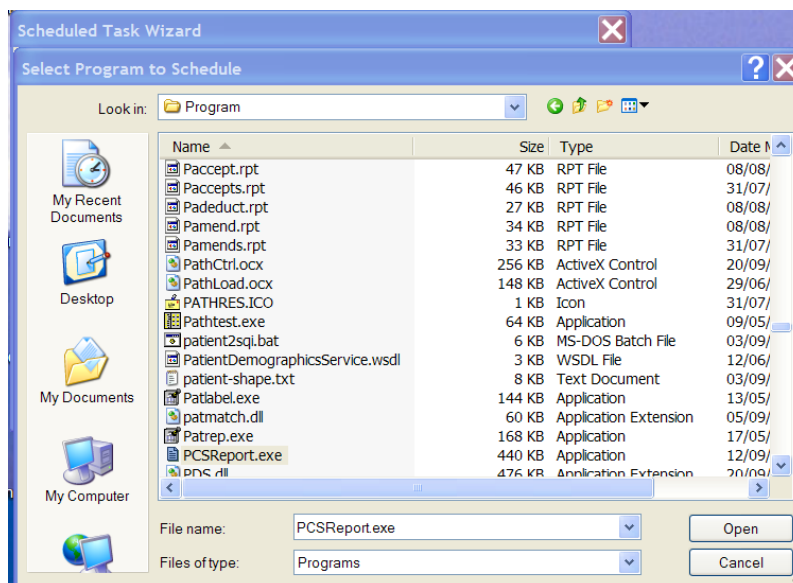
6. To the name of the task, add REV so it reads: **PCSReportREV**.   Select whether the run daily, weekly, monthly, one time only, when your computer starts or when you login.

7. Click on **Next**.

8. Select the time and day you want this task to start. As the GPC workstation is usually left open all the time, this is why we advise you run the PC reports on this machine.
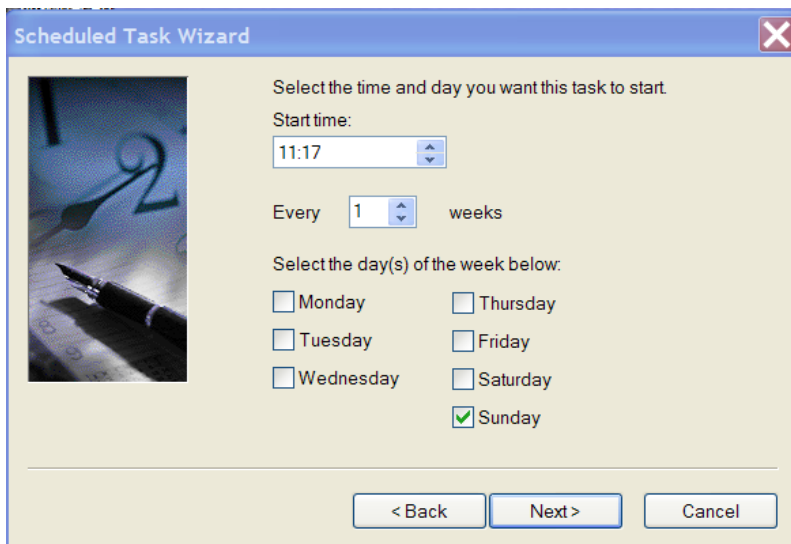
9. Click on **Next**.

10. Enter your user name and password as used on the GPC machine.

11. That completes the scheduling. Click on **Finish**.

12. This is now listed on the front Scheduled Task screen.

13. If you have scheduled the MDT report, right click on the newly added report and select **Properties**.

14. Check that the correct path in Run is **O:\Program\pcsreport.exe REV** (with a space between exe and REV).
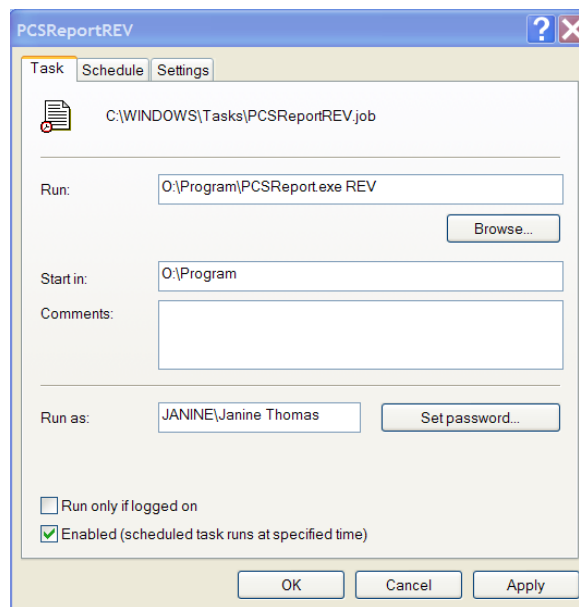

To schedule the MDT report:

1. **Start - Programs - Accessories - Systems Tools - Scheduled Tasks**. This displays the **Scheduled Task** screen.

