Vision 3

# Quick Reference - the basics

INPS

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## Table of Editions and Contents

| Date | Version | Contents | Output |
|---|---|---|---|
| 23/9/04 | 005 | Amended Chapter 15 Training Guide | PDF |
| 03/11/04 | 006 | Standalone version, HTML on website | PDF |
| 09/05/05 | 007 | Change to cytology add default, Printed with Starter Pack | PDF |
| 23/09/04 | 008 | Quick Ref cover | PDF |
| 15/02/06 | 009 | TDES Alt GP Click Thru Review | PDF |
| 24/10/07 | 010 | Update to DLM 260 Predicted peak flow not calculated for under 16's | PDF |
| 06/02/08 | 011 | Update to DLM 260 Change in drug check displays | PDF |
| 24/09/08 | 012 | Electronic MED3 | PDF |
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| 15/11/10 | 016 | Vision User Guides details updated | Docx & PDF |
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# Contents

# Quick Reference – The Basics

## What this Quick Reference Guide covers

This Quick Reference Guide is designed to help a user find the simplest and quickest method to carry out a task in an unambiguous way. It concentrates on which keys to press. There may well be other ways to carry out the same task and many of these are explored in other relevant sections of the Vision User Guides with accompanying screenshots.

Some of these basic tasks in Vision are covered:

- An introduction to Vision
- Login to Vision (conventionally, but NOT with a smartcard)
- Getting Started in Vision
- How to register a new patient
- How to select a patient
- How to add clinical data in **Consultation Manager**
- How to add a hospital in Control Panel - File Maintenance
- How to set up an Appointments system (particularly for practices with trial data pre-Go-Live).

### Who is the Quick Reference Guide designed for?

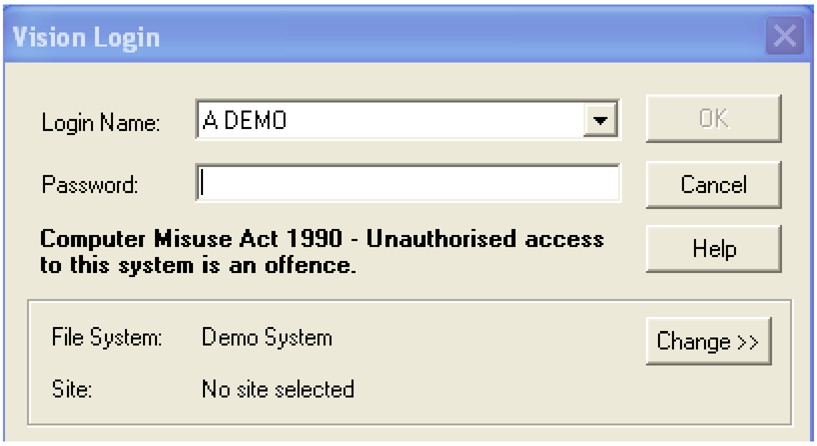
- Users in practices looking at trial data prior to Go-Live in Vision
- New users to Vision
- Users just trained, wanting an aide-memoire
- Locums and temporary staff who want a basic guide to data entry
- Any user wanting a quick recap of a simple task

# Starting Vision and Sign on

1. 

Either double click with the left-hand mouse button on the Vision icon; or click on the minimised **Vision** icon on your Task bar. A **Vision / In Practice Systems** screen is shown briefly.


*Vision innovation in practice screen*



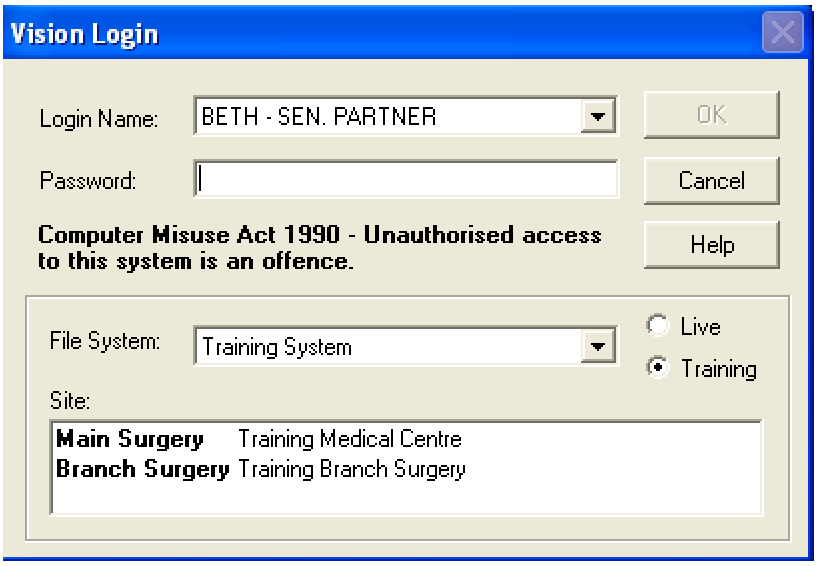

*Vision Login screen*

2. At the **Vision Login** screen, if your login name is not displayed, the **Login Name** box will appear empty (this is for security reasons). Type in your login name - if you are not sure what this is, see your system administrator. Users from practices looking at trial data pre Go-Live should type in **SYS** and press Enter.
3. Once your login name is displayed, click in the **Password** window and enter your password - **<u>your password will not be visible as you type, nor will there be asterisks</u>.** Users from practices looking at trial data pre Go-Live should type in **Password1** and press Enter.
4. Click **OK** to reach the **Vision front menu**.
5. Select **Consultation Manager** from the **Home** menu if you are about to enter clinical data, or select **Registration** from the **Home** menu if you are adding a new patient.

## Dummy patients

One of the best ways to learn about what Vision can and cannot do is to create dummy patients or use the Vision Training system. This lets you try out a range of things without affecting your data. You can either:

- Use the **Training system**: at the **Vision Login** screen, click on the **Change** button, then click on the **Training** radio button, and then select **Training System** from the picklist of File System. Pretend you are one of the partners BETH - SEN PARTNER and enter a password of "**password**" - click **OK**.




*Logging into the Training System*

- Use your live system: but add new "fictitious" patients in **Registration** with a registration status of **Referred** (to avoid involving Registration Links). Add a fictitious address and phone number, but you can leave out the NHS number. In **Consultation Manager**, at the **Select patient** screen, make sure to <u>uncheck</u> the box **Active Patients only** before entering the dummy patient's name.

# Vision Front Menu

The Vision front menu gives quick access to Vision modules.

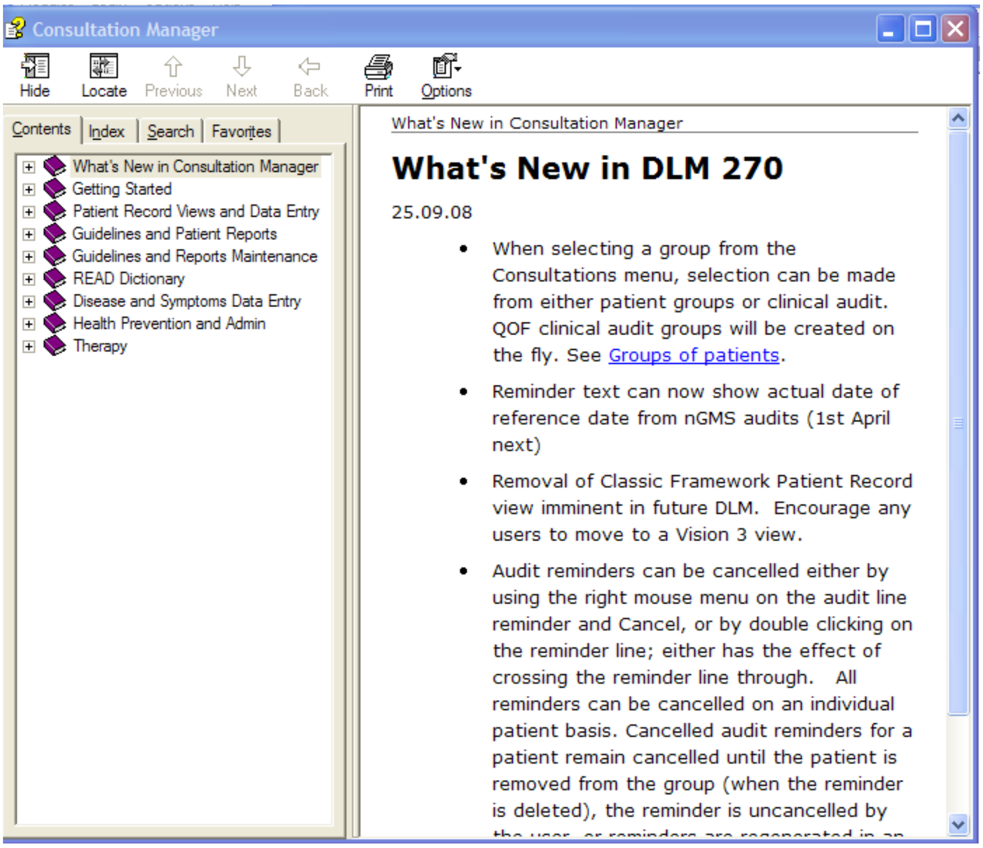
- There are five main sections: **Home, Reporting, Messaging, Utilities** and **Management Tools**, each with options to further Vision modules.
- The modules that are visible for selection are the ones that you, as the logged on user, are permitted to see.
- The **Home** menu includes **Consultation Manager** - where clinical entries are made - and **Registration** - where patient demographic details are recorded.
- **Control Panel** in **Management Tools** is where the set up of staff, organisations and practice details is made, together with access and security options to Vision functions.


*Vision Front Menu*

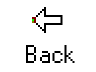
**At the bottom of each menu list is the link to the In Practice Systems website [www.inps.co.uk](http://www.inps.co.uk)
Click to use.**

# Using On-screen help

1. First access the Vision module relevant to the topic, for example, to look up help on prescribing, first go into Consultation Manager and access Help from the top menu. Or for help on registering patients, go into Registration.




2. Click on **Help** on the top menu, then either **Contents** or **Search**.
3. On the Contents tab, click on  to expand headings, and click on  for help on sub-topics.
4.  Next topic in Contents,  Previous topic in Contents.
5. 

If the text is coloured and underlined, click once on this to jump to that topic. Use 

to return to the previous topic you were viewing.
6. To print a topic, right click and select **Print** or click on the Print icon 

.
7. To print a series of topics, right click on a main heading in the left-hand column, select Print, then select Print the selected headings and all sub-topics.
8. 

lists topics and contents headings alphabetically. In the top box, type in the required topic, either partly or in full. Relevant topics will be listed in the lower box. Double click on the required topic (or click once, then click on Display).

9. Search or Find searches ALL the help text and thus is one of the most powerful tools for finding help on a subject. For example, to find aspirin references, go to the Search tab, type aspirin and press List Topics which lists any sections that contain the word aspirin. Click on one of these to highlight, then click on Display, or double click on the line. That help screen will be displayed.

10. To exit from Help, click on .

# Screensaver

If there has been inactivity on the Vision screen after 10 or 20 minutes, the Vision screensaver may blank the screen with *Time to system lockout in [n] seconds*. Any single keystroke or mouse action will clear the screensaver and re-allow access where you left off.

If the countdown period has passed, then a keystroke or mouse action displays a prompt for the current user's password with a log off button. There are two options either:

- Enter the password of the user who was at this computer, in which case the Vision screen will go back to where it was left.
- If no password is entered and the Close button is used, then Vision closes without displaying any Vision screens (i.e. another person closing Vision is not allowed to see the Vision screen the original user was at), and any open data entry forms in Vision will be cancelled.

# Vision User Guides

There are numerous User Guides available to Vision users. They can be downloaded from the INPS website at : www.inps.co.uk - My Vision – User Assistance – User Guides. They are in .pdf format which you can read with Adobe Acrobat Reader (this can be downloaded for free from the internet).

The guides are categorised as follows:

- **Getting Started** – The user guides listed in this section help new users to get started with Vision.
- **Clinical –** This section contains user guides to enable Clinical staff to use Vision.
- **Practice Administration –** This section contains user guides useful to Secretarial and Administrative staff.
- **Reporting –** These user guides describe how to run searches and produce reports within Vision.
- **Messaging –** These user guides give details of how to use the messaging tools in Vision, eg Registration Links.
- **Management Tools –** These user guides are useful to staff who setup and maintain the Vision system.

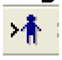
The website also gives details of recent Down Line Manager (DLM) updates which may have a user guide available to explain what is new or updated in the release.

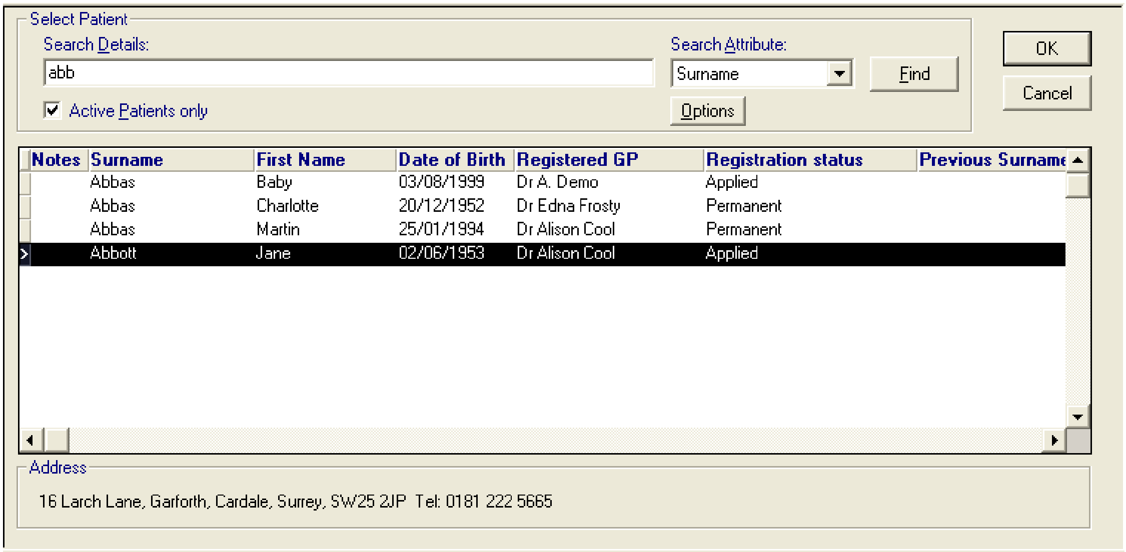
There is also Regional Assistance section which gives details of documentation relevant to regional projects.

