



Vision 360

Patient Summary

User Guide

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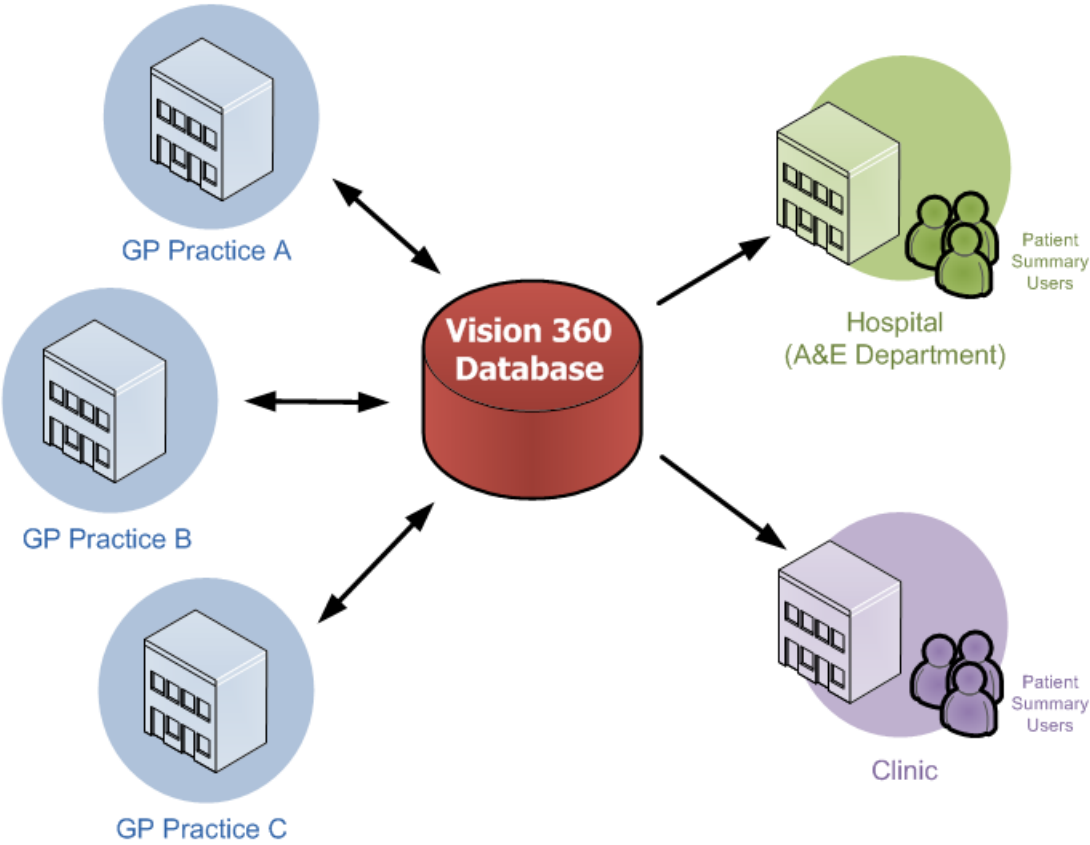
Getting Started

About Vision 360 Patient Summary

Welcome to Vision 360 Patient Summary, part of the Vision 360 suite of applications which allows users to manage and view centralised patient records across both primary and secondary care.

Patient Summary provides up-to-date, summary patient information on a predetermined population of patients, excluding those who have chosen to opt out of local electronic data sharing.

Ongoing, tailored communication between GP practices and the Vision 360 database ensures that Patient Summary data is kept up-to-date.



Patient Summary Data Flow

Log In

Enter user name and password in the **User Name** and **Password** fields and press the **Log in** button.

Change your Password

You can access the Change Password pop-up window in two ways:

From the Login screen

Click on the **Change Password** button to open the Change Password dialog.

From the Task Menu

Click on the Task Menu and select Change Password.

Note: All fields are limited to 50 characters. If you have forgotten your password, please contact your system administrator.

Administration

Organisation Management

The organisational structure in Patient Summary should reflect how your health system is composed.

The Patient Population Level (PPL) is used to control at what level, in an organisational hierarchy, users can access a patient population.

For example, in the organisational structure shown below, if the Patient Population Level is defined at Primary Care Trust level, then users in Local Health Community B, Practice 1 will be able to access patients from both practices in Local Health Community B but not patients belonging to practices in Local Health Community A.

Name	Type
▼ Country	Strategic Health Authority
▼ Local Health Community A	Primary Care Trust
Practice 1	General Practice
▼ Local Health Community B	Primary Care Trust
Practice 1	General Practice
Practice 2	General Practice

Example Organisational Structure

User Management

Vision 360 Patient Summary users must be assigned one or more roles which should reflect their job function. Roles available include:

- Super Administrator - Responsible for the initial set up of the organisational structure and the creation of Administrators within the organisation
- Administrator - Responsible for the assignment and administration of Auditor and User roles
- Auditor - Access to auditing data
- Service Manager - Access to error message management and patient statistical data
- User - Access to Patient Summary patient records

For example, a member of staff in a practice may be required to assign roles to other staff as well as view patient records. In this situation, the employee must be assigned both the "Administrator" and "User" roles.

Service Management

Vision 360 Patient Summary Service Management enables the monitoring and management of data flowing between the GP Adaptor and Vision 360. Error messages may be viewed and Vision 360 patient data may be viewed and analysed. This information may be accessed by those with Service Management access rights and can be found in the following two tabs - the **Message Management tab** (page 16) and the **Data Integrity tab** (page 17).

Auditing

With Auditor access rights, you can view what access users have had to Patient Summary, as well as which patient records have been viewed - and by whom. See **Search Audit Logs** (page 21).

Administration Screens

Organisation Management Screen

Purpose

The Organisation Management screen allows the configuration and maintenance of an organisation's structure.

Access

Access to the Organisation Management screen is given only to users with the role of **Super Administrator** (page 8).

Select Manage Organisations from the Task Menu to open the Organisation Management screen.

Actions

The following buttons are included on the initial screen:

Button	Action
PPL Lvl	Choose the Patient Population Level (PPL) of the organisation from the drop-down list.
Add	Allows you to add an organisation.
Delete	Deletes the selected organisation.

The following columns are displayed in the grid:

Column	Description
Name	The name of the organisation, such as, "Local Health Community A". Double-click to activate this cell. Max. 100 characters.
Type	The organisation type; for example, "Primary Care Trust". You can choose the organisation type from a system-defined drop-down list.
National Identifier	The National Identifier is the unique code which is assigned by the Organisation Data Service (ODS), previously known as the National Administrative Code Service (NACS). Max. 12 characters.