2. Double click on **Add Scheduled Task**. This displays the wizard screen.
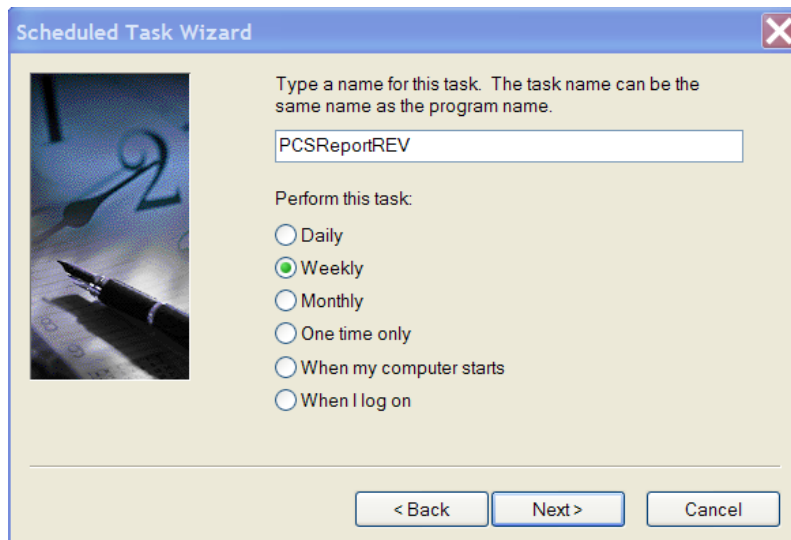
3. Click on **Next**.

4. Click on **Browse** at the list of applications.

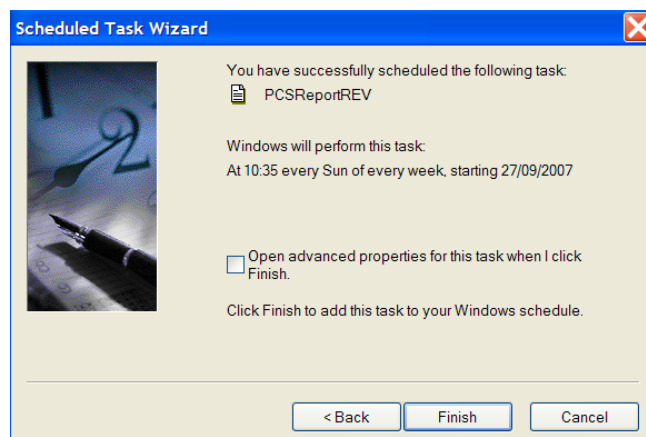5. Select **O:\program\PCSReport.exe** and click on **Open**.

6. To the name of the task, add MDT so it reads: **PCSReportMDT**.   Select whether the run daily, weekly, monthly, one time only, when your computer starts or when you login.
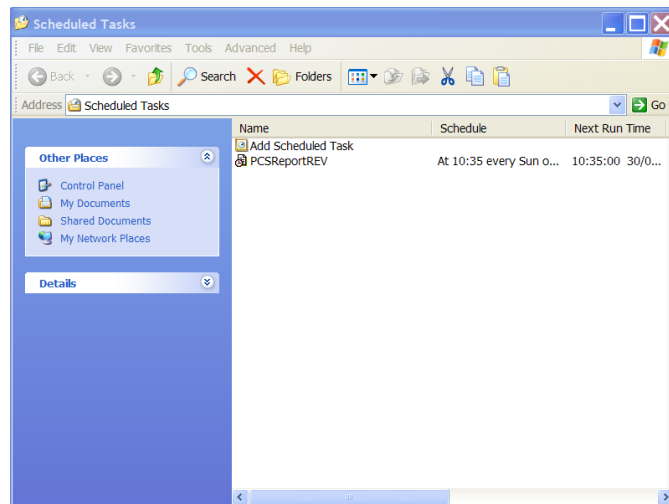
7. Click on **Next**.