If you have any comments or queries about any user documentation contact the User Assistance Department at vua@inps.co.uk.

# Select a patient

This section explains how to select a patient IF you are not using the Smartcard necessary for connecting to the spine.

1. Within either **Registration** or **Consultation Manager**, click on the **Select Patient** icon  .
2. In **Search Details,** type a few letters of the patient's surname, space, then the first letter(s) of the forename, e.g. **SMI CH** for Charles Smith, and then press Enter. This should list patients who match what you typed in.




*Example of Select Patient screen*

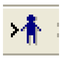
3. Once the patient list is displayed, find the patient you want (you may need to scroll down) and double click on that patient line, or single click and click **OK**.
4. When the patient has been selected, their name and address appears on the title bar at the very top of the **Consultation Manager** or **Registration** screen.
5. Their Patient Record screen is displayed, and a consultation is usually started automatically. There is a whole chapter on the different views in the Patient Record (see Section 17, Vision 3 User Guide).

**Note** - The view of the Patient Record that is displayed is the one that has been chosen by this user currently logged on. The setting up of the screen is very flexible and is also covered in detail in Section 17 of the User Guide on **Consultation Manager** – the Patient Record.

# In Consultation Manager

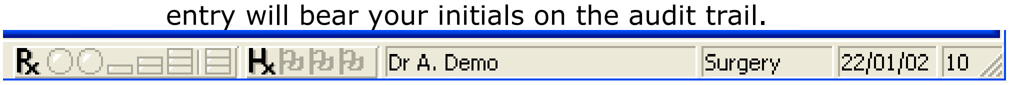
## Whenever you are adding data, start a consultation first

In **Consultation Manager**, you cannot add new data until a consultation is started.

1. First select your patient by either:
    - Using **Select Patient**  (see Select a patient on page 8)
    - From the Appointments List (see Select an appointment on page 11).
2. The Patient Record screen should be displayed and a consultation automatically started (see Whenever you are adding data, start a consultation first on page 9).
3. **If there is no consultation open**, the Consultation icon looks like this  and the status bar:


*No Open Consultation on bottom task bar*

4. Clicking on this icon starts a consultation.
5. You can tell a consultation is open by the following:
    - The Consultation icon  appears depressed on the toolbar.
    - The status bar at the bottom of the screen, just above the Windows Task Bar, shows your name (as the current user signed on), the date, and the start time of the consultation, followed by the current time (so you know how long the consultation has been). Any data entry will bear your initials on the audit trail.




*Surgery Consultation open displayed on bottom task bar*

**Note** - The easiest way to start a consultation automatically when you select a patient is to set this up in advance. Click on **Consultation** (top menu) **– Options** - **Setup**. On the **Consultation** tab, tick **Start New Consultation Automatically When a Patient is Selected**. Also tick **Deselect the Patient Automatically When a Consultation is Closed**. Click **OK**.

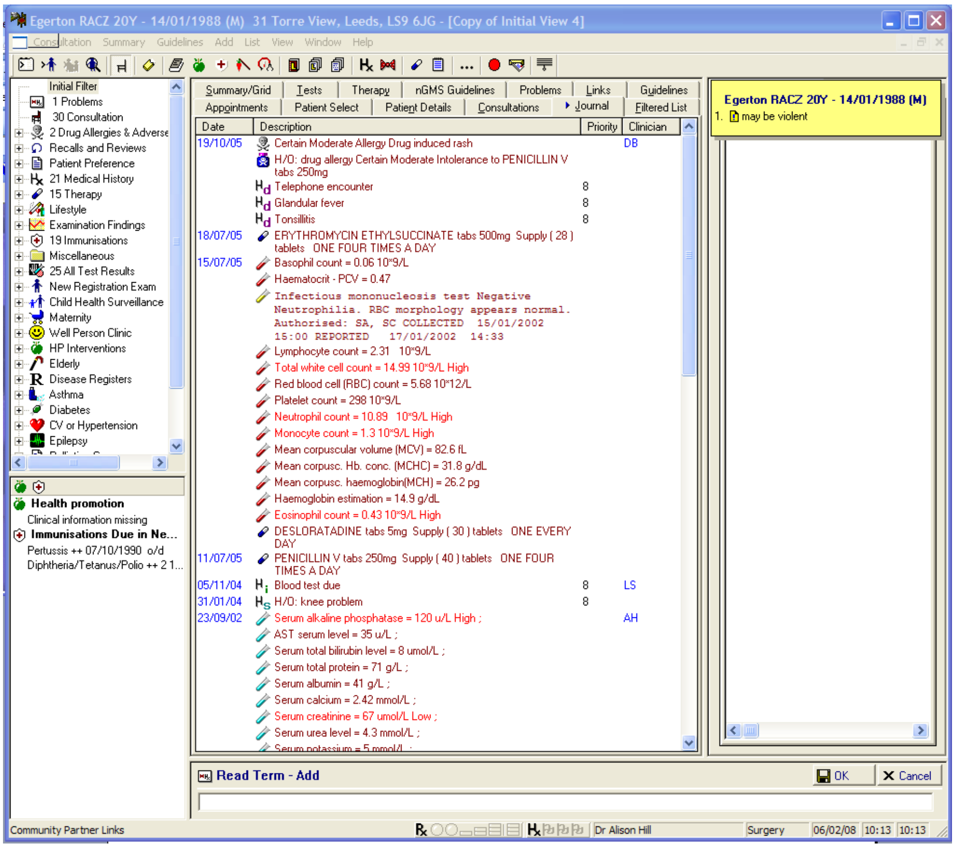
## Choosing the initial Patient Record view

This Quick Reference Guide assumes you are using one of the following Patient Record views:

- Initial View 4,
- Initial View 7, if you use problem-oriented medical records.

To make sure one of these views is selected:

1. In Consultation Manager, click on **Consultation** (top menu) - **Options** - **Setup**.
2. On the **Startup** tab, make sure both Patient Record boxes are ticked.
3. Untick the MRO box.
4. Go to the **Patient Record** tab.
5. If you can see copy of Initial View 4 or 7, then click on this. If not, click on  under Views, select **Standard system-distributed options**, then click on **Initial View** 4 (no Problems tab) or **Initial View 7** (with a Problems tab).
6. Click **OK** at the Copy screen.

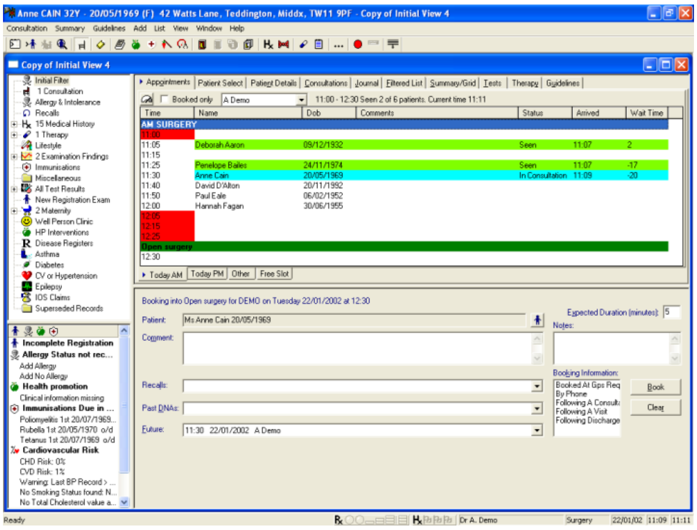



*Consultation Manager Initial View 4*

## Select an appointment

If your practice is using the Appointments module, then you can call the next patient in from an Appointments List.

1. In Consultation Manager, click on the Appointments tab or List Appointments icon .



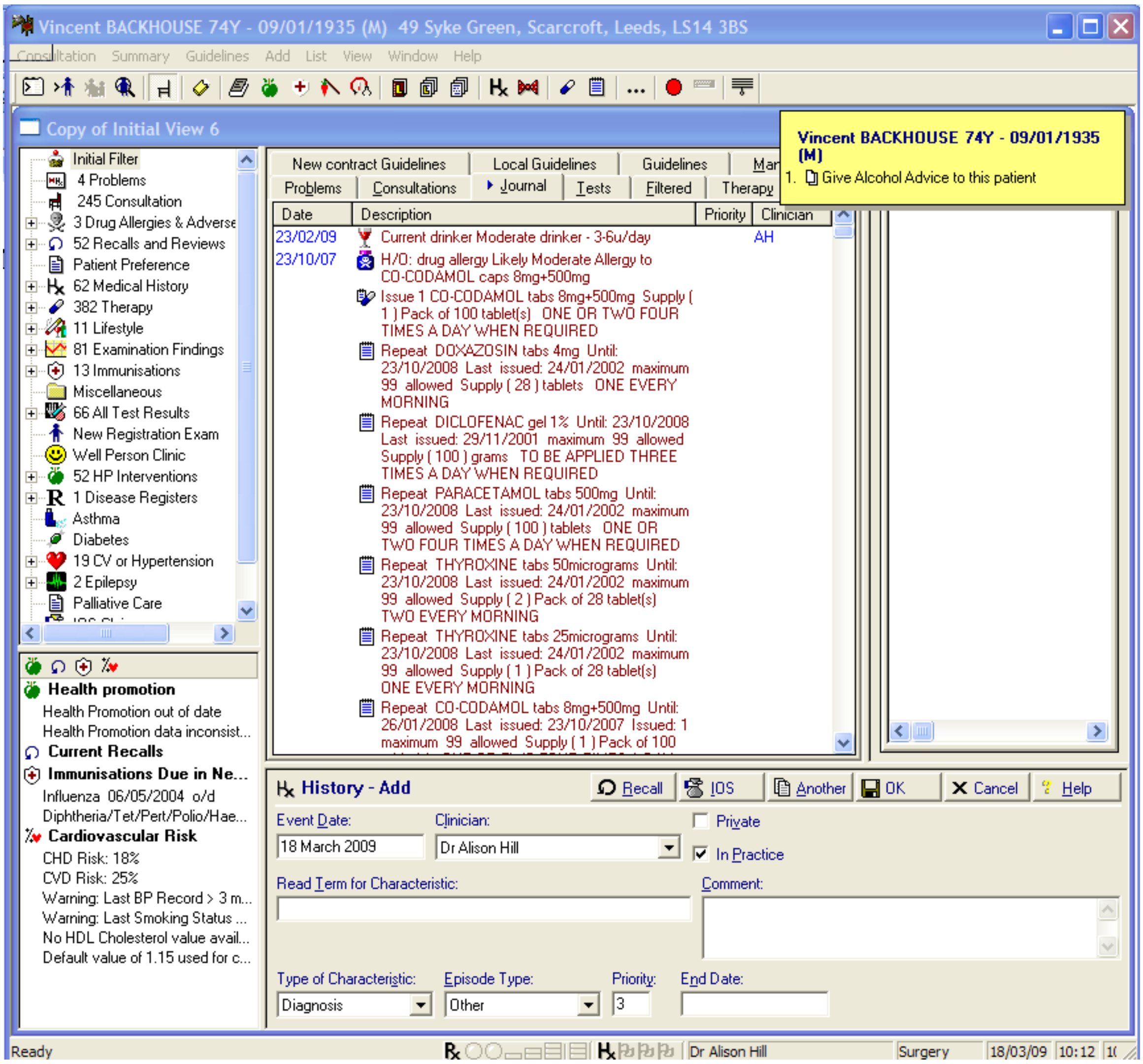
*Consultation Manager Appointments tab*

2. Your own appointment book is displayed by default as the user signed on. If you cannot see your list, click on  to the right of **Booked only** and select the correct session.
3. The appointment list defaults to Today AM if it is morning or Today PM if it is afternoon.
4. **Select Next Patient by double clicking on a booked appointment line** – This brings up their patient record.
5. If the patient is not marked as *Waiting* by the receptionist, then a warning may be shown telling you the patient has not arrived: *Are you sure you wish to select the patient? The patient has not arrived;* click either **Yes** to select the patient, or **No** to cancel selection.
    - **Call Patient** button or right click – This is only for practices using the Vision Appointments (Jayex) Call Display (ACD) option. It selects and displays the patient's record and visually calls the patient in.
    - **Select Patient** button or right click **-** selects the highlighted patient's record.
6. Once the patient is selected, a consultation is either started or not. This depends on the set up (see Whenever you are adding data, start a consultation first on page 9)
7. When the Patient Record is displayed, switch to the Journal tab for a **Read Term Add** window, or to the **Therapy** tab to prescribe.

**Note** - Press this **Refresh** icon  now and again so that any last minute appointments or waiting status are updated on your Appointments list.

## Add Medical History

1. In **Consultation Manager**, select the patient  (see page 8), or select from the Appointments list (see page 11). Make sure a consultation is started  (see page 9).
2. From the **Add** menu, select **Medical History**.



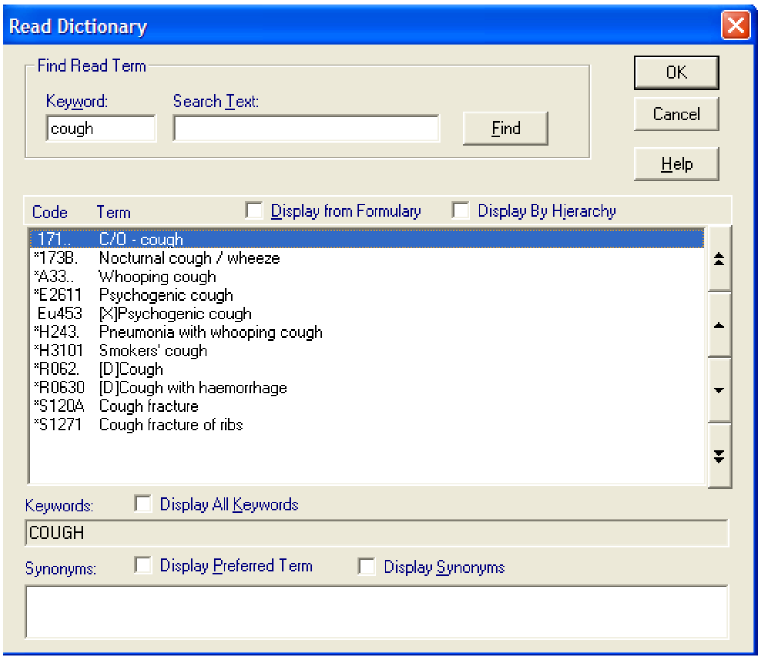

*Consultation Manager – History Add*

3. The cursor is flashing in the **Read Term for Characteristic** field.
4. To enter a history entry either:
   - Type in a keyword, such as headache, cough, asthma and press **Enter**. This should display the first matching entry. Then use the up ↑ and down ↓ keys to display the next or previous entry until you find what you want. Click **OK**.