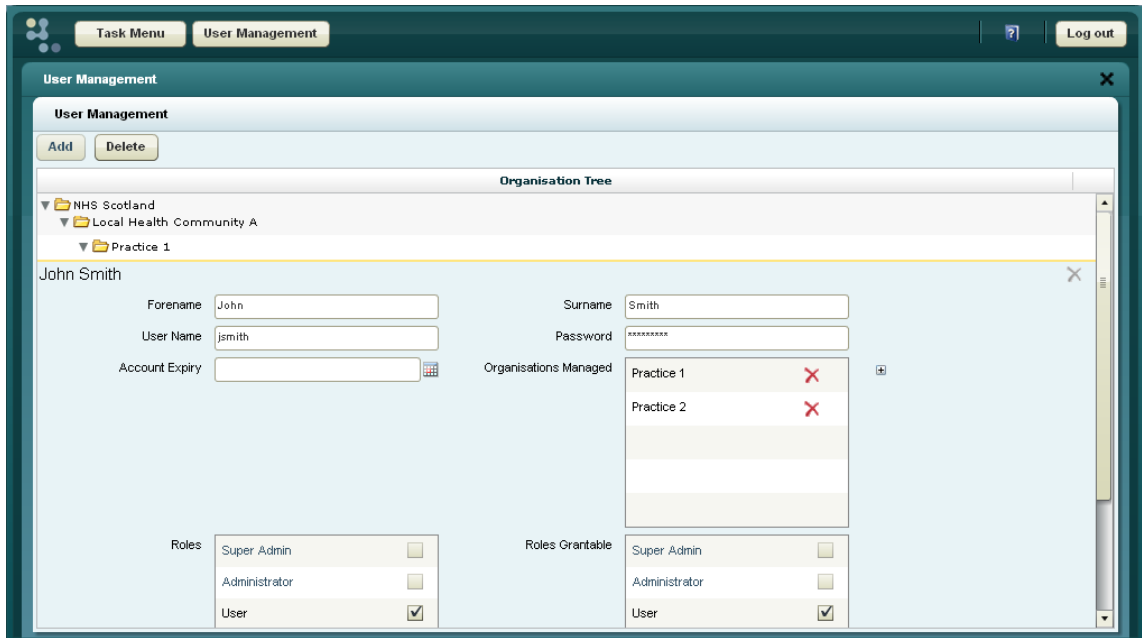
Column	Description
Contributor	After clicking the check box in the Contributor cell, 'true' is displayed. This confirms the contribution of data from the selected practice to the Vision 360 database. If the box is unchecked, 'false' is displayed, signifying that Vision 360 will not receive data from that practice.
Security Code	The Security Code acts as a label which identifies the organisation's data. Max 50 characters, A-Z, a-z, 0-9.
Support Email	The email address of the person to be alerted when the heartbeat message for a practice has not been received for a given interval. A valid email address should be entered. Max. 50 characters.
Start End	The Start and End fields should specify the times (hh:mm) during which communications are monitored between the practice and Vision 360. If, during that period, there is any lapse in communications (see the Interval field description, below), either one or both of the following will occur as dictated by your system configuration: <ul style="list-style-type: none"> ▪ The lapse in communication is logged. ▪ The email alert process will be triggered and the Support Email recipient will be notified.
Interval	To ensure that communications do not fail between the practice and Vision 360 in the Data Centre, Vision 360 is configured to check periodically for either of the following: <ul style="list-style-type: none"> ▪ Data being sent from the practice ▪ A heartbeat message <p>Vision 360 does this with the use of the Interval. The value specified for the interval is the amount of time that should elapse before Vision 360 checks for data or a heartbeat message from the practice.</p> <p>GP Adaptor on the practice server is configured to send a heartbeat message as often as the 'polling interval property' dictates. Vision 360's Interval must be greater than this 'polling property interval' to give time for the practice to send a heartbeat message (taking latency into account).</p> <p>For example, a practice may be configured to send a heartbeat message every 15 minutes. In this case, Vision 360 could specify an Interval of 20 minutes. Every 20 minutes, Vision 360 will look for data from the practice or listen for a heartbeat message.</p> <p>If no data or heartbeat is received, this is logged and/or an alert email is sent to the user defined in the Support Email field (above).</p> <p>Max. 5 characters, 0-9.</p>

Note: Double-click to activate a cell in the grid.

User Management Screen

Purpose

The User Management screen allows you to set up and maintain Patient Summary users and corresponding access rights.







Access

Access to the User Management Screen is granted to users with **Super Administrator or Administrator** (page 8) rights.



Select Manage Users from the Task Menu to open the screen.

Actions

The following buttons are included in the screen:

Button/icon	Action
Add	Adds a user.
Delete	Deletes the selected user.
	Expands to reveal data.
	Removes the selection from the list within the grid.
	Displays calendar.
	Closes current user window.

The table below indicates fields available on the screen:

Field	Description
Forename	User's forename (one character minimum).
Surname	User's surname (one character minimum).
User Name	Enter the user name (one character minimum).
Password	User's password. The default value is "Password1" and should be changed to a unique value to enhance security.
Account Expiry	Click  to display the calendar and select a date.
Organisations Managed	When clicked, the expand icon  reveals the organisation structure. Click to choose organisations that the user can manage.
Roles	The roles available to the user. One or more of: <ul style="list-style-type: none"> ▪ Super Administrator ▪ Administrator ▪ Auditor ▪ Service Manager ▪ User
Roles Grantable	The roles that this user can assign to other users.

Reference Data Screen

Purpose

The Reference Data screen allows the maintenance of an organisation's reference data including:



- Clinical Exclusion List
- Consent Text
- Acute Medication Date Range
- Registration Status
- Priorities

Access

To display the Reference Data screen, select **Manage Reference Data** from the Task Menu.

Actions

The table below describes the fields available on the screen.

Field	Description
Organisation	A drop-down list allows you to choose the organisation.
Exclusion List	The Exclusion List contains clinical terms which will not be available in the Patient summary viewer. You can add to this list by inserting the relevant code and description in the Code and Description fields and clicking the Add button. To delete an item from the Exclusion List, click to select, and click on the delete icon  .
Consent Text	The Consent Text list contains the values available in the Reason for Selecting patient drop-down menu which appears after the Select a Patient (page 37) screen. You can add to this list by typing a value in the Add Consent field and clicking the Add button. To delete an item, select the value and click on the delete icon  .