8. Select the time and day you want this task to start. As the GPC workstation is usually left open all the time, this is why we advise you run the PC reports on this machine.

9. Click on **Next**.

10. Enter your user name and password as used on the GPC machine.

11. That completes the scheduling. Click on **Finish**.

12. This is now listed on the front **Scheduled Task** screen.

13. If you have scheduled the MDT report, right click on the newly added report and select **Properties**.

14. Check that the correct path in Run is **O:\Program\pcsreport.exe MDT** with a space between exe and MDT.
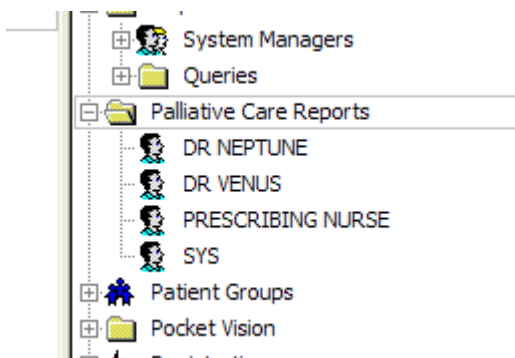
Palliative Care Reports in Security

For Scottish practices, there is a new option in Control Panel - Security which lets you permit access to specific users for Palliative Care Reports.

1. To set up specific users who are allowed access:

2. Go into **Control Panel** and select **Security**.

3. From the right-hand side under **Vision functions**, click on the line **Palliative Care Reports**.

4. Click on the line **All users** and select **Remove Group from function**.

5. Now right click on the line **Palliative Care Reports** and select **Add user(s) to function**.

6. Select one with a single click, or to multi-select, hold the Control key down then click on each required selection.

7. Click OK. These are the people allowed access to the reports.

8. Select one with a single click, or to multi-select, hold the Control key down then click on each required selection. Click OK. These are the people allowed access.

Palliative Care Messaging

In Scotland, the GSFS extracted data goes to the Emergency Care Summary (ECS) system, through Vision GPC. A full send of palliative care data is sent initially, and thereafter, incremental data since the previous send.

Mail Gateway

We advise you to look regularly in Mail Gateway to make sure the most recent ECS message has been successful. Mail Gateway shows the details of the DC, ECS and PTI extracts on the bottom section. In a future DLM, the display will be changed and there will be individual tabs for DC, ECS and PTI. The section will also highlight red if a problem exists.

Checking log files may be a struggle, depending on what is turned on, and the single line you may be interested in could be buried several pages from the end. To see the most recent ECS attempt logged to, you would need to check from the end backwards.

You should ring the Helpline if you see that the most recent ECS message has failed.

DLM 260 changes for Scotland only

Scotland - SCI Pathology

SCI Pathology will be released shortly, allowing Scottish practices to receive pathology messages into Vision Mail Manager via SCI Stores.

There are a number of user guides which can help you set out and use SCI Pathology.

- **Setting up SCI Pathology in Vision -** This User Guide can be downloaded from the INPS website **www.inps.co.uk** under Client Zone - Downloads - Scotland. This User Guide explains to system administrators in Scotland how to set up SCI Pathology and should be followed by the Quick Reference to Mail Manager Setup.

- **Quick Reference to Mail Manager Setup** - This User Guide is aimed at System Administrators in all countries and can be downloaded from the INPS website **www.inps.co.uk** under Client Zone - Downloads - General. This explains how to set up Staff Access to messages in Control Panel - Mail Maintenance, as well as adding or editing Actions and Action status, and creating staff groups in File Maintenance.

- **Quick Reference to Mail Manager for Clinical Staff** - This User Guide is aimed at GPs and others who receive pathology messages, and explains how to handle the messages - viewing, marking as read, actioning, completing. This User Guide can be downloaded from the INPS website **www.inps.co.uk** under Client Zone - Downloads - Scotland.

- **Quick Reference to Mail Manager for Administrative Staff** - This User Guide is aimed at the admin staff who are dealing with the pathology messages, assigning them if unassigned, allocating them if unallocated, actioning them and filing. This User Guide can be downloaded from the INPS website **www.inps.co.uk** under Client Zone - Downloads - Scotland.

The display, functions and applications of Mail Manager are also described in the **Mail Manager on-screen help**.