- Enter a known Read code preceded by #, e.g. #H33 (for Asthma) and press Enter.

If the required entry is found like this, move to Step 5.

If this is not the correct entry, double click or press the <F3> function key to display a Read Dictionary screen which gives a list based on the keyword entered. This will include Read descriptions from different parts of the Read dictionary, shown by the different codes, e.g. chapter 1 History and Symptoms, 7 Operations, N Musculo-skeletal and connective tissue diseases.

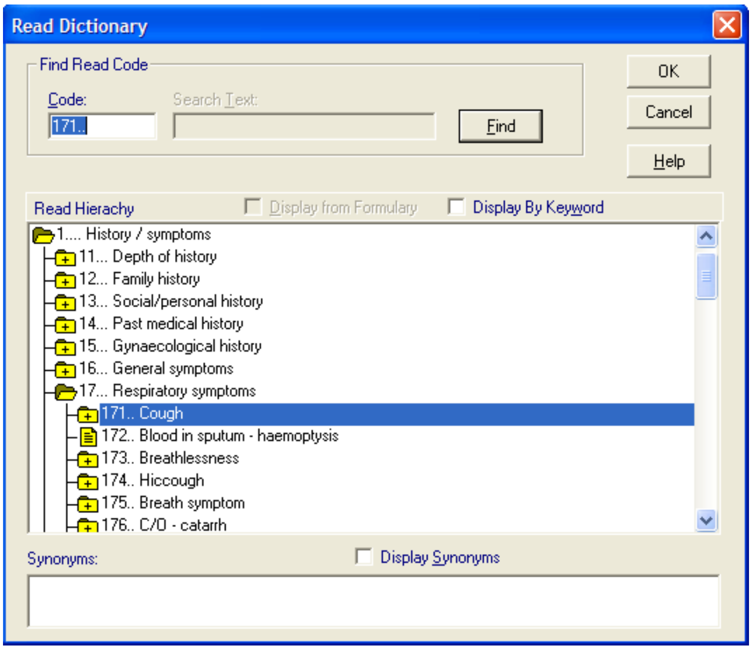



*Read Dictionary screen*

If the required entry is shown on the list, double click on it.

The following options are available if the required entry is not listed:

- Deselect **Display from Formulary** by removing the tick from the box (click with the left mouse button). This will display all matching entries from the whole Read dictionary.
- Bearing in mind the fact that many Read Terms do not have keywords, it may be necessary to display entries by Read code. To do this, highlight a suitable line and click on **Display by Hierarchy** to tick/check the box.



*Read Dictionary by Hierarchy*

- A Find Read Code screen will be displayed (see above). To open one of the closed folders and view the contents of that branch of the hierarchy, double click on the symbol . The path through the hierarchy is clearly visible by following the open folder symbol up the branch. The selected entry is highlighted. To close an open folder, double click on . Any entries with a 'piece of paper' symbol cannot be expanded any further - they are at the bottom of that branch of the hierarchy and can be selected.
- Once the correct entry has been found and highlighted, click on the **OK** button.

5. The **History Add** screen is displayed again with the Read term you selected entered in Read Term for Characteristic. All you need do now is press **OK** unless you want to make one of the optional changes:
    - **Event date** - Change from today if you are adding a historical record or night visit from the previous evening. Hold down the left mouse button and drag your mouse over the date until it is highlighted, then just overtype the historical date in the format d.m.yy (e.g. 2.1.10).
    - **Clinician** - Defaults to the GP signed on, or, if you are a member of staff, to the Second Choice Default set up in **Consultation - Options - Setup - Data Entry** - often the Usual GP.
    - **Comment** box – Optional, click within this box and type in free text to record extra comments.
    - **Type of Characteristic**: Optional, change to one of the following - Administration, Symptoms, Examination, Diagnosis, Intervention, Management, Presenting Complaint.
    - **Episode Type**: Optional, select from Other, Continuing, First Ever, New event.
    - **Priority** - The Priority regime differs in different practices. Many use Priority 1 for major diagnoses, Priority 3 for run-of-the mill

(and usually the default). Priority 0 is sensitive data which can be hidden from view.

6. Click **OK** when you have finished. The entry will appear on the Journal tab (which shows all entries) and also when you press <F2> (List-Medical History).

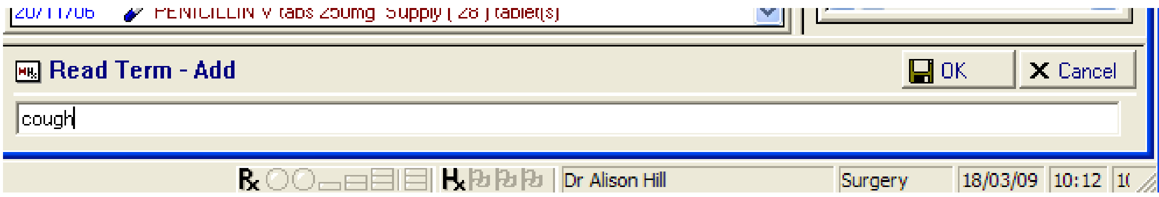
## Add Past Medical History

1. In **Consultation Manager**, select the patient (see page 8), or select from the Appointments list (see page 11). Make sure a consultation is started (see page 9).
2. From the **Add** menu, select **Medical History**.
3. The cursor is flashing in the **Read Term for Characteristic** field.
4. To enter the medical history either:
    - Type in a keyword, such as **headache**, **cough**, **asthma** and press Enter. This should display the first matching entry. Then use the up ↑ and down ↓ keys to display the next or previous entry until you find what you want. Click **OK**.
    - Enter a known Read code preceded by #**,** e.g. #H33 (for Asthma) and press Enter.
    - Press <F3> function key within Read Term for Characteristic for the full Read Dictionary select screen, and follow step 4 in Add Medical History on how to use the Read dictionary screen (see page 12).
5. In **Event Date**, hold down the left mouse button and drag your mouse over the date until it is highlighted, then just overtype the historical date in the format d.m.yy (e.g. 2.1.10) or dd.mm.yy (02.01.10). You can also use just a month and year, e.g. 6.54 for June 1954, or just a year, 1954.
6. Click **OK** to complete the screen, after first changing any other options such as Priority, Type of Characteristic or entering free text in Comment.

## Adding a Read term

Vision stores its records either in a generalised Medical History or in Structured Data Areas, such as Blood Pressure, Epilepsy, Serum Cholesterol, and so on. You can let the system do all this for you.

1. In **Consultation Manager**, select the patient (see page 8), or select from the Appointments list (see page 11). Make sure a consultation is started (see page 9).
2. Go to the **Journal** tab of the patient record.




*Read Term – Add at the bottom of the Consultation Manager screen*

3. In the **Read Term - Add** window either:
    - Type in a keyword, such as headache, cough, asthma and press Enter. This should display the first matching entry. Then use the up

↑ and down ↓ keys to display the next or previous entry until you find what you want. Click OK.

- Enter a known Read code preceded by #, e.g. #H33 (for Asthma) and press Enter.
- Press <F3> function key within the Read Term window and follow step 4 in Add Medical History (see page 12) on how to use the Read dictionary screen.

4. Vision will then present you with the appropriate Add screen. In many cases this will be a History Add screen, for example, after entering **headache** or **cough**. For others, such as **peak flow**, **diet**, **exercise**, you will see the appropriate Add screen.
5. Complete this screen - you can open up the picklist in Read Term by clicking on  if you want to select another term.
6. Click **OK**.

## Updating an entry if you have made a mistake

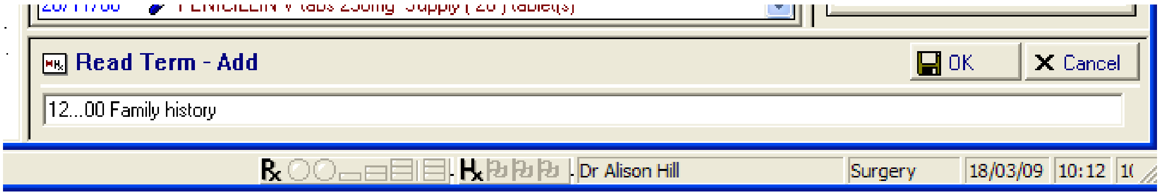
You can view all a patient's entries on the Journal tab of the patient record in **Consultation Manager**, where they are listed chronologically, latest at the top.

If you have made a mistake, editing an entry is easy:

1. In Consultation Manager, go to the **Journal** tab of the patient record.
2. Right click on the line you want to amend. This means pointing to the line, and clicking the right mouse button. A menu pops up.
3. Move the highlight down and select **Edit** with a left mouse click.
4. The data is displayed in the bottom pane. Make your amendment and click **OK**.

## Add Family History

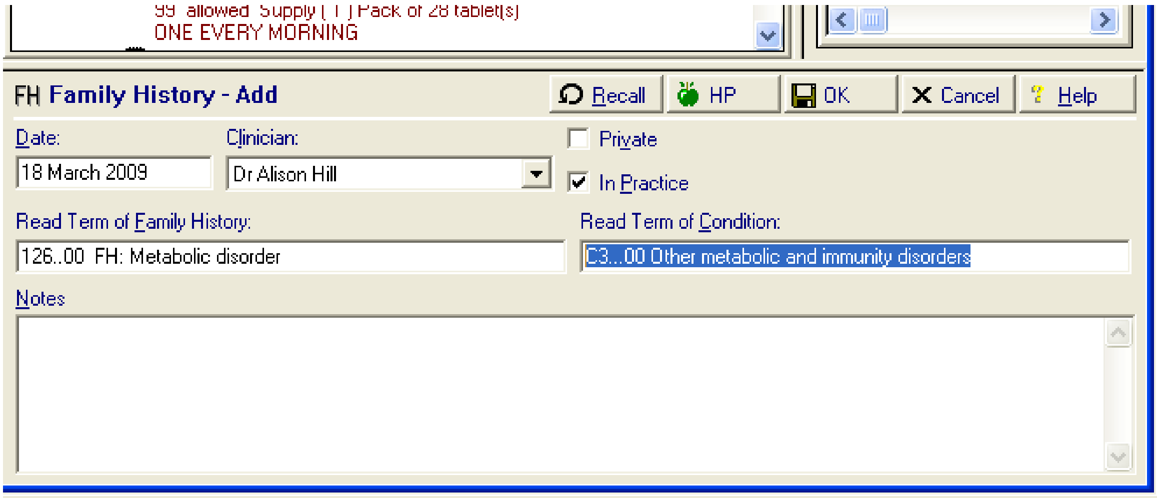
1. In **Consultation Manager**, select the patient - Either click on (see page 8), or select from the Appointments list (see page 11). Make sure a consultation is started (see page 9).
2. Go to the **Journal** tab of the patient record.
3. In **Read Term Add**, type in **#12**, press Enter.




*Read Term – Add with Family History selected*

4. To select from the full Read dictionary, press function key <F3>. The dictionary should be listed by codes, but if not, tick the box **Display by Hierarchy**. Navigate to 12 and double click the by 12... Family history. Look down the codes until you find the one you want. Highlight it and click on **OK**.
5. At **Read Term Add**, this should now have your selected term, click **OK**.
6. The **Family History Add** screen is then displayed. **Read Term of Family History** has the term you selected from chapter 12, e.g. 126.. FH:Metabolic disorder.
7. **Read Term of Condition** should have a corresponding entry, e.g., C3... Other metabolic and immunity disorders.

**Note** - You are NOT able to put Family History codes from chapter 12 in Read Term of Condition.




*Family History – Add screen*

8. **If there is no relevant family history**, place your cursor in Read Term of Family History and press the down arrow key until you reach 122..00 No Relevant family history. Leave Read Term of Condition blank.

9. Click **OK**.

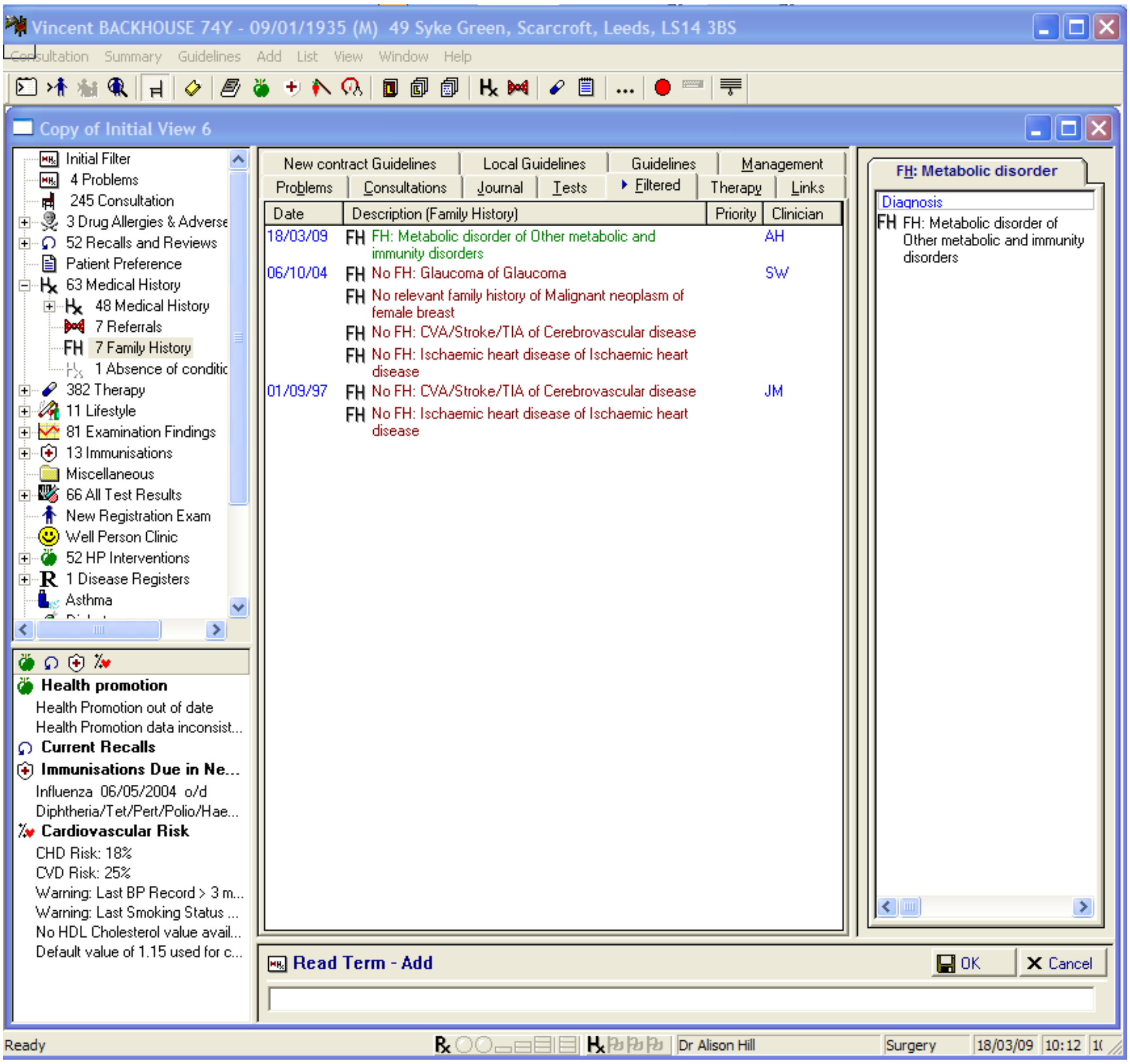
You can also add Family History data from:

- **New Registration Management Plan** - Right click on **New Registration** on the left-hand navigation pane, and select **Management Plan**. Click on the top left row to show hidden rows without data. Click on the **Family History** line for a Family History - Add form. Enter as above. Optionally, enter any free text Notes. Click **OK**.