Field	Description
Registration Status	<p>You can choose to view users with a specific registration status by selecting from the Registration Status list.</p> <p>Select at least one checkbox, choosing from:</p> <ul style="list-style-type: none"> ▪ Applied ▪ Permanent ▪ Temporary Resident < 16 days ▪ Temporary Resident 16 days to 3 months ▪ Immediately Necessary Treatment ▪ Emergency Treatment ▪ Child Health Surveillance ▪ Contraception ▪ Maternity ▪ Minor Surgery ▪ Private ▪ Referred
Acute Medication Date Range	<p>This value determines the date range in which acute medication will be displayed in the Medications Panel in the patient record, and can be defined in days, months or years. The default medication date range is 3 months, which means that acute medication will be displayed for the previous 3 months. For example, if you want to define a period of six months, insert "6" and select "Months" from the drop-down list.</p> <p>The "All" checkbox, when checked, displays all medication with no date restrictions.</p>
Priorities	<p>This table allows you to filter which medical data is listed (according to medical priority) in a patient's medical history. Values range from 0-9 and priority 0, which is the only system-defined priority, covers sensitive data (for example HIV status). The others (1-9) are based on your own practice-defined priority rating. For example a practice might reserve priority 1 for life-threatening conditions and priority 9 for minor conditions.</p>

Search Audit Logs Screen

Purpose

The Search Audit Logs screen allows staff assigned the Auditor role to view a history of user access over a defined time period. Information displayed can include:

- Access type
- Patients viewed

Access

To display the Search Audit Logs screen, select **Search Audit Logs** from the Tasks menu.

Actions

The table below describes the fields and menus available on the screen:

Field/Menu	Description
User	A drop-down list allows you to choose which user you wish to audit.
Access Type	This drop-down list allows you to define the access type. If, for example, you want to look at when the selected user has updated any Reference Data, select Update Reference Data from the list.
From To	The From and To fields are used to specify the date range for which you wish to view audit logs.

The following buttons are included on the screen:

Button	Action
Choose Patient	If you want to view audit logs on patients viewed, click the Choose Patient button which will allow you to select a patient from the Select a Patient (page 37) screen.
Clear	Clears all data on the screen and reverts to the default Search Audit Logs window.
Search	Runs the search on the selected criteria.

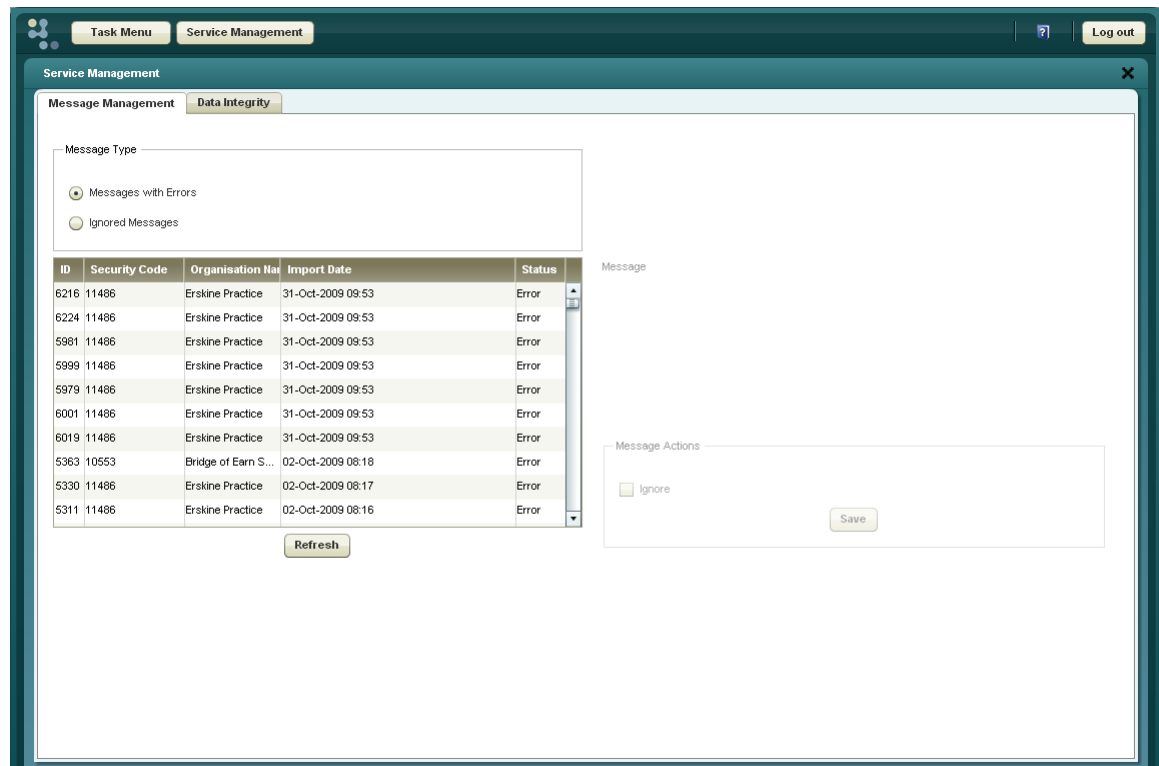
Service Management Screens

Message Management Tab

Purpose

The Message Management tab allows the Service Management user to:

- View error messages sent from the GP Adaptor to Vision 360
- Monitor data integrity



Access

To display the Message Management tab, select Task Menu > Service Management.

Actions

The table below describes the fields and menus available on the screen:

Field/Menu	Description
Message Type	Offers the following options: <ul style="list-style-type: none"> ▪ Messages with Errors - displays all messages with errors in the grid ▪ Ignored Messages - lists all messages which are labelled 'Ignored'

Field/Menu	Description
Message Actions	This button is only available when the Messages with Errors option is selected. You can flag highlighted messages with the 'Ignore' status by selecting the Ignore checkbox.

The following buttons are included on the screen:

Button	Action
Save	This button is only available when the Messages with Errors option is selected. Saves the messages which have been flagged 'Ignore'.
Refresh	Refreshes the message grid to display any new messages.

Note: Should you receive any error messages, contact INPS Support.

Data Integrity Tab

Purpose

The Data Integrity tab allows the Service Management user to view an organisation's patient statistics using data grids and pie charts.

Access

1. Select Task Menu > Service Management to open the default Message Management tab in the Service Management window.

2. Click on the Data Integrity tab.

The screenshot displays the 'Data Integrity' tab within the 'Service Management' application. The interface is organized into three main sections:

- Number of registered patients:** This section features a search input for a registration code and a 'Search' button. Below the search is a table with columns 'Category' and 'Count', showing 'Permanent' with a count of 2405. To the right of the table is a pie chart with a single orange slice, and the number '2405' is displayed next to it.
- Number of patients with code:** This section includes a search input for a terminology code and a 'Search' button. Below the search is a table with columns 'Category' and 'Count', listing categories 0214, 0927, 0AK., 0F1., and 0F16 with counts of 1, 1, 2, 1, and 1 respectively. To the right of the table is a multi-colored pie chart.
- Excluded codes:** This section has a search input for an exclusion code and a 'Search' button. Below the search is a table with columns 'Category' and 'Count', showing 'AD22.' with a count of 1. To the right of the table is a pie chart with a single orange slice, and the number '1' is displayed next to it.

Actions

The table below describes the panels displayed on the screen:

Panel	Description
Number of registered patients	Displays the statistics of patients within that organisation per Registration code.
Number of patients with code	Displays patient statistics in relation to medical terminology codes.
Excluded codes	Displays that organisation's patient statistics relating to Exclusion codes.