Scotland - eAMS

eAMS is being implemented in DLM 260 though it was released in DLM 237.

The most up-to-date ePharmacy User Guide can be downloaded from the INPS website **www.inps.co.uk** under Client Zone - Downloads - Scotland.

eAMS is the electronic Acute Medication Service which forms the first phase of ePharmacy. Very similar to ETP in England, eAMS prescriptions are printed with a barcode and given to the patient. An XML message is transmitted (via AMS) through the NHSnet to the ePharmacy store to await call down by the pharmacist when the patient first presents at the pharmacy. The pharmacist is then able to scan the bar code to retrieve the corresponding message.

> Currently nurses and supplementary prescribers are not allowed to print bar-coded AMS prescriptions in Scotland. Other prescribers' use of the ePharmacy application will be considered after implementation of eCMS (electronic Chronic Medication Service), the second phase of ePharmacy.

eAMS and Mail Manager

We have the following advice for Scottish practices taking part in eAMS:

1. **Use Mail Manager regularly** for checking outgoing eAMS messages. This is to ensure that outgoing eAMS messages are updated from Sent Awaiting Acknowledgement to Complete, as the act of opening Mail Manager allows receipt of the *incoming* acknowledgements from the eAMS database. If Mail Manager is not opened for a while (varying from 1 day to some weeks), outgoing eAMS messages remain incomplete, the collection of outstanding acknowledgements locks the eAMS system and prevents new messages being sent.

2. **Retransmit outgoing 'transmission error' messages regularly**. View the Audit tab. You could try ReProcess from the Message menu as a first remedy (or right click on the message in the Message List and select Message - ReProcess). If this fails, you may need to phone the Helpline.

3. **The ebXML Server/GPC machine must remain a dedicated messaging machine** and should not be used as a normal workstation

Printing Bar codes and quality

Pay particular attention to the section in the ePharmacy User Guide on Printing Bar Codes and Quality. For the codes printed at the GP practice to be read successfully at the pharmacy, the printing must be of good quality. To ensure this, the following guidelines must be met:

- Only Laser Printers may be used;
- The printer must be capable of printing at a resolution of at least 600 dots per inch (dpi);
- The printer consumables must not be past the end of their useful life;
- Regular maintenance is carried out on the printer.

Scotland - SCI Gateway Referrals

SCI Gateway is the national product in NHSScotland for the electronic exchange of clinical information – such as referral letters and discharge documents – between Primary and Secondary Care. You can use SCI Gateway to send referrals directly to healthcare providers via the NHSNet, and you can monitor the progress of referrals once they have arrived at the hospital.

The most up-to-date User Guides explaining the full referrals features and SCI Gateway can be downloaded from: **http://www.sci.scot.nhs.uk/training/train_docs.htm**

What's New

- You are now able to change the way that individual Vision priorities are mapped to SCI priorities. See "SCI Gateway - Priority Mapping" on page 133

- Advice re two issues from NHSScotland regarding pre-population of SCI Gateway referrals that some practices have been experiencing intermittently - see "SCI Gateway " on page 135

- Advice re error message The Patient context could not be set
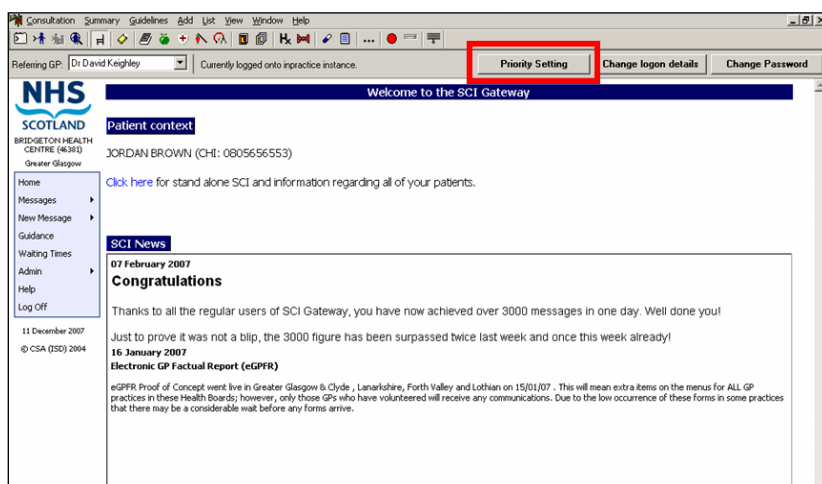
SCI Gateway - Priority Mapping

Medical Histories which are sent from Consultation as part of a SCI Gateway referral are mapped by default to SCI priorities according to the following table. If the priority box is left empty or a Structured Data Area (i.e. Blood Pressure) is used, the Vision priority is classed as Other and is mapped to medium in SCI Gateway by default.