## *Listing Family History data*

Click on the **Medical History** line on the navigation pane (Medical Records Overview column) of the Patient Record. The Family History entries can be shown separately from other Medical History entries.

Click on the plus sign by **Medical History** to see how many Family History entries there are – clicking on the **Family History** line shows only these under Filtered tab.

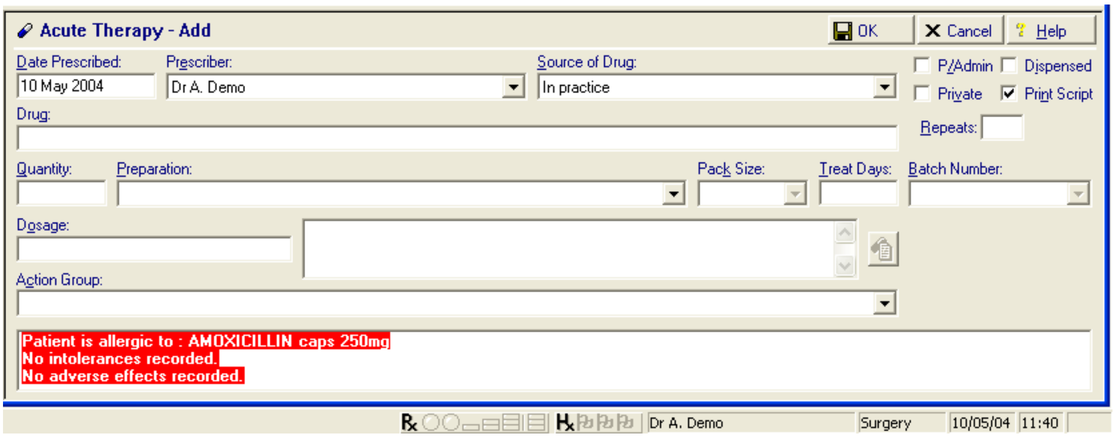


*Consultation Manager with Family History displayed in Filter tab*

## Add Acute Prescription and Print

An acute prescription is for a one-off therapy item which you do not envisage repeating. If you find later that you do want to prescribe it again, you will enter a second acute prescription, copy this one or set up a new repeat master prescription.

1. In Consultation Manager, select the patient - Either click on (see page 8), or select from the Appointments list (see page 11). Make sure a consultation is started (see page 9).
2. On the Patient Record, click on the **Therapy** tab. (Remember that practices using trial data pre-Go-Live will not see any therapy histories from your previous system until the **Bulk Change Utility** has been run).




*Acute Therapy – Add screen*

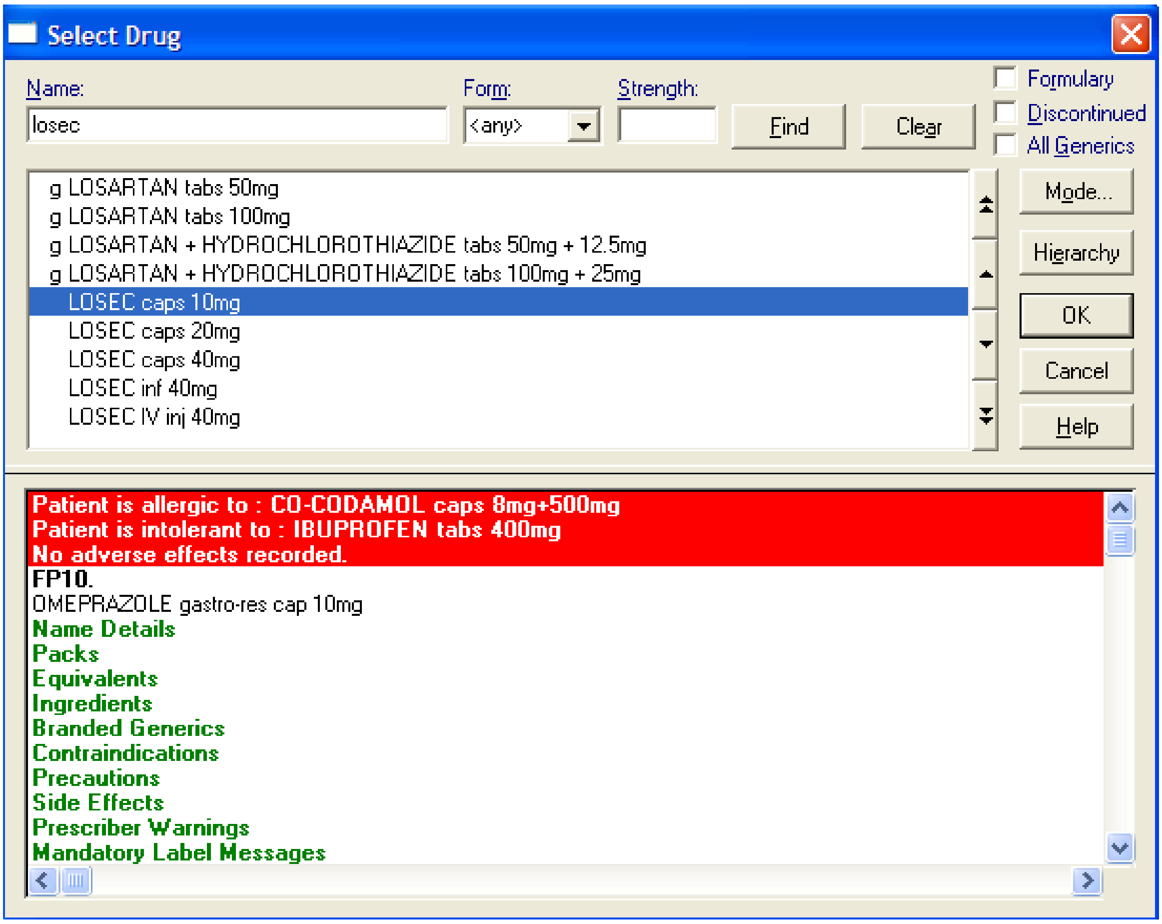
3. Click on the Current tab which lists all repeat masters , and any acutes issued within a recent period.
4. Press **Esc** to display the **Acute Therapy - Add** screen in the bottom pane, if it is not already displayed.

> **Note** - You may find you have by mistake selected Repeat Master - Add. If so, press **Cancel**. Click on the Current tab and press Esc to display the Acute Therapy - Add screen.

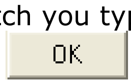
5. The cursor is flashing in the Drug selection window. Type in the first few letters of the drug name, e.g. losec (optionally followed by a space and the form - caps, tabs etc, followed by a space and the strength, e.g. losec cap 10) and press Enter. Alternatives at the Drug name window are to press F3, or just to double click, without typing anything in first. Both go straight to the **Select Drug** screen.
6. If the displayed drug is the correct one, move to Step 8.

   If the displayed drug is not the correct one, you have the following options:

   - Use the up and down arrow keys to display the next or previous entry.
   - Click on the Switch to generic button Drug: to replace the selected drug with a generic.
   - Double click or <F3> on the Drug field to access the Multilex dictionary on the Select drug screen.

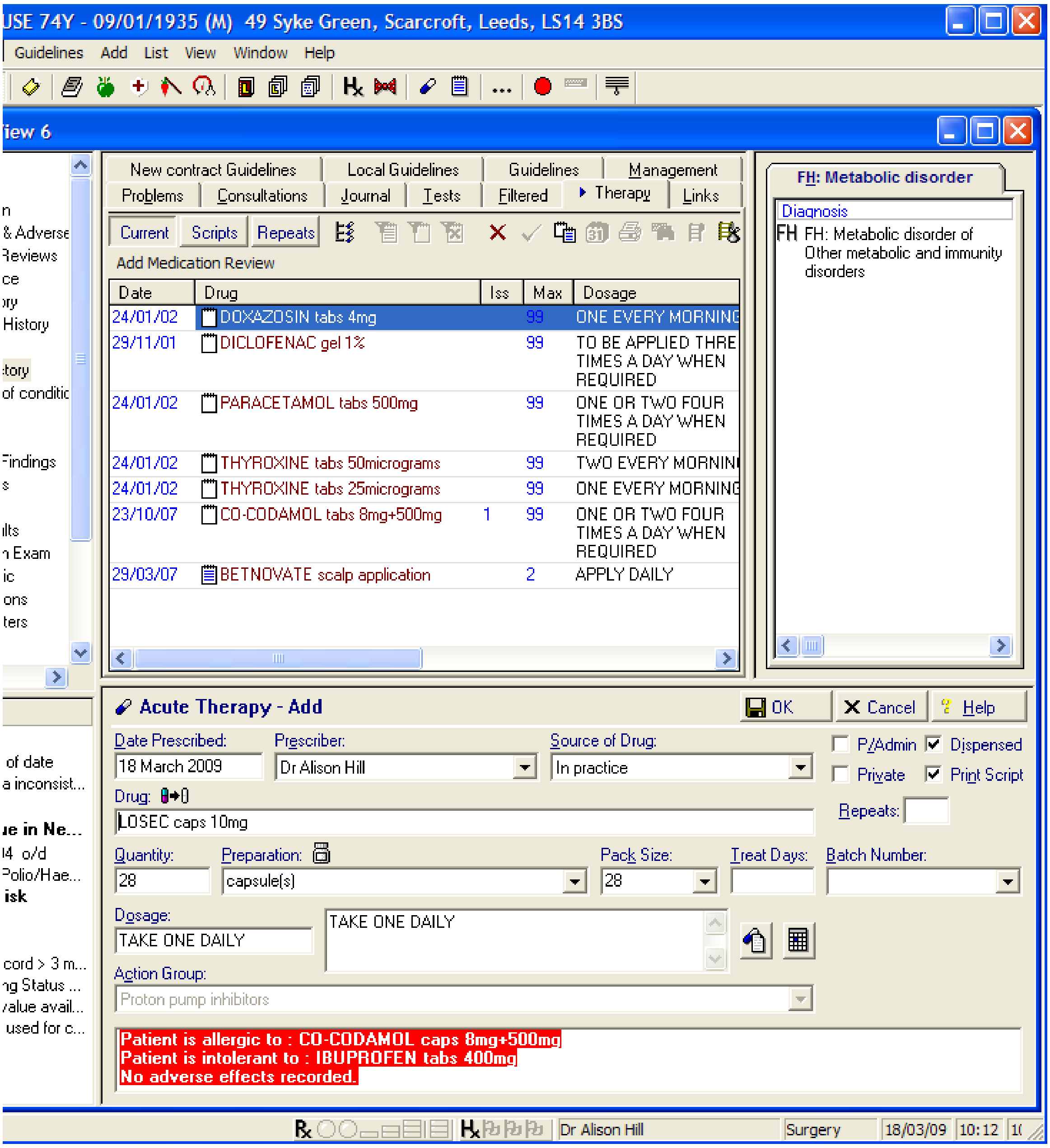



*Select Drug screen*

The Select Drug screen lists the drug dictionary or formulary from the nearest match you typed in. When the required drug name has been found, click on the 

button to confirm.

7. Further options on the Select Drug screen:
   - When typing a drug name, you do not need to specify the form and strength at this stage – just type the first few letters of the therapy item and press Enter, e.g. LOS Enter.
   - To find appliances or codes, type in # then the code.
   - The red box in the middle displays Drug Allergy and Intolerance information for the patient.
   - The bottom pane has more Multilex product information about the selected therapy item. Clicking on an individual heading can expand it.
   - Check the currently highlighted drug against the patient's other therapy and clinical data, by pointing to it and clicking with the right mouse, selecting Drug Check for any potential contra-indications, interactions or drug doubling.
8. You are returned to the **Acute Therapy-Add** screen. The **dosage** and **quantity** are entered automatically for most drugs (if in **Consultation – Options – Setup – General –** the option **Use Normalex drug defaults** is selected).




*Consultation Manager with completed Acute Therapy – Add screen*

9. **Quantity, Preparation, Packs** – Pack Information for the selected drug can be displayed by clicking on the bottle icon by **Preparation**. This lists packs for the therapy item, whether divisible or indivisible, and the number per pack. If more than one pack, select a suitable pack or quantity by double clicking. You can amend a quantity by overtyping in **Quantity**.

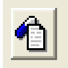
   **Note** - The prescription will show the quantity and preparation exactly as displayed on the screen.