The following buttons are included on the screen:

Button	Action
Choose an Organisation	You must first choose an organisation before you can view that organisation's patient data. Clicking on this button opens the Choose Organisation popup.

Button	Action
Search	<p>The Search facility is present in all three panels and allows you to search for particular Registration, Exclusion and Terminology codes. If you click Search when the Search field is blank in any of the panels, all existing data will be displayed in the grids and pie charts. If you do this in the 'Number of patients with code' panel, the high number of medical terminology codes will take the search function a longer time to process.</p> <p>Note: Searches are case sensitive.</p>

Add an Organisation

1. Select Task Menu > Maintain Organisations. The Organisation Management screen opens.
2. Select the Patient Population Level from the PPL Lvl drop-down list. For example, options may include: "Strategic Health Authority", "Primary Care Trust" and "General Practice".

Note: Users in a given population level may only access those patients who belong to organisations in or below the same population level. If, for example, you define the Patient Population Level at the "Primary Care Trust" level, this means that users within "Primary Care Trust A" can only view patient data from that specific trust and no other.

3. Click on an organisation (below which you wish to add a new organisation) and click **Add**. An entry called "New Organisation" is created.
4. Double-click to highlight the Name field and replace the name.
5. Double-click the Type field and choose, from the drop-down list, the type of organisation. For example, "General Practice".
6. Enter the national identifier in the National Identifier field. For example, "Y00001".
7. Double-click in the Contributor field and check the box to confirm that this organisation is contributing to the Vision 360 database.
8. Enter the security code in the Security Code field. The security code acts as a label for the organisation's data.
9. In the Support Email field, enter the email address of the user who will be alerted when communication between the organisation and the central data hub has ceased. The email alert process notifies those specified of any lapse in communication.
10. In the Start field, enter the start time of the email alert process.
11. In the End field, enter the time when the email alert process should end.

12. Double-click to select the Interval field and enter the desired interval in minutes. The interval is the amount of time to elapse before the system checks for any data or a heartbeat message being sent from the GP Adaptor in the practice. It prevents network down-time going undetected.

Edit an Organisation


1. Select Task Menu > Maintain Organisations to open the Organisational Management screen. The grid displays your organisational structure and consists of a number of editable columns.
2. Locate the organisation you wish to edit and double-click the cell within the column you want to change. For example, to change the Support Email of a practice:
 1. Double-click the relevant cell in the Support Email column. The existing email address is highlighted.
 2. Enter the new email address to replace the old one.


Note: Refer to the *Organisational Management Screen* (page 9) for a description of all the different cell formats in the Organisational Management grid.

Delete an Organisation


In the Organisation Management grid, select the organisation you wish to delete and click on the **Delete** button.

Add a User

1. Select Task Menu > Maintain Users, to open the User Management screen.
2. Select to highlight the organisation to which you want to add a user and click on the **Add** button. An entry called "New User" is created.
3. Click on "New User" to expand the user details form.
4. Insert the forename of the user in the Forename field.
5. In the Surname field, type the user's surname.
6. In the User Name field, insert the name which the user will use to log in to Patient Summary.
7. Define the user's password in the Password field. The default value is "Password1".
8. Click on , next to Organisations Managed, to display the Choose Organisation window. From the list, select the organisations that the user will be able to manage.

9. From the Roles list, assign the required roles to the user. For example, if the user needs to administrate other users and view patient records, assign both Administrator and User roles.
10. In the Roles Grantable list, select the roles that the user may assign to others.
11. Click on the Close icon  to collapse the user details.

Edit a User

1. Select Task Menu > Maintain Users to open the User Management screen. Your organisational structure is displayed and lists all users belonging to each level of the organisation.
2. Click on the expand icon  to reveal user details. Any changes that you make are saved automatically.

Note: For a description of all screen content, see the ***User Management Screen*** (page 11).

Delete a User

1. Select Task Menu > Maintain Users to show the User Management screen.
2. Click to highlight the user.
3. Select **Delete** at the top left of the User Management screen to delete the user.

Search Audit Logs

You must first choose which logged data you wish to view:

To search for access types by user:

1. Select Task Menu > Search Audit Logs to display the Search Audit Logs screen.
2. Choose which user you wish to view from the User drop-down list.
3. Select the access type from the Access Type drop-down list; for example, selecting "Add User" will display all occasions when the selected user has added a new user to the system.

To search for user access to patient records:

1. Click on the **Choose Patient** button to open the Select a Patient screen.
2. Perform a search and select for the required patient.

To display logged data between specific dates:

1. Click on the calendar icon and select a date in the From and To fields.
2. Click the **Search** button to display logged data.

View Message Errors

1. Select Task Menu > Service Management to view the Service Management screen. The **Message Management tab** (page 16) is displayed by default.
2. Below Message Type, ensure that Messages with Errors is selected. All messages with errors are displayed in the grid.

View Patient Statistics by Registration Code

1. Select Task Menu > Service Management to open the default Message Management tab in the Service Management window.
2. Click on the Data Integrity tab.
3. Click on the **Choose an Organisation** button to open the Choose Organisation window.
4. Click on the desired organisation from the folder hierarchy and select **OK**.
5. In the 'Number of registered patients' panel, insert a registration code to refine your search or leave the field blank to run a search on all Registration codes. Patient statistics are displayed in the grid and pie chart.

View Patient Statistics by Medical Terminology Code

1. Select Task Menu > Service Management to open the default Message Management tab in the Service Management window.
2. Click on the Data Integrity tab.
3. Click on the **Choose an Organisation** button to open the Choose Organisation window.
4. Click on the desired organisation from the folder hierarchy and select **OK**.
5. In the 'Number of patients with code' panel, insert a medical terminology code (e.g. SNOMED code) to refine your search, or leave the field blank to run a search on all medical terminology codes. Patient statistics are displayed in the grid and pie chart.

Note: If you do run a search on all codes, due to the potential high number of codes, this may take a long time to process.

View Patient Statistics by Exclusion Code

1. Select Task Menu > Service Management to open the default Message Management tab in the Service Management window.
2. Click on the Data Integrity tab.

3. Click on the **Choose an Organisation** button to open the Choose Organisation window.
4. Click on the desired organisation from the folder hierarchy and select **OK**.
5. In the 'Excluded codes' panel, insert an Exclusion code to refine your search or leave the field blank to run a search on all Exclusion codes. Patient statistics are displayed in the grid and pie chart.

Clinical Data

Access to Patient Records

Vision 360 clinical data may be accessed via Vision 360 Patient Summary or a third-party viewer. The Clinical Data section of the user guide is intended solely for users who are accessing patient records from Vision 360 Patient Summary.

As with all Vision 360 products, access to Patient Summary is governed by role-based user access control. Those with "User" access rights, as defined in the **User Management Screen** (page 11), are permitted access.

Note: Only patients with an active patient registration status (as defined by the system) and who have consented to sharing their patient record may be viewed.