Vision Medical History Priorities	SCI Gateway Priorities
0	Not sent
1	High
2	Medium
3	Medium
4	Medium
5	Medium
6	Medium
7	Medium
8	Medium
9	Medium
Other	Medium

Changing default priority mapping

As every practice can use priorities in a different way, you are now able to change the way that individual Vision priorities are mapped to SCI priorities. This done from the SCI referral screen and is a per user setting.

1. Login to SCI Gateway from **Summary – SCI Gateway**.

2. Select the **Priority Settings** button.

3. For each Vision priority and items with no priority, you are able to select a corresponding SCI Gateway Priority (either low, medium or high) from the drop down boxes. You can also opt to not send any information for a chosen priority.

Select the SCI priority to which you would like to map each Medical History priority. If you do not want any information to be sent for certain priorities, select Don't Send. You can also change the priority mapping for Medical Histories with no priority or SDA entries

4. Click OK to save the settings. These settings are saved on a practice basis.

Note - If your role within Vision is not clinical, you are not able to change the priority mapping settings.

SCI Gateway Troubleshooting

The table below details how to troubleshoot some known issues with SCI Gateway that some practices have been experiencing intermittently.

Error Message	Description/Solution
An unexpected error occurred retrieving the patient details	This error message displays on the referral web form if there has been a memory leak. This is a Microsoft problem which SCI are trying to resolve. In the mean time, if you see this error, please create the referral again at a later date. There is also an issue with the pre-population of the Smoking, Alcohol and Exercise status dropdown questions which can also generate the same error message. The solution for this is to not pre-populate the smoking, alcohol and exercise questions but to use examination type questions instead, which also allows for the inclusion of any free text.
The patient context could not be set 	If you see this error on the referral web form, check that the patient's registered GP has a GMC code set up in their staff record. This can be added in Control Panel - File Maintenance - Staff.
The patient details could not be validated. No Patient information has been received.	If you see this error message on the patient web form, please contact the Vision helpdesk.
Incomplete Date Format	As you may be aware, Vision allows historical data to be recorded using an incomplete date format i.e. a history entry may have an event date of 1999 or 02/1999. SCI Gateway requires that all information that is included in a SCI Gateway Referral must have a date format of dd/mm/yyyy. This issue will be addressed by INPS in a future DLM update by allowing Vision to annotate any entries with an incomplete date format with 01. Therefore 1999 will become 01/01/1999 and, 02/1999 will become 01/02/1999. Until this update is implemented, the system date, which reflects the date of data entry, will be used for data with an incomplete event date.

SCI error messages are normally displayed at the bottom of the SCI Referral Form

GPC Scheduler - Scotland

GPC Scheduler is used to schedule the timings for the extracts for:

- SCI DC (Diabetic Care)
- ECS (Emergency Care Scheme)
- PTI (Practice Team Information)

Viewing the time of extracts

The time of the extracts for ECS are set by default as a twice a day task (SCI DC extracts are once a day) and for PTI extracts as a once a month task. To view the GPC Scheduler timings:

1. In GP Communicator click on **GPC - Tools – Options.**

2. Select the **Scheduler** tab.

3. Within the Task Scheduler section, you can see the Current tasks and the scheduled times for each extract type.
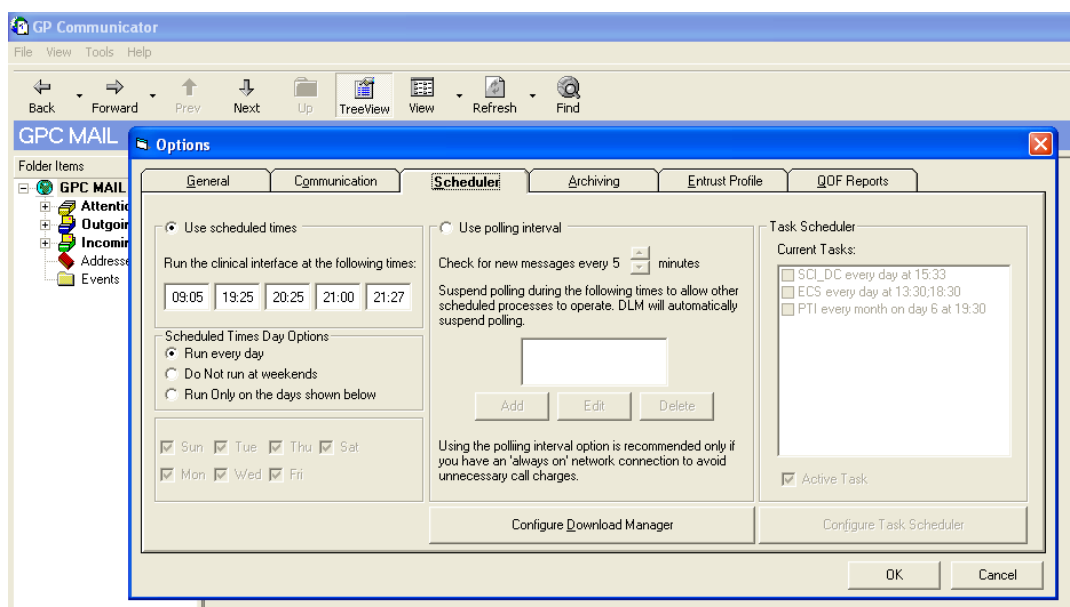
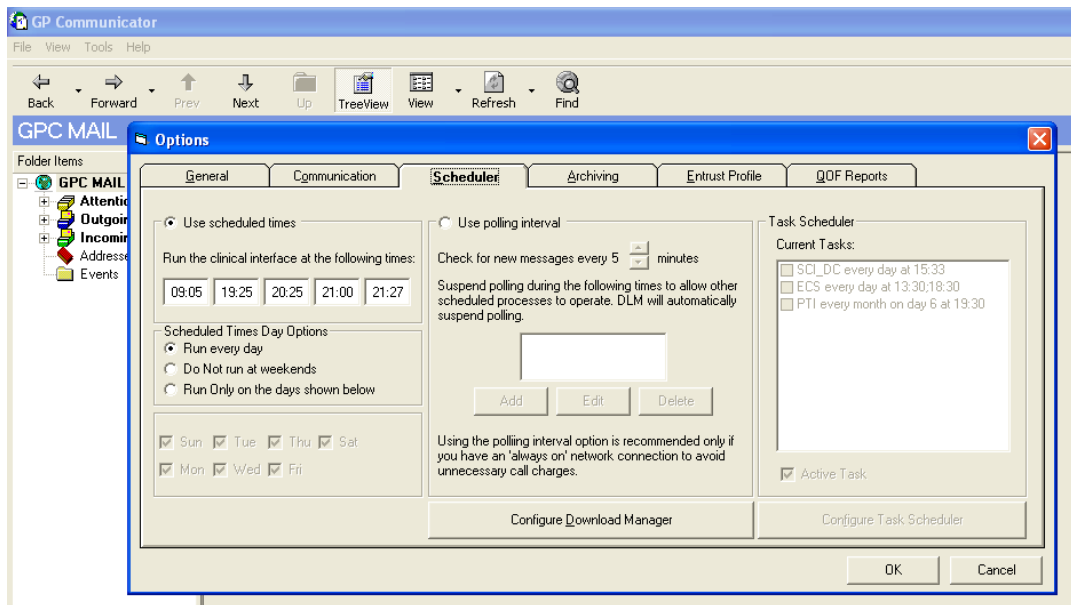*This example shows that the PTI extract is scheduled to run on day 6 of every month at 1930*

Changing the time of extracts

To change the timing of the extracts:

1. From GP Communicator select **Tools – options – Scheduler**.

2. Select **Configure Task Scheduler**.

3. The times can be adjusted here.

Click on Configure Task Scheduler to change the extract timings

> **Note -** If you do decide to change the extract times, please make sure that the times you select do not clash with other scheduled tasks, the backup or the automatic reindex.

Checking for Extract Errors

It is imperative that the extracts are checked for any errors. The status of the extracts can be viewed from the Mail Gateway Window.

SCI DC and ECS messages must be checked on a **DAILY** basis. Please check the date and that the transmissions are successful and report any errors by email to the INPS Helpdesk.

For **PTI** messages, please also check the date and that the transmission was successful and report any errors to the INPS Helpdesk via email.