   If the preparation details need to be changed, delete the displayed details and enter the required preparation, e.g. *5 ml bottle(s)*

10. **Dosage** - Click in the **Dosage** field and enter the dosage, e.g. 1 tds. The system accepts standard dosage codes, e.g. 1 om, which can be displayed by right mouse clicking anywhere on the screen and selecting **Dosage Codes** and **List** from the displayed menus. You can build up the dosage message, for

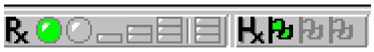
example, *od ac (Every day before food)*. Any free text can be typed in the **Dosage** field and this will be printed exactly on the prescription, e.g. a flavour – chocolate – for some children's preparations.

11. Check the other default entries are correct.
12. If you have chosen a brand name, you can change to its **generic** equivalent by clicking on 

. Once you have done this, the icon will disappear.
13. If you need to **re-select the drug**, double click within the **Drug** name window to return to the **Select Drug** screen.
14. To add **free text** that will print on the right-hand side of the prescription form, click on the **Notes for Patients** button , type in your free text and **OK**. The icon is then ticked.
15. Finally, after checking the entries and entering the dosage and quantity (see below), accept **Acute Therapy - Add** screen by clicking **OK**.

## *Drug Checks*

16. Drug Checks are then performed, showing any warnings of contraindications, interactions or drug doubling before you proceed with the prescription (see page 31). Depending how it is set up in **Consultation – Options – Setup – Drug Checks**, you will either see a full Drug Check Results screen; or flags on the status bar which you can double click on to display the full screen:

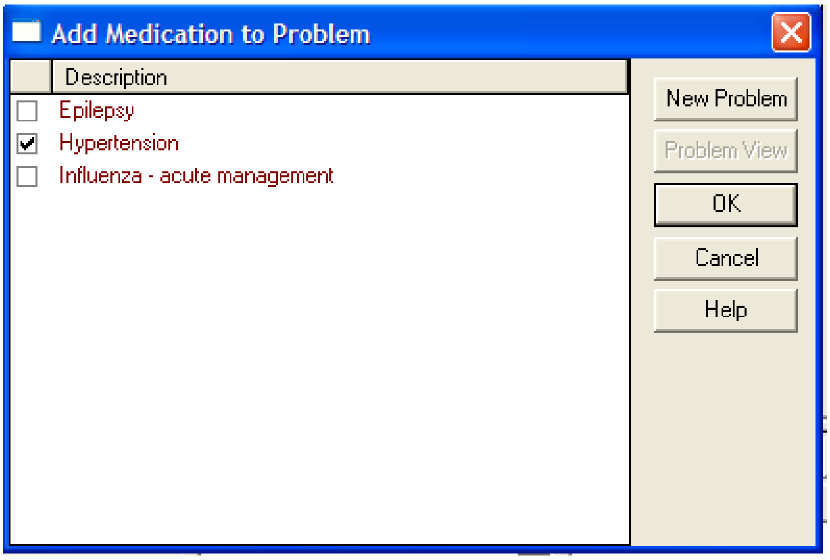


*Drug check indicators on the bottom task bar*

If you answer **Yes** to *Do you still wish to prescribe this drug*? The Therapy Records screen is re-displayed, from which you can print the prescription.

## *Add Medication to problem*

17. Some practices have switched on the option medication linked to problems. If you see the following screen, then tick the appropriate related diagnosis or problem associated with this medication.

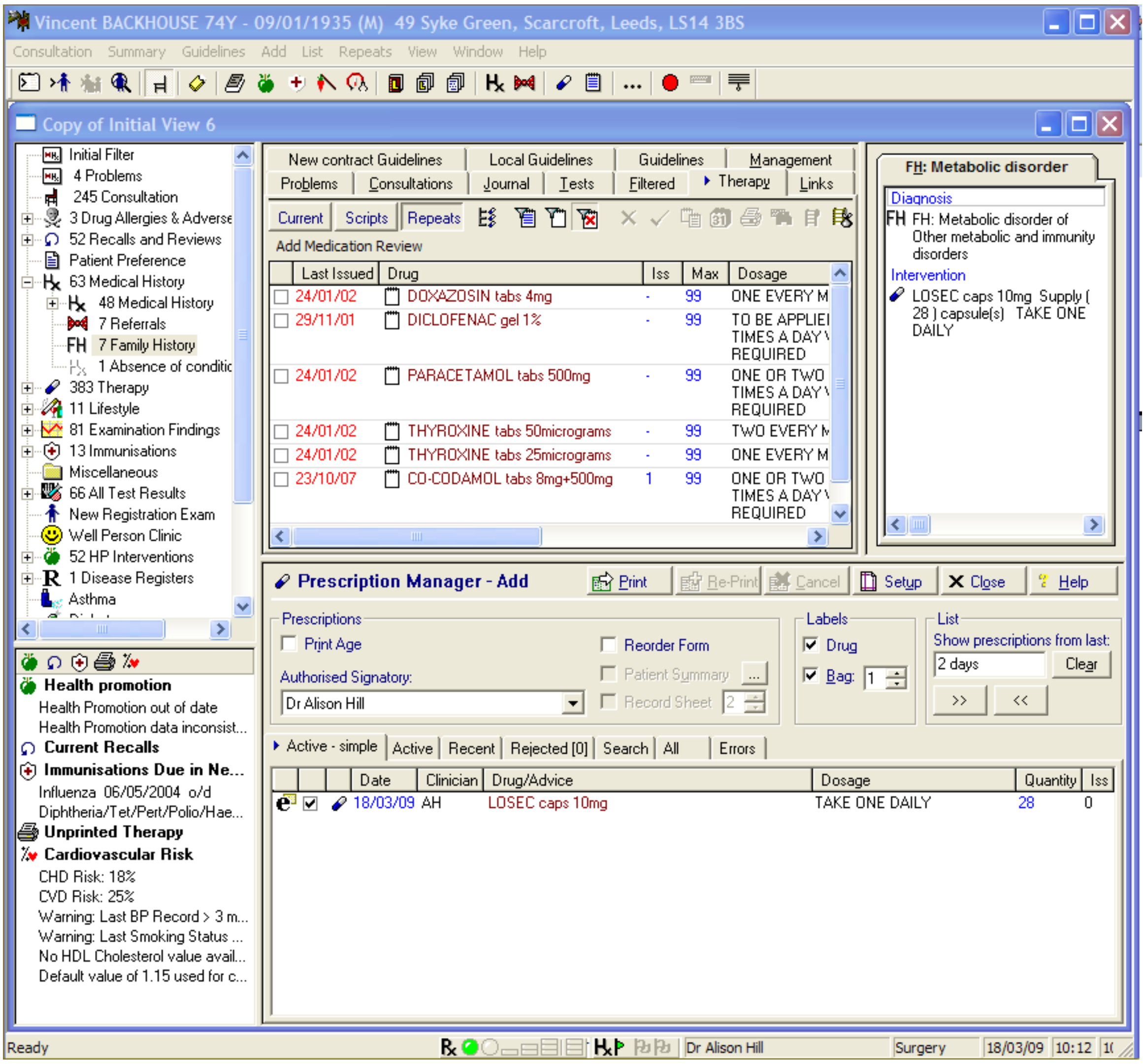



*Add Medication to Problem screen*

## *Print the prescription*

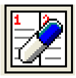
18. **To print the prescription**, press <**F9**> or press .

- The Therapy Print Records / Prescription Manager screen is displayed after the first F9. All acutes added with today's date will be listed.
- At the **Therapy Print Records – Add / Prescription Manager** screen, check the prescriber (**Doctor to sign prescription**) – this is the GP signed on, but you can change it to another (if the setup allows on **Consultation – Options – Setup – General**, check the box **Print Signing GP Name**), so the name of whichever doctor is selected in **Doctor to sign prescription** will print on the prescription.
- Proceed to print by clicking on the **Print** icon  or pressing <**F9**> again. The second Print command starts the printing.




*Consultation Manager with Prescription Manager – Add displayed*

## Make an Acute into a Repeat

1. Find the acute prescription on the **Current** tab.
2. Hold down the left mouse button over this line and start to drag the line away. A Floating Drop Target is displayed.
3. Drag until the cursor is over the "pill" icon  (Make Acute into Repeat) and drop it by releasing the mouse button. Then complete the Repeat details on the **Repeat Prescription Master - Add** then click on **OK**.
4. Alternatively, you can drag an acute line on to the Another icon  for a copy of the Acute Therapy with the same drug, details and dosage already selected. Fill in the details and click **OK**.

## Add repeat prescription

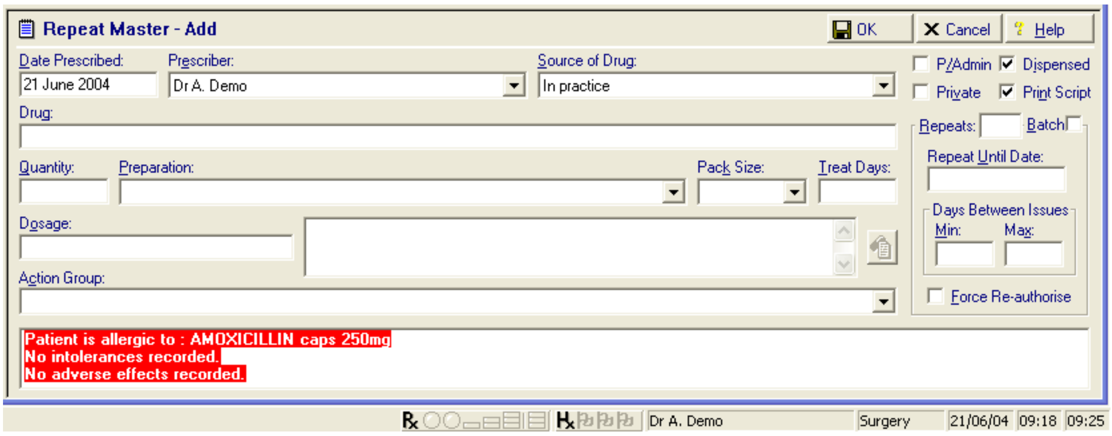
**Note** - This is the same as adding an acute item (see page 20) EXCEPT in addition you enter a number in the field Repeats before pressing **OK**.

A repeat master is for therapy items which the patient can repeat, usually in a month from the initial prescription, and for some months after that before the repeat master needs re-authorising by the GP. Each repeat has a repeat master line, from which issues are printed.

Adding a repeat is very similar to adding an acute therapy, with a few extra fields.

Note in step 3, however, that the starting screen is different.

1. In **Consultation Manager**, select the patient - Either click on  (see page 8), or select from the Appointments list (see page 11). Make sure a consultation is started  (see page 9).
2. On the Patient Record, click on the **Therapy** tab, then **Repeats** tab. (Remember that practices using trial data pre-Go-Live will not see any therapy histories from your previous system until the Bulk Change Utility has been run).




*Repeat Master – Add screen*

3. Press **Esc** to display the **Repeat Master Add** screen if not already displayed.
4. Enter the first few letters of the drug name, eg **ibupro** and press Enter. Follow the steps to add the required medication (see Add Acute Prescription on page 20).
5. BEFORE PRESSING OK, move the cursor to the **Repeats** field (nearly top right of the **Repeat Master - Add** under **Private / Print Script**) Enter the required maximum number of repeats that the patient can make of a prescription, before the GP must see him or her again in order to re-authorise the prescription (e.g. 6 repeats). This is a mandatory entry.
6. **Repeat Until Date** is an optional field. Note that a drug will become expired if either the maximum number or the Repeat Until date is reached. To enter a date, use the date abbreviated format: e.g., 56D (56 days) 3M (three months), or 6W (six weeks). 1Y (one year).
7. **Days between Issues** is an optional field. Note that a drug will not be prescribable if the maximum number of days between issues has been exceeded and / or the minimum number of days between issues has not been reached.
8. When the number of issues (**Issues Made**) equals the maximum number allowed (the figure in **Number of Repeats**), no further prescriptions can be issued until the repeat is re-authorised. The repeat master is then said to have expired and will be listed under Expired with this icon on **Repeat Masters**. On the **Repeat Prescription Master - Add** screen:
9. If **Force Re-Authorise** is blank, anyone can re-authorise a repeat master.

   If this box is checked, only the prescriber can re-authorise the master (Prescribers are all GPs or clinicians entered with a GMP number).

---

**IMPORTANT**: The 

field should only be checked if the prescriber alone is to re-authorise the medication. Otherwise, to enable anybody to re-authorise the medication when it expires, do not check this field.

---

10. If you have Normalex defaults switched on in **Consultation – Options – Setup – General – Use Normalex drug defaults**, the dosage and quantity will be entered automatically. If not, enter these now manually e.g. 2 bd
11. **Quantity, Preparation, Packs** – See step 9 of Add an Acute Prescription.
12. **Dosage** - See step 10 of Add an Acute Prescription.

13. To add **free text**, which will print on the right-hand side of the prescription form, click on the **Notes for Patients** button, type in your free text and **OK**. The icon is then ticked.

14. Check the details and click on the OK button to confirm the new entry.

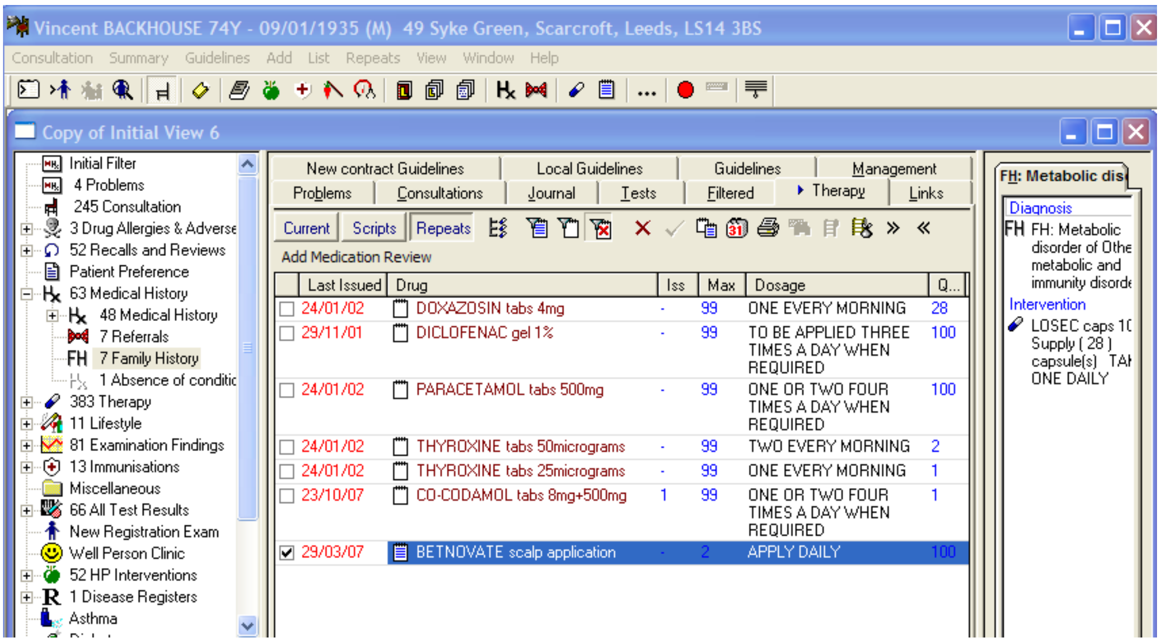
15. At the **Drug Checks** screen, look for warnings of any possible contra-indications, interactions or drug doubling (see Drug Checks on page 23 and a fuller explanation on page 31). To continue, answer **Yes** to *Do you still wish to prescribe this drug*?