Third Party Clinical Data Viewer

Your system may be set up so that you can access Vision 360 Patient Summary data from a third-party viewer which is using a Vision 360 style sheet to control the display of data. The following is an example of how patient summary data may look in a third-party viewer, using a Vision 360 style sheet:

The screenshot displays a patient summary interface with a navigation bar at the top containing tabs for Summary, PatDetails, Problems, Diagnosis, Medications, Risks & Warnings, Procedures, Investigations, Examinations, and Events. The patient's name, GILL, MICHAEL, is shown in a dark blue header bar, along with their gender (Male), birth date (05-Apr-2008), and NHS number (4111270298). Below this, the patient's address (35, ST MARTINS ROAD, LEEDS, LS7 3LX) and telephone number (Not known) are listed. The main content area is divided into several sections: Current Problems, Medication, Allergies and Adverse Reactions, and Recent Tests. The Current Problems section lists seven entries with dates and descriptions, such as 'O/E - mouth rash' on 12-Oct-2009 and 'Administration' on 15-Apr-2008. The Medication section is further divided into 'Acute' and 'Repeat' categories, both of which state there are no records in the patient's record. The Allergies and Adverse Reactions and Recent Tests sections are currently empty.

Summary	PatDetails	Problems	Diagnosis	Medications	Risks & Warnings	Procedures	Investigations	Examinations	Events
GILL, MICHAEL Gender: Male Born: 05-Apr-2008 NHS: 4111270298									
Address: 35, ST MARTINS ROAD, LEEDS, LS7 3LX Tel.: Not known									
Current Problems									
12-Oct-2009	O/E - mouth rash								
28-May-2008	Lloyd George record received								
28-May-2008	Computer summary updated								
20-May-2008	Letter from specialist								
23-Apr-2008	Administration								
17-Apr-2008	Administration								
15-Apr-2008	Administration								
Medication									
Acute									
There are no Acute Medications records in the patient's record									
Repeat									
There are no Repeat Medications records in the patient's record									
Allergies and Adverse Reactions									
Recent Tests									

The style sheet used in the example shown above displays patient data in a number of tabs and enables the user to expand and collapse panels, revealing and hiding patient information as required.

Unique Patient Number

The unique patient number, assigned to a patient on registration with a practice, varies from country to country. For example, in England and Wales, this unique identifier is called the NHS Number and, in Scotland, the CHI Number. Your system will be set up to reflect the correct term and format.

Clinical Data Screens

As described in ***Access to Patient Records*** (page 25), only users viewing clinical data using the Vision 360 Patient Summary application will see the screens as they are described in this section. Users of a ***third-party clinical data viewer*** (page 25) will see an alternative display, which may be defined by the use of a Vision 360 style sheet.

Select a Patient Screen

Select a Patient - Search Tab

Purpose

The Search tab on the Select a Patient screen allows you to search for a patient using various criteria including surname, date of birth and **unique patient number** (page 26). From the search results, you can select a patient and view that patient's summary record.

The screen provides two search modes:

- Quick Search - a single search field where you can enter surname and optionally forename and/or date of birth.

Surname	Forename	Date of Birth	Patient Number	Address
LINLEY	JEAN	27-Jan-1930	411 113 5714	1 ALDERTON MOUNT, LEEDS, LS17 5LQ
LIBURD	JEAN	06-May-1944	411 113 4637	20 ROUNDHAY GARDENS, LEEDS, LS8 4EG
LIMBERT	JEAN	26-May-1961	411 113 3444	58 HARTLEY AVENUE, LEEDS, LS6 2LP
LIMBERT	JEAN	25-Oct-1963	411 113 6540	84 MEXBOROUGH AVENUE, LEEDS, LS7 3ED
LISTER	JEAN	05-Feb-1999	411 114 6414	66 LOUIS STREET, LEEDS, LS7 4BN
LIBURD	JEAN	06-Aug-1996	411 115 6606	98 THE AVENUE, LEEDS, LS17 7PB
LINCOLN	JEAN	27-Feb-1974	411 112 6499	6 FIR TREE GARDENS, LEEDS, LS17 7EQ
LIBURD	JEAN	25-Nov-1959	411 114 5477	41 CHRISTOPHER ROAD, LEEDS, LS6 2JX
LIMBERT	JEAN	04-Nov-1988	411 115 5340	35 MEXBOROUGH DRIVE, LEEDS, LS7 3EL

Select Patient - Quick Search

- Detailed Search - various search fields including: surname, forename, date of birth, **unique patient number** (page 26) and address.

Surname	Forename	Date of Birth	Patient Number	Address
LIBURD	JEAN	06-May-1944	411 113 4637	20 ROUNDHAY GARDENS, LEEDS, LS8 4EG






Select a Patient - Detailed Search

Access

To access this screen, select **View Patient Record** from the Task Menu.

Actions

The following buttons and icons are used:

Button/icon	Action
	Shows detailed search fields.
	Hides detailed search fields.
<input checked="" type="checkbox"/> Enable Soundex	Enables Soundex.
	Runs search on criteria entered in Quick Search, Search Criteria field.
	Runs search in Detailed Search mode.
	Clears entered criteria currently on screen in Detailed Search Mode.

Data Entry and Display

The table below indicates fields available on the screen:

Search Type	Field	Description
Quick Search	Search Criteria	Runs simple search on surname and, optionally, forename and/or date of birth. For example, to search for all patients with surnames beginning K and forenames beginning J, you would enter "K J" (remember to separate the values with a space). "K J 1993" will return only those who were born in 1993.
Detailed Search	Surname	Patient's surname (one character minimum required).
	Forename	Patient's forename (one character minimum required).
	Date of Birth	The Day, Month and Year fields allow you to enter the patient's date of birth such as "27", "May" and "1958".

Search Type	Field	Description
	Unique Patient Number (page 26) (NHS/CHI)	Patient's number. For example this could be the patient's NHS or CHI Number.
	Address	Patient's address. For example, "22 Field House Drive".
	Postcode	Patient's postcode.

Note: In Detailed Search mode, you must enter a search term for at least one of the fields: surname, date of birth, address, forename, NHS number or postcode.

Select a Patient - Recent Patients Tab

Purpose

The purpose of the Recent Patients tab is to provide users with a quick means of accessing recently viewed patient data.

Access

Select **Open Patient Summary** from the Task Menu and in the Select a Patient window, click on the Recent Patients tab.

Any patients previously viewed will be listed in the grid.

Click on a patient and select **OK** to view this patient's summary record.