16. See Add Medication to problem on page 23 if necessary.

17. The new repeat master can now be issued.

## Issue Repeat Prescription

**Summary** - First select the repeat items on the **Therapy - Repeat** tab, then press <F9> and <F9> again.



*Betnovate is ticked as the repeat to be printed. Note that the other repeats have a blank symbol - they have "expired" and need re-authorising before being re-issued.*

1. In Consultation Manager, select the patient: Either click on the Select Patient icon (see page 8), or select from Appointments list (see page 11). Make sure a consultation is started (see page 9).

2. If you are a receptionist issuing repeat scripts and this is a fresh consultation, keep the consultation statistics accurate by changing the Consultation Type from *Surgery Consultation* to *Repeat Issue* – double click on the name or **Surgery** on the status bar at the bottom of the screen to display the Consultation Update screen, and re-select the Type of Consultation as *Repeat Issue*, then **OK**.

3. Click on the **Therapy** tab then on the **Repeats** tab, or press <F5>.

4. When the **Therapy Repeats** screen is displayed, check that the requested items are shown.
    - If this is the case, continue to Step 6.
    - If the requested item(s) is not shown, click on **Filter Expired Repeats** and **Filter Inactive Repeats** to give a list of valid repeats (leave **Filter Valid repeats** undepressed).
    - If the required items are still not shown, proceed to Step 11. There may be an expired item that needs reauthorising.
    - Valid repeat master which can be issued
    - Expired repeat master which needs reauthorising before issuing
    - Inactivated repeat master, i.e. discontinued
    - Prescribed out of practice
5. **Select the lines to be issued** (see back to screenshot above):
    - Either click in the checkbox by each item required to tick it.
    - Or, if all items are to be selected, click on the **Select All** icon to select all and tick.
    - Or, if all except one or two items are to be selected, click on the **Select All** icon to select **All**, then single click on any items NOT required.
6. Click on the **Print** icon or press the <**F9**> function key to issue the required items. This displays the Print Therapy or Prescription Manager screen.
7. When the **Prescription Manager** screen is displayed, check the **Doctor to Sign Prescription** (the Prescriber) is correct.
8. Click on the **Print** icon or press <**F9**> again to print the prescription.
9. Give the patient the prescription and the right-hand repeat re-order form.

## *What if you cannot find the repeat master in Step 5*

1. If a required item is not shown in Step 5 above, click on Filter Inactive Repeats and Filter Valid repeats to give a list of Expired Repeats.
2. To re-authorise an expired repeat, click on the required item to tick it, and then click on the Re-authorise icon. This will display the Therapy details screen and allow you to make changes if required (e.g. change the maximum number or the dosage). Click on the OK button to confirm the details. The repeat master is now valid.
3. Click on Filter Expired Repeats and Filter Inactive Repeats to give a list of valid repeats (leave Filter Valid repeats undepressed).

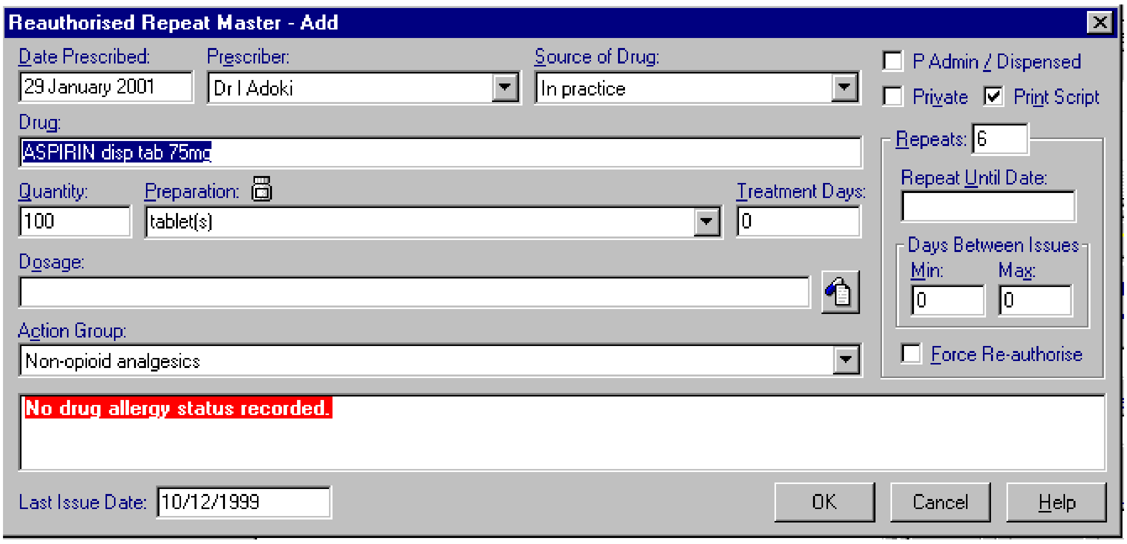
4. If the requested item is not shown under the expired view, it may have been inactivated (discontinued). Click on Filter Valid repeats and Expired Repeats to list any inactive repeat masters . If the drug is shown here and it can be reactivated (check with the GP first), click on the required item to tick it, and then click on the Reactivate icon. This will make the repeat master active again. It may still need to be re-authorised as well (see Step 12).
5. If a requested item is not shown at all and needs to be added, see Add repeat prescription on page 25.
6. NHS prescriptions are printed on the left-hand side of the prescription paper, and a repeat re-order form is printed on the right. The repeat re-order form can be customised with your own practice message in Consultation – Options – Repeat Therapy Reorder Form.

## Re-authorise repeat

Once a repeat master has been issued a maximum number of times (determined by the GP when he or she originally adds the repeat), then the repeat becomes "expired" with the icon on the **Repeats** tab list in **Therapy**.

1. On the **Therapy** tab, click on the **Repeats** tab.
2. Click on **Filter Inactive Repeats** and **Filter Valid repeats** to give a list of Expired Repeats masters.
3. To **re-authorise** an expired repeat, click on the required item to tick it.
4. Then click on the **Re-authorise** icon .
5. This will display the **Therapy** details screen and allow you to make changes if required (e.g. change the maximum number or the dosage).
6. Click on the OK button to confirm the details.

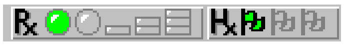
If you are a member of staff and find the system prevents you from re-authorising a repeat master, this may be because the GP has ticked the box **Force Re-authorise** on the original **Repeat Master Add** screen. In this case, only the GP can re-authorise the repeat.

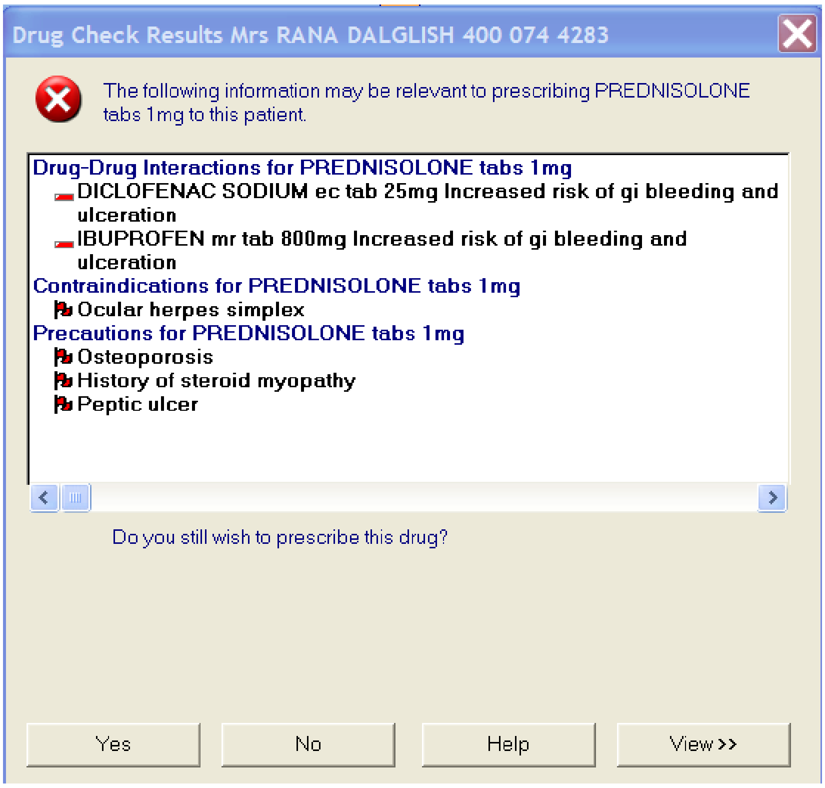



*Reauthorised Repeat Master – Add screen*

## Drug check displays

The **Drug Check Results** and status bar signal if there are any drug interactions, drug doubling or contraindications of which you should be aware. This checks against the currently selected patient's data.

 Drug interactions (circles), Contra-Indications (red bars)



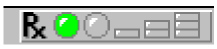

*Example Drug Check Results screen*

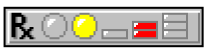
If you answer **Yes** to *Do you wish to prescribe this drug?* You are encouraged to enter a free text reason why you are overriding the prescriber warning. This is logged in the Event Log Viewer.

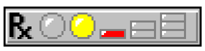
**Note** - Warnings are given if the patient is pregnant or lactating.

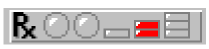
### *Drug Interactions warning signals*

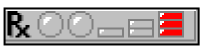
The left-hand circles and bars warn of drug interactions, between the drug currently selected and the patient's existing therapy.

 **Green light** - No Drug Interactions

 **Yellow light** - Context sensitive interactions exist e.g., elderly or females, those on digoxin etc.

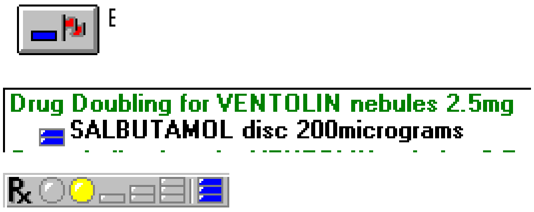
 **Red single bar** - Warn that mild interaction exists

 **Red double bar** - Avoid if possible - serious interaction exists

 **Red triple bar** - Life threatening interaction exists

## *Drug Doubling Warning Signals*

Checks are also made for drug doubling. This looks at the patient's current therapy to see if there is any item that has the same ingredients, or is in the same action group, or is the same drug, as the therapy being added. The doubling drug check warnings are shown as a series of blue bars:




**One blue bar - Same action group**

**Two blue bars - Same ingredient**

**Three blue bars - Same drug**

## *Contraindication warning signals*

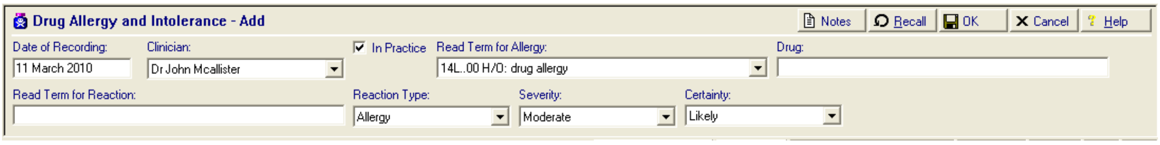
The contraindications warning signals are shown as flags on the right on the status bar:

- **Green flag** No Contraindications exist
- **Yellow flag** General warnings exist for Contraindications
- **Red flag** Patient specific Contraindications

Contraindications are checked against the patient's clinical history and also include precautions, prescriber warnings and special morbidities such as pregnancy and lactation.

## Add drug allergy

1. To enter a drug allergy, first select a patient and start a consultation.
2. From the **Add** menu, select **Drug Allergy/Adverse Reaction**.
3. If the patient gives a history of previous allergy or intolerance, then enter the approximate date in **Date of Recording** and <u>remove the tick from the **In Practice** box</u>.

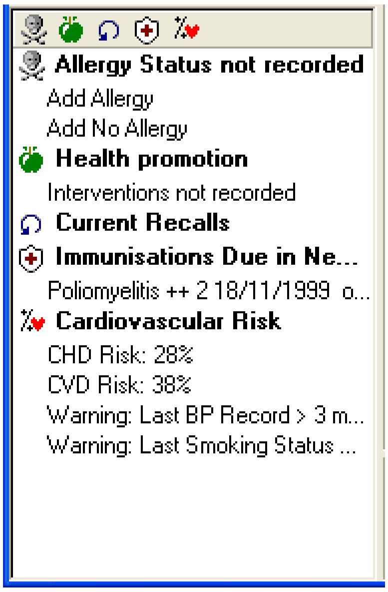



*Drug Allergy and Intolerance – Add screen*

4. **Read Term for Allergy** – 14L.. H/O drug allergy is the default Read code. Click on the picklist arrow to display further options and click on the Read code required.
5. **Drug** - Double click in the Drug window, and select the drug to which the patient is allergic. In *Name* on the *Drug Select* screen, type in the drug name, e.g. penicillin, and click on **Find**. Click on **OK**.
6. **Read Term for Reaction** - Selection here is optional.
7. **Reaction Type** - The choice is *Allergy, Adverse Effect* or *Intolerance*.
8. **Severity** is a mandatory entry. The options are: Blank (no entry), *Minimal, Mild, Moderate, Severe, Very severe, Potentially Fatal*
9. **Certainty** is a mandatory entry. The options are: Blank (no entry), *Tentative, Unlikely, Possible, Likely, Certain, Absolute.*
10. Enter any free text notes, or recall date, if required.
11. Once you are satisfied with your entry, click on **OK**.
12. The allergy or adverse effect warning is shown on the Repeat Master or Acute Therapy Add screen. If you try to prescribe items with a severity of Potentially Fatal. The Drug Sensitivities warning is displayed stating that "*It will not be possible to prescribe this item due to the presence of potentially fatal reaction.*

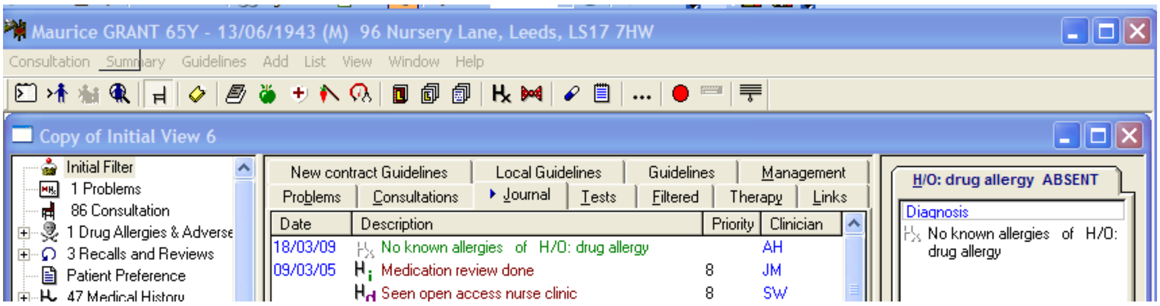
## Enter no known allergies

**If the patient has no allergies** and you want to record this as No *known Allergies*, double click on **Add No Allergy** at the bottom left of the left-hand navigation pane, on the Alerts (Vision 3 view).




*Bottom right-hand corner of Consultation Manager showing Add No Allergy*

This will automatically enter a *No Known Allergies* record for the patient, which you can see at the top of the Journal list.




*Consultation Manager showing No Know Allergies on the Journal tab*

It will also be displayed on a Therapy - Add screen:


*No Known Allergies showing on Therapy screen*

## Add Med 3

This is to record that you have issued a Med 3 medical certificate for a period of incapacity of a patient, after seeing the patient on the day or day before.

1. Select the patient and make sure a consultation is started and the Patient Record displayed.
2. From the **Journal** tab, in **Read Term Add**, just start typing **med3** and press Enter. You should have a **Read Term Add** window displayed at the bottom of the screen with the entry *9D1..00 MED3 – doctor's statement*.
3. Click **OK**
4. Enter a period of time or a date into the **For** or **Until** fields.
5. Enter a valid Read term into the Diagnosis field and any comments in to the Remarks field if required.
6. Click **OK**

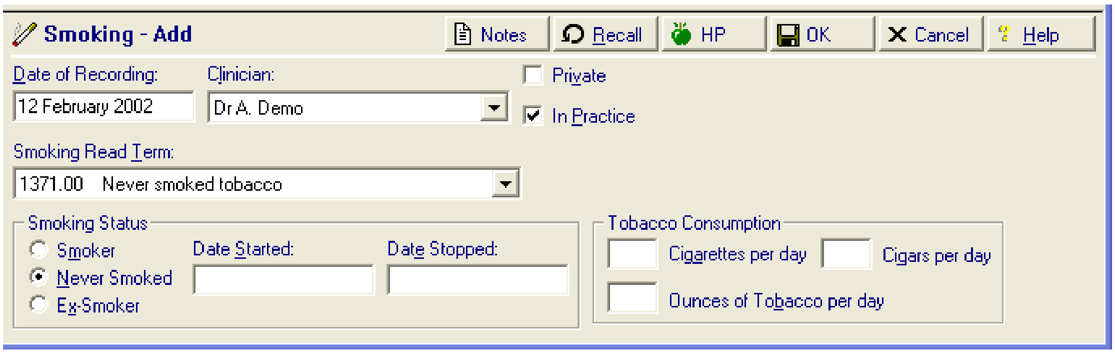
   **Note** - Step 2 will not work if you have the **Therapy** tab displayed. Click on the **Journal** tab and try typing again. Alternatively, click on **Add – MED3** and continue from step 4.

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

# Add Smoker / Non-smoker/ Ex-Smoker / Smoking Cessation advice

## *Add Smoker*

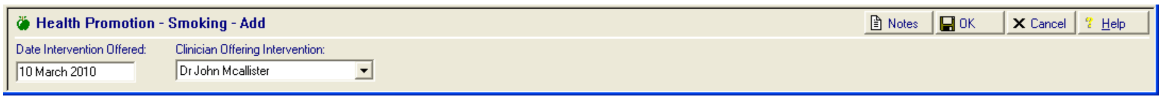
1. Select the patient and make sure a consultation is started.
2. From the **Add** menu, select **Smoking**.
3. At the **Smoking – Add** screen, change the Smoking Status to Smoker.
4. In Smoking Read term, click on the selection arrow and scroll down, selecting a suitable Read term, e.g. 1373.00 Light smoker – 1-9 cigs. /day. When the line is highlighted, press Enter.
5. Optionally, enter a figure in Tobacco Consumption, e.g. 5 in Cigarettes per day.
6. If you have talked to the patient about giving up smoking, then click on the Health Promotion icon to record smoking cessation advice.
7. Click **OK**.




*Smoking – Add screen*

## *Add Smoking Cessation Advice*

1. Select the patient and make sure a consultation is started and the Patient Record displayed.
2. From the **Add** menu, select **Health Promotion Interventions - Smoker**.
3. At the Health Promotion - Smoking - Add screen, click **OK**.




*Health Promotion – Smoking – Add screen*

## Add Non-Smoker

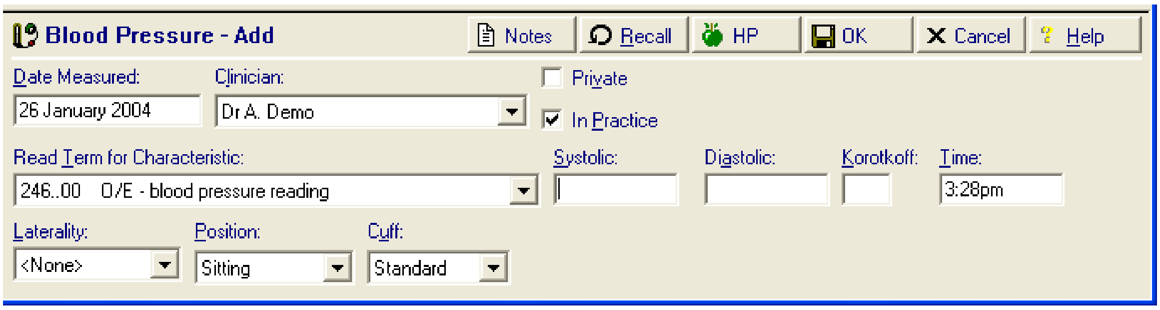
1. From the **Add** menu, select **Smoking**.
2. At the Smoking – Add screen, the Smoking Status will be set to Never Smoked, as this is the default selection if the patient has no previous smoking record.
3. In Smoking Read term, the default becomes 1371.00 Never smoked tobacco.
4. Click **OK**.

## Add Ex-Smoker

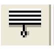
1. From the **Add** menu, select **Smoking**.
2. At the **Smoking – Add** screen, change the Smoking Status to Ex-Smoker.
3. In Smoking Read term, the default becomes 1375.00 Ex smoker.
4. An optional step - Press the Tab key to reach **Date Started**, and type in a year, e.g. 1964, press the Tab key and enter a year in Date Stopped, e.g. 1980.
5. Optionally, enter a figure in Tobacco Consumption, e.g. 15 in Cigarettes per day.
6. Click **OK**.

## Add blood pressure and list BPs and graph

1. Select the patient and make sure a consultation is started and the Patient Record displayed.
2. From the **Add** menu, select **Blood Pressure**.

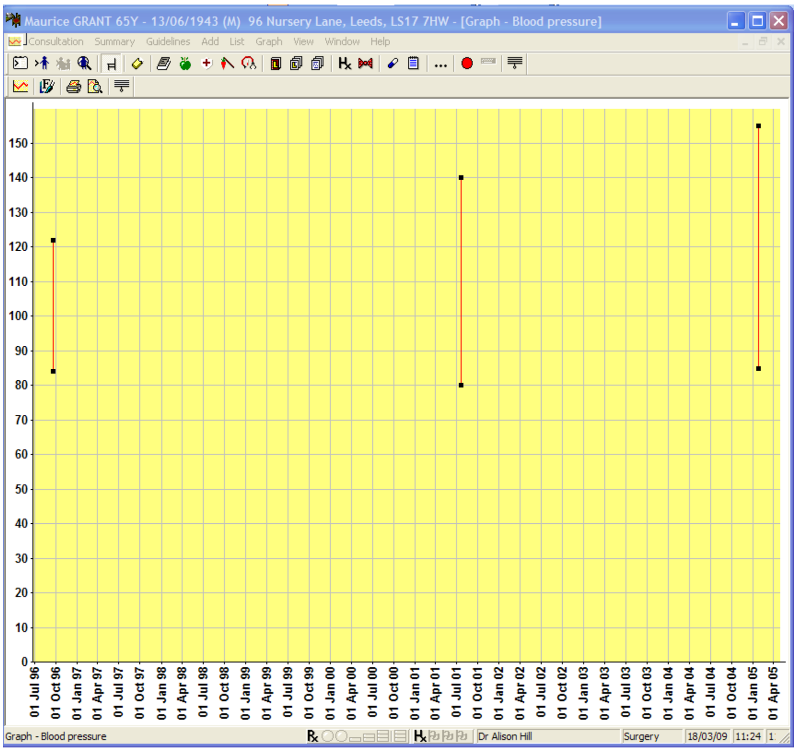



*Blood Pressure – Add screen*

3. At the **Blood Pressure - Add** screen, the cursor is in **Systolic**. Type in a reading and press the Tab key, and type in a **Diastolic**.
4. Optionally, using , change **Laterality** (<None>), **Position** (Sitting), **Cuff** (Standard).
5. Click **OK**.
6. Find the BP entry you have just made at the top of the Journal tab, or select **Blood Pressure** from the **List** menu.
7. Right mouse click on this line and select **Graph** with a left mouse click.
8. This graphs all the patient's BP records. To focus on a particular set of dates:
    - either double click within an area of the graph to expand those dates.
    - Or you can position the cursor to the left and above the area you are interested in, hold down the left mouse button and drag the resulting square around the area. Let the mouse button go. The area will now be expanded.
    - Clicking on the Fit to Graph icon  to revert it to the way it was initially.
    - Print the graph out using the print icon .
    - Print Preview  first before printing out.
9. Click on **Close**  on the left to close the graph and exit.

# Graphs

**Note** - You can right click and select **Graph** for any numerical result line, such as BP, weight, or test results.



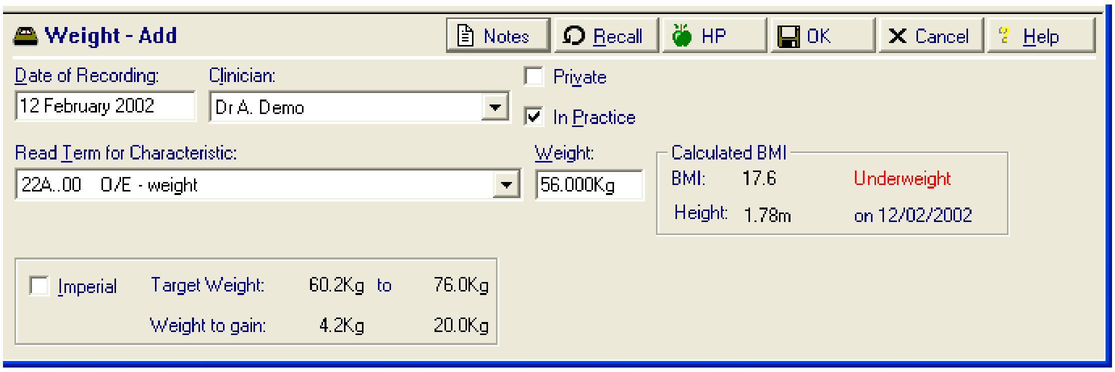

*Blood pressure graph*

Once the graph is displayed:

- Expand the area you are interested in by positioning the cursor to the left and above the area, holding down the left mouse and dragging the resulting square around that result. Let the mouse button go. The area will now be expanded.
-  To revert to the way it was - i.e. unexpand it - use the Fit to Graph icon
-  The Style icon changes the style of the graph - colours of the Paper, Line, Grid, Tracker or Axes by clicking on the buttons and selecting from the colour palette. Click on Default to return the screen colours to the default values. When you are finally satisfied, either click on OK so the graph style is changed for this session only, or first click on Save as Default so it is checked if you always want graphs displayed in the style you have just chosen.
-  Print the graph out using the print icon.
-  Print Preview first before printing out.
-  Close graph and exit.

## Add Weight and Height

1. Select the patient and make sure a consultation is started and the Patient Record displayed.
2. From the **Add** menu, select **Height**.
3. Height records are stored in metres, but you can enter the height in either metric or imperial. For example, either type in 1.68, which the system will understand as 1.68 metres; or type in 5'6", or 5ft 6in, which converts into a metric equivalent. Height can be recorded to three decimal places, e.g. 1.765 M, or 35.4 cms. Click **OK**.
4. From the **Add** menu, select **Weight**.




*Weight – Add screen*

5. Weight records are stored in kilograms, but you can enter the weight in either metric or imperial. For example, type in 72.5 for 72.5 kg, or 11st 6lb, which will automatically convert to its metric equivalent, when you press Enter or the Tab key. Optionally, change the Read Term by clicking on the selection arrow and select another Read term. Click **OK**.

   The height and weight together are used to work out the **BMI,** the Body Mass Index for adult screens. The BMI is automatically calculated by dividing the weight in kg by the height squared in metres. If the BMI falls outside the normal range of 19-24 for women and 20-25 for men, the word *Overweight* will be displayed when viewing this record. Once 30 or over, the patient is classed as *Obese*.