Patient Summary Record

Purpose

The Vision 360 Patient Summary screen is shown below the **Patient Banner** (page 32) and displays a read-only, summarised record of patient data in four panels:

- **Medical History** (page 33)
- **Medications** (page 34)
- **Lifestyle** (page 35)
- **Clinical Measurements** (page 36)

Patient Clinical Summary

LIBURD, Jean Born 05-May-1942 (66 yrs 10 months) Gender Female CHI 060 542 0521
Address TOP FLAT, 77 OLD PARK ROAD, LEEDS, LS8 1JB

Medical History

Date	Term
24-Mar-2009	Consent given for upload to local shared electronic record
02-Feb-2009	Consent given for upload to local shared electronic record
02-Feb-2009	Refused consent for upload to local shared electronic record
30-May-2008	Letter from specialist
30-May-2008	Medication increased
28-May-2008	Thrush
28-May-2008	Productive cough -green sputum
28-May-2008	O/E - resp. examination NOS
28-May-2008	O/E patient well
19-May-2008	Thrush

Medications

Acute Medication Date Range: 60 Days

Issue date	Type	Drug	Dosage	Quantity
25-Mar-2009	R	SALBUTAMOL breath act pwrdr inh 100micrograms/actuation	INHALE 1 DOSE AS NEEDED	1
26-Feb-2009	A	PARACETAMOL caps 500mg	TAKE TWO 4 TIMES/DAY	80
26-Feb-2009	A	H-F ANTIDOTE topical gel 2.5%	10ML	25
26-Feb-2009	R	RABBIT FUR tabs 30c	TAKE 1 OR 2 AS DIRECTED	125
08-May-2008	R	GAVISCON ADVANCE sf oral susp	5 ml 4 times daily	500
08-May-2008	R	TELMISARTAN tabs 80mg	TAKE ONE ONCE	56

Lifestyle

Date	Term	Status
25-Feb-2009	Very heavy smoker - 40+cigs/d	Smoker
25-Feb-2009	Alcohol consumption	Currently Drinks
28-May-2008	Never smoked tobacco	Never Smoked
10-Mar-2008	Non-smoker	Never Smoked
04-Jan-2008	Alcohol consumption	Currently Drinks
17-Dec-2007	Ex smoker	Ex-smoker
20-Apr-2007	Never smoked tobacco	Never Smoked
01-Nov-2006	Never smoked tobacco	Never Smoked
20-Oct-2005	Never smoked tobacco	Never Smoked
02-Jun-2005	Never smoked tobacco	Never Smoked

Clinical Measurements

Date	Term	Value	Units
19-May-2008	O/E - blood pressure reading	164/82	mm/Hg
08-May-2008	BMI	28.1	Kg/m2
08-May-2008	O/E - blood pressure reading	171/90	mm/Hg
08-May-2008	O/E - weight	65	Kg
12-Dec-2007	O/E - blood pressure reading	148/83	mm/Hg
22-Nov-2007	BMI	20.7	Kg/m2
22-Nov-2007	O/E - height	1.52	Meters
22-Nov-2007	O/E - blood pressure reading	162/82	mm/Hg
22-Nov-2007	O/E - weight	48	Kg
30-Oct-2007	O/E - blood pressure reading	172/87	mm/Hg

Patient Record

Access



1. Select Open Patient Summary from the Task Menu and **select a patient from the Select a Patient window** (page 39).
2. Select a value from the Reason for Selecting Patient drop-down list and click on **Show Summary Record**.

Note: If you select a patient who has refused consent to access their Patient Summary record, you will be unable to view their data and the following message will be displayed: "Patient has refused consent".

Note: Some sensitive patient information may be **excluded** (page 40) due to the sensitivity of its nature.

Actions

The following icons are used:

Icon	Action
	Increases the panel size and decreases all others.
	Decreases large panel to display default four-panel view.

Customise Screen

To move panels, click in the panel heading bar to drag and drop into the preferred location.

You can also move columns within panels by dragging and dropping.

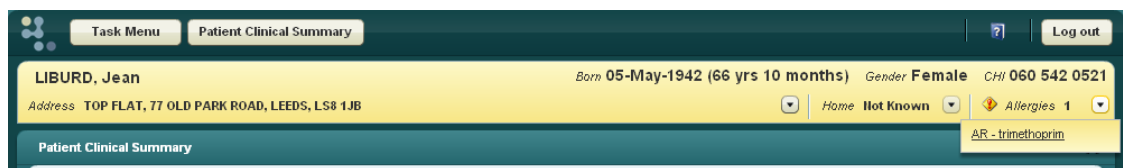
You can change column widths by placing the cursor over the column border and clicking and dragging to the preferred size.

Patient Banner

The Patient Banner is used across the Vision 360 suite of applications to provide information on the currently open patient.

It displays concise patient information including:

- Name
- Address
- Date of Birth
- Gender
- Allergies
- **Unique patient number (NHS, CHI)** (page 26)

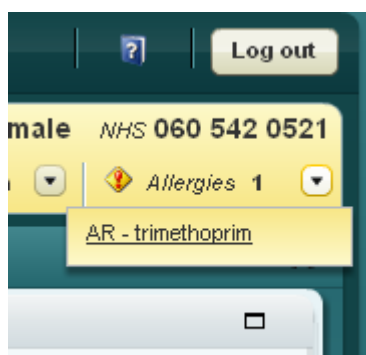


Patient Banner

Allergies

Allergy information includes drug and non-drug allergies and is displayed in the following way:

- "Allergies -" means no recorded allergies.
- "Allergies (2)" for example, means two recorded allergies. Click to display details including Date and Description.



Patient Banner - Known Allergies Drop-down List

Note: If "No Known Allergies" is listed under recorded allergies, this means that a clinician has recorded this data at some point.

Medical History Panel

The Medical History panel displays medical and surgical historical data and is summarised by Date and Term.

Patient Clinical Summary

LIBURD, Jean Born 05-May-1942 (66 yrs 10 months) Gender Female CHI 060 542 0521
 Address TOP FLAT, 77 OLD PARK ROAD, LEEDS, LS8 1JB

Medications

Acute Medication Date Range: 60 Days

Issue date	Type	Drug	Dosage	Qt
25-Mar-2009	R	SALBU TAMOL breath act powdr	INHALE 1 DOSE AS NEEDED	1

Lifestyle

Date	Term	Status
25-Feb-2009	Very heavy smoke	Smoker
25-Feb-2009	Alcohol consumptic	Currently Drinks
28-May-2008	Never smoked toba	Never Smoked
10-Mar-2008	Non-smoker	Never Smoked
04-Jan-2008	Alcohol consumptic	Currently Drinks

Clinical Measurements

Date	Term	Value	Units
19-May-2008	O/E - blo	164/82	mmHg
08-May-2008	BMI	28.1	Kg/m2
08-May-2008	O/E - blo	171/90	mmHg
08-May-2008	O/E - we	65	Kg
12-Dec-2007	O/E - blo	148/83	mmHg

Medical History

Date	Term
24-Mar-2009	Consent given for upload to local shared electronic record
02-Feb-2009	Consent given for upload to local shared electronic record
02-Feb-2009	Refused consent for upload to local shared electronic record
30-May-2008	Letter from specialist
30-May-2008	Medication increased
28-May-2008	Thrush
28-May-2008	Productive cough -green sputum
28-May-2008	O/E - resp. examination NOS
28-May-2008	O/E patient well
19-May-2008	Thrush
16-May-2008	Letter encounter from patient
16-May-2008	Letter encounter from patient
08-May-2008	Memory loss symptom
08-May-2008	Mouth symptoms
08-May-2008	Depression screening using questions
23-Apr-2008	Chr dis monitor - 1st recall
04-Jan-2008	O/E - coarse crepitations
04-Jan-2008	Pain in joint - arthralgia
04-Jan-2008	Productive cough -green sputum
17-Dec-2007	O/E - resp. examination NOS
17-Dec-2007	Productive cough -green sputum
26-Nov-2007	Dressing of skin

Medical History Panel

Medications Panel

The Medications panel is listed by:

- Issue Date
- Type
- Drug
- Dosage
- Quantity

Medications are displayed in reverse chronological order (most recent at the top).

Patient Clinical Summary

LIBURD, Jean Born 05-May-1942 (66 yrs 10 months) Gender Female CHI 060 542 0521
Address TOP FLAT, 77 OLD PARK ROAD, LEEDS, LS8 1JB

Medical History

Date	Term
24-Mar-2009	Consent given for upload to local sharec
02-Feb-2009	Consent given for upload to local sharec
02-Feb-2009	Refused consent for upload to local sha
30-May-2008	Letter from specialist
30-May-2008	Medication increased

Lifestyle

Date	Term	Status
25-Feb-2009	Very heavy smoker	Smoker
25-Feb-2009	Alcohol consumptic	Currently Drinks
28-May-2008	Never smoked toba	Never Smoked
10-Mar-2008	Non-smoker	Never Smoked
04-Jan-2008	Alcohol consumptic	Currently Drinks

Clinical Measurements

Date	Term	Value	Units
19-May-2008	O/E - blo	164/82	mmHg
08-May-2008	BMI	28.1	Kg/m2
08-May-2008	O/E - blo	171/90	mmHg
08-May-2008	O/E - wei	65	Kg
12-Dec-2007	O/E - blo	148/83	mmHg

Medications

Acute Medication Date Range 60 Days All

Issue date	Type	Drug	Dosage	Quantity
25-Mar-2009	R	SALBUTAMOL breath act pwdr inh 100micrograms/actuation	INHALE 1 DOSE AS NEEDED	1
26-Feb-2009	A	PARACETAMOL caps 500mg	TAKE TWO 4 TIMES/DAY	80
26-Feb-2009	A	H-F ANTIDOTE topical gel 2.5%	10ML	25
26-Feb-2009	R	RABBIT FUR tabs 30c	TAKE 1 OR 2 AS DIRECTED	125
08-May-2008	R	GAVISCON ADVANCE sf oral susp	5 ml 4 times daily	500
08-May-2008	R	TELMISARTAN tabs 80mg	TAKE ONE ONCE DAILY	56
08-May-2008	R	SYMBICORT TURBOHALER 200micrograms + 6micrograms/actuation	1 PUFF TWICE A DAY	1
08-May-2008	R	RISEDRONATE SODIUM tabs 35mg	1 Tab weekly	8
08-May-2008	R	RANITIDINE tabs 150mg	1 Tab Twice daily	112
08-May-2008	R	CALCEOS chewable tab	TAKE ONE TWICE DAILY	112
08-May-2008	R	SIMVASTATIN tabs 20mg	TAKE ONE AT NIGHT	56
08-May-2008	R	AMLODIPINE tabs 5mg	TAKE ONE DAILY	56
08-May-2008	R	VITAMIN B comp STRONG tabs	TAKE 1 TABLET(S) DAILY	56
08-May-2008	R	METFORMIN tabs 500mg	TAKE ONE 3 TIMES/DAY	168
08-May-2008	R	DIAMICRON MR tabs 30mg	2 Tabs In the	112

Medications Panel

The Medication Type can be one of the following:

- A (Acute) - This is a one-off prescription, usually entered by a GP during a consultation. The Acute Medication Date Range, found in the **Reference Data** screen, defines the period in which acute medications will be displayed.
- R (Repeat Issue) - This is a record relating to an individual issue based on a Repeat Master. Only current repeat medications are displayed within the Patient Summary record.

Note: A Repeat Master is a proforma prescription that will be used to generate a series of identical prescriptions for printing over time. They are usually entered by GPs for the long-term treatment of a condition, where the patient requires regular repeats without having to see the GP each time, such as insulin for diabetics.

Lifestyle Panel

The Lifestyle panel displays data relevant to a patient's lifestyle, such as exercise, smoking status and alcohol status, and lists the following:

- Date - The date that the information was recorded in the patient's record.
- Term - The coded description (Read or SNOMED CT) from the donating system.

- Status - The status field for lifestyle entry (smoking status, alcohol status and exercise)

Patient Clinical Summary

LIBURD, Jean Born 05-May-1942 (66 yrs 10 months) Gender Female CHI 060 542 0521
 Address TOP FLAT, 77 OLD PARK ROAD, LEEDS, LS8 1JB

Medical History

Date	Term
24-Mar-2009	Consent given for upload to local sharec
02-Feb-2009	Consent given for upload to local sharec
02-Feb-2009	Refused consent for upload to local sha
30-May-2008	Letter from specialist
30-May-2008	Medication increased

Medications

Acute Medication Date Range 60 Days

Issue date	Type	Drug	Dosage	Qt
25-Mar-2009	R	SALBU TAMOL breath act pwdr	INHALE 1 DOSE AS NEEDED	1

Clinical Measurements

Date	Term	Value	Units
19-May-2008	O/E - blo	164/82	mmHg
08-May-2008	BMI	28.1	Kg/m2
08-May-2008	O/E - blo	171/90	mmHg
08-May-2008	O/E - wve	65	Kg
12-Dec-2007	O/E - blo	148/83	mmHg

Lifestyle

Date	Term	Status
25-Feb-2009	Very heavy smoker - 40+cigs/d	Smoker
25-Feb-2009	Alcohol consumption	Currently Drinks
28-May-2008	Never smoked tobacco	Never Smoked
10-Mar-2008	Non-smoker	Never Smoked
04-Jan-2008	Alcohol consumption	Currently Drinks
17-Dec-2007	Ex smoker	Ex-smoker
20-Apr-2007	Never smoked tobacco	Never Smoked
01-Nov-2006	Never smoked tobacco	Never Smoked
20-Oct-2005	Never smoked tobacco	Never Smoked
02-Jun-2005	Never smoked tobacco	Never Smoked
31-May-2005	Never smoked tobacco	Never Smoked
29-Oct-2004	Never smoked tobacco	Never Smoked
03-Aug-2004	Ex smoker	Ex-smoker
16-Feb-2004	Ex smoker	Ex-smoker
15-Aug-2003	Current non drinker	Teetotaler
15-Aug-2003	Current non-smoker	Never Smoked
16-Feb-1969	Date ceased smoking	Ex-smoker

Lifestyle Panel

Clinical Measurements Panel

Clinical Measurements for the items listed below are shown by date, criteria, value and units:

- Blood Pressure
- Weight
- Height
- Pulse
- Pulse Oximetry

- Peak Flow Current

Patient Clinical Summary

LIBURD, Jean Born 05-May-1942 (66 yrs 10 months) Gender Female CHI 060 542 0521
 Address TOP FLAT, 77 OLD PARK ROAD, LEEDS, LS8 1JB

Medical History

Date	Term
24-Mar-2009	Consent given for upload to local sharec
02-Feb-2009	Consent given for upload to local sharec
02-Feb-2009	Refused consent for upload to local sha
30-May-2008	Letter from specialist
30-May-2008	Medication increased

Medications

Acute Medication Date Range 60 Days

Issue date	Type	Drug	Dosage	Qt
25-Mar-2009	R	SALBU TAMOL breath act powdr	INHALE 1 DOSE AS NEEDED	1

Lifestyle

Date	Term	Status
25-Feb-2009	Very heavy smoke	Smoker
25-Feb-2009	Alcohol consumptic	Currently Drinks
28-May-2008	Never smoked toba	Never Smoked
10-Mar-2008	Non-smoker	Never Smoked
04-Jan-2008	Alcohol consumptic	Currently Drinks

Clinical Measurements

Date	Term	Value	Units
19-May-2008	O/E - blood pressure reading	164/82	mmHg
08-May-2008	BMI	28.1	Kg/m2
08-May-2008	O/E - blood pressure reading	171/90	mmHg
08-May-2008	O/E - weight	65	Kg
12-Dec-2007	O/E - blood pressure reading	148/83	mmHg
22-Nov-2007	BMI	20.7	Kg/m2
22-Nov-2007	O/E - height	1.52	Meters
22-Nov-2007	O/E - blood pressure reading	162/82	mmHg
22-Nov-2007	O/E - weight	48	Kg
30-Oct-2007	O/E - blood pressure reading	172/87	mmHg
29-Oct-2007	O/E - blood pressure reading	185/95	mmHg
27-Oct-2007	O/E - blood pressure reading	148/72	mmHg
23-Oct-2007	O/E - blood pressure reading	174/95	mmHg
27-May-2007	O/E - BP reading raised	148/72	mmHg
20-Apr-2007	O/E - weight	47	Kg
20-Apr-2007	O/E - height	1.52	Meters
20-Apr-2007	BMI	20.3	Kg/m2
20-Apr-2007	O/E - blood pressure reading	156/74	mmHg
27-Oct-2006	BMI	19.9	Kg/m2
27-Oct-2006	BMI	19.9	Kg/m2
27-Oct-2006	O/E - height	1.52	Meters
27-Oct-2006	O/E - height	1.52	Meters

Clinical Measurements Panel

View Vision 360 Patient Record

1. Select **View Patient Record** from the Task Menu to display the Select a Patient Screen. This screen provides a patient search and select facility. For more information, see **Search for and Select a Patient** (page 39).
2. Select a value from the Reason for Selecting Patient drop-down list and click on **Show Summary Record**. The Patient Clinical Summary window opens displaying the Medical History, Medications, Lifestyle and Clinical Measurements panels.

Note: If you are using a third-party viewer, refer to any available training or the Help provided with the third-party application.

Medical History

This panel displays the patient's medical history. When you mouse over an entry, a tooltip appears showing:

- Date (of the entry)
- Term - description of the entry (for example, 'Ear infection')
- Clinician - the clinician who made the entry
- the Source - whether the information has come from Vision 3 or an external application

Medications

The Medications panel lists all medications prescribed to the patient over a selected date range. The tooltip over each entry displays:

- Issue Date
- Drug - the drug name
- Dosage
- Notes for Patient - any patient notes accompanying medication.
- Quantity - the drug quantity
- Issue - the number of issues (if this is a repeat medication)

Lifestyle

In the Lifestyle panel, details of a patient's lifestyle (with reference to diet, exercise, alcohol intake etc) are displayed. The tooltip shows:

- Date - the date that the entry was made
- Term - the entry description
- Status - lifestyle entry status (for example, 'Never smoked')
- Clinician
- Source - the source of the information (Vision 3 or an external application)

Clinical Measurement

Any clinical readings taken from the patient are displayed in the Clinical Measurements panel. The tooltip over each entry displays:

- Date
- Term (for example, blood pressure reading)
- Value
- Units - the unit of measurement (for example, mm/Hg)
- Clinician
- Source - the source of the information (Vision 3 or an external application)

Search for and Select a Patient


Quick Search

1. In the Search tab, you can perform a quick search for a patient by entering all or part of the patient's surname and optionally forename and/or date of birth in the Search Criteria field.
2. If you wish Soundex to be enabled, place a tick in the Enable Soundex box.

Note: If you choose to set Enable Soundex, the search is performed using 'sounds like' criteria. For example, searching on 'Tomson' returns any patients with the surname 'Thomson' or 'Thompson'.

3. Click on the magnifying glass icon  or press **Enter** to perform the quick search.

Detailed Search

1. Alternatively, to perform a detailed search, click on the  icon to display more search fields and enter the required criteria.
2. If you wish Soundex to be enabled, place a tick in the Enable Soundex box.
3. Click on **OK** to perform the search.

Selecting a Patient from the Search Results

1. To select a patient from the list of results, either double-click on their details in the grid, or highlight the row and click **OK** to display the next Patient Select window.
2. If you are accessing a patient from another practice in the same Patient Population Level as yourself, you will see the **Reason for Selecting Patient** button. Click to reveal the drop-down list and select one of the following options:
 - Patient has given consent
 - Emergency access for urgent treatment
 - Patient incapacitated due to illness or injury
 - Patient incapacitated due to mental ill-health or learning difficulties
 - Patient is a child with no accompanying parent or guardian
 - Other

If you select Other, you must enter details in the box provided (up to 200 characters).
3. A message is displayed stating that some sensitive diagnostic data relating to psychosexual matters, alternate lifestyle and termination of pregnancy will NOT be shown by this summary. Click on **Show Summary Record** to display the patient's summary data.

Note: If the patient has refused consent to their patient record, a pop-up will inform the user that "The patient has refused consent" and access will not be allowed.

View Exclusion List

The Exclusion List contains a list of data types which are excluded from the Patient Summary viewer due to their sensitive nature. The list can be modified from the Organisation Reference Data screen by those with **Administrator access status** (page 8).

1. From the Task Menu, select **Open Patient Summary** and select a patient using one of the methods described in **Search for and Select a Patient** (page 39).
2. In the next window click on **Show Exclusion List** to display a list of excluded data and corresponding Read or SNOMED Codes.

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