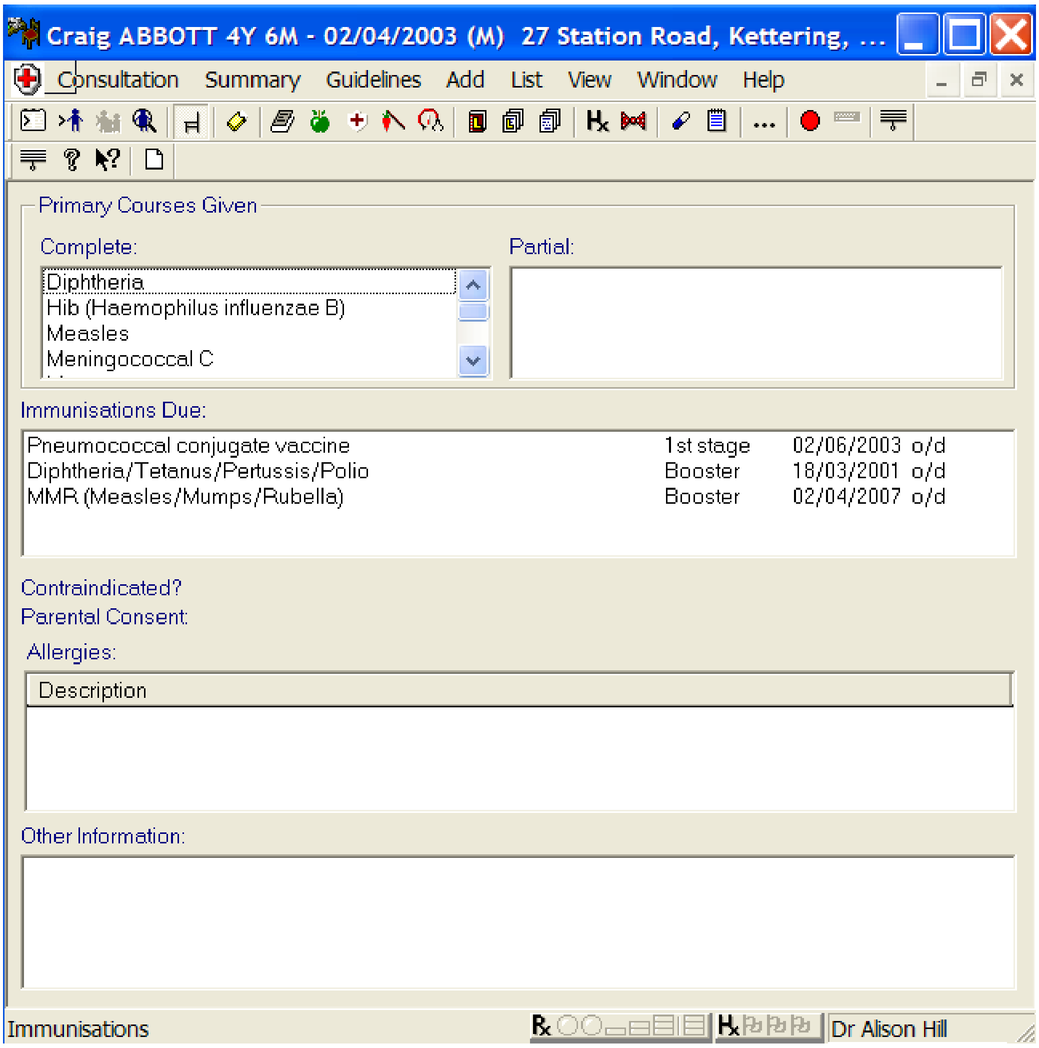
   A **Target Weight** is given for overweight patients, and the weight they should lose to achieve this. To see this in stones and lbs, click in the *Imperial* box.

6. For subsequent weight records, start at step 5 above. There is no need to keep re-entering the height.
7. Point to any weight or height entry on a form, List screen, e.g. Journal tab, right click and select Graph to graph all the patient's weight records. To focus on a particular set of dates, double click within an area of the graph to expand those dates. Or position the cursor to the left and above the area you are interested in, hold down the left mouse button and drag the resulting square around the area; let the mouse button go to expand the area. Click on Fit to Graph icon reverts it to the way it was initially. Print or Print Preview. Click on Close on the left to close the graph and exit.

## Add Immunisations

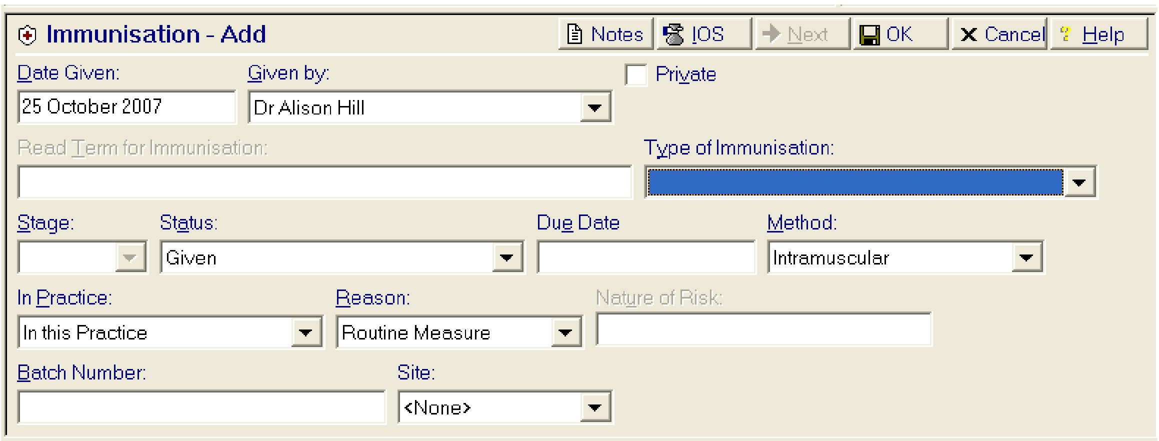
Immunisations Add record immunisations given. You may also enter refusals to start or complete a course in the Status field, having first selected the type of immunisation.

1. First select a patient and start a consultation.
2. To check what immunisations the patient already has, click on  for the **Immunisations Summary** screen which lists what are due and those that have already been given.




*Immunisation Summary screen*

3. Display **Immunisations – Add** by right clicking on **Immunisations Summary** and selecting **Add**. If you skipped step 2, then from the **Add** menu, select **Immunisations**.



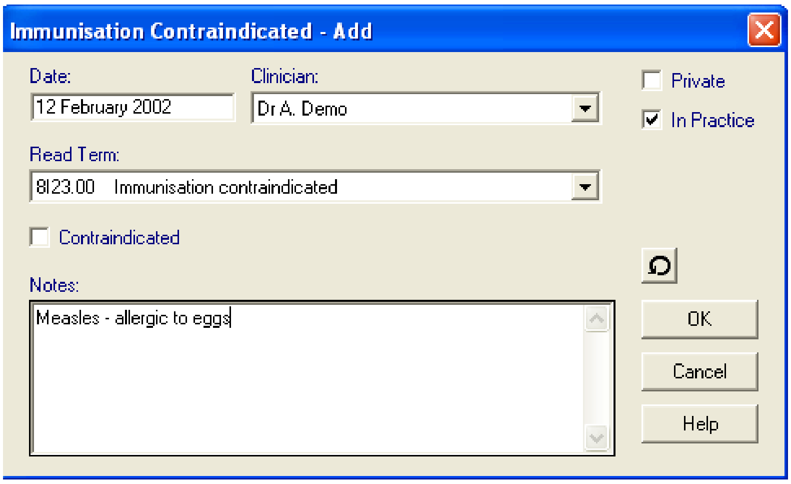

*Immunisation – Add screen*

4. On the **Immunisations – Add** screen, select the **Type of Immunisation** either by clicking on and scrolling down, and clicking on your choice. For a full list of immunisations, see on-screen help.
5. Select the **Stage** – e.g. $1^{st}$, $2^{nd}$, $3^{rd}$, booster. **Status** defaults to Given. **Due Date** depends on the Type of Immunisation and is worked out automatically. **Method** depends on the Type of Immunisation, e.g. Oral for polio.
6. Click in **Batch Number** and type in the batch number on the vial. This is a mandatory entry if you want to make an Immunisation IOS claim.
7. In **Reason - Routine, Epidemic, Special Risk Group or Traveller**. This is optional.
8. In **Country / Nature of Risk**, this depends on the Type of Immunisations and what you have selected in Reason. If you have selected Traveller, click on under **Country** and select the area to the visited. If you have selected Special Risk Group, in **Nature of Risk**, type in the risk, e.g. Animal lab technician.
9. Click **OK** at the **Immunisations – Add** screen to save and exit, or click on **Next** to enter another immunisation.
10. If you have added a Tetanus or Cholera booster for an adult, you may be reminded if you have not entered the first, second and third stages of Tetanus or Cholera immunisation. Click on **Yes** to continue. There is no obligation to record the previous stages.
11. Click **OK**.

## *Add Contraindicated immunisations*

You can record that a vaccination or immunisation is contra-indicated, and whether it has parental consent.

1. Click on , or **Summary - Immunisations**. The Immunisations - Summary screen is displayed.
2. To add Contraindicated information: Point to the Contraindicated? Line, right mouse click (it should be headed Immunisation contraindicated) and select **Add**.
3. Check the box Contraindicated on the Immunisation **Contraindicated - Add** screen, and optionally select one of the available Read terms.
4. Enter the vaccination type, e.g. Measles, which is contra-indicated in the free text notes window before you click on **OK**. Any free text is shown on the front screen.




*Example of Immunisation Contraindicated – Add screen*

## *Add Parental Consent*

1. To add a Parental Consent entry – Display the Immunisations Summary .
2. Point to the row Parental Consent, right click and select **Add**.
3. In Read Term, scroll down and choose from the various Read terms of parental consent status. For example:
    - Consent status for immunisation - i.e. no consent, full consent,
    - Immunisation refused
    - Immunisation contra-indicated (C/I)
4. In Type of Consent, choose from <None>, Full consent, partial consent, No consent.
5. Enter any free text notes that will be displayed on the front screen.
6. Click on **OK**.

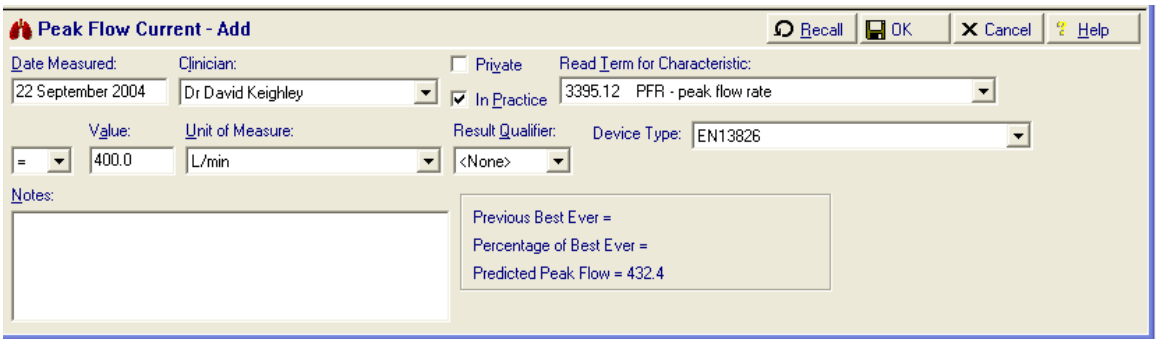
## Add contraception and prescribe oral contraceptive

1. First select the patient and start a consultation.
2. To list the patient's contraceptive entries, From the **List** menu, select **Contraception**.
3. To enter a contraception record, from the **Add** menu, select **Contraception** to display the **Contraception Services - Add** screen.
4. **Service Type** - The default is <None>. Display the other options by clicking on the down arrow and select as required:
    - Either **First Service** if this is the start of treatment for contraceptive services (this was more relevant under Items of Service)
    - Or **Subsequent Service** if there is a previous claim and this is continuation of care.
    - **Service End** - If contraceptive services have ended (e.g. pregnancy, menopause), select Service End.
5. **Service Read term**. Click on and scroll down to choose another more specific Read term, e.g. *614.. 00 Oral Contraception*.
6. **Date Seen -** This defaults to today. If you recording an entry of contraceptive services given by an outside source, block highlight the date then change it (e.g. type –7D for seven days ago).
7. **In Practice:** This box is ticked by default, i.e. contraceptive services provided from your practice under GMS. Untick the box if the services were provided by an outside source.
8. **New Claim Expiry Date** – This is no longer relevant.
9. **Date IUCD Fitted**: Leave blank unless a coil has been fitted, in which case enter the fitting date.
10. **Recall, Notes**: To enter either free text notes and recall dates, click on these respective icons . Note that you may want to record a recall date that may be different from the Claim Expiry date. Recall due dates for contraception are usually displayed alongside existing contraception records, for example, on the Journal tab of the Patient Record.
11. **OK**: Once you are satisfied with your entry, click on **OK**.

## Add Peak Flow Record

1. Select the patient and make sure a consultation is started and the Patient Record displayed.
2. Click on the **Journal** tab.
3. To record a peak flow, display the **Peak Flow Current - Add** screen by typing pfr in Read Term Add, and press Enter for 3395.12 PFR - peak flow rate.

> **Note** - If you type peak flow in step 3, you will enter 3393.11 Peak flow rate normal which leads to the Pulmonary Function Tests - Add screen. The picklist on this screen shows a different selection. This does not shows Predicted Peak Flow, Previous Best Ever or Percentage of Best Ever.




*Peak Flow Current – Add screen*

4. On the Peak Flow Current – Add screen, the default in Read Term for Characteristic is 3395.12 PFR - Peak flow rate Use the  picklist to select another Read term and press Enter.
5. Enter the Device Type - either Wright or EN 13826. This affects the calculation of predicted peak flow.
6. Enter the value into the **Value** field.
7. Click **OK**.

The **Predicted Peak Flow** and **Previous Best Ever** calculations are shown automatically in the bottom left of the **Peak Flow Current – Add** screen, together with the **Percentage of Best Ever**. The calculation of Predicted Peak Flow is dependent on a height record being present, and on selection of the correct Device Type.

Predicted peak flow will NOT be calculated for children under 16.

## Add cholesterol test result

Although most practices receive their pathology results electronically from hospital laboratories, there may be times when you need to enter one manually. You can apply this same method to entering any test result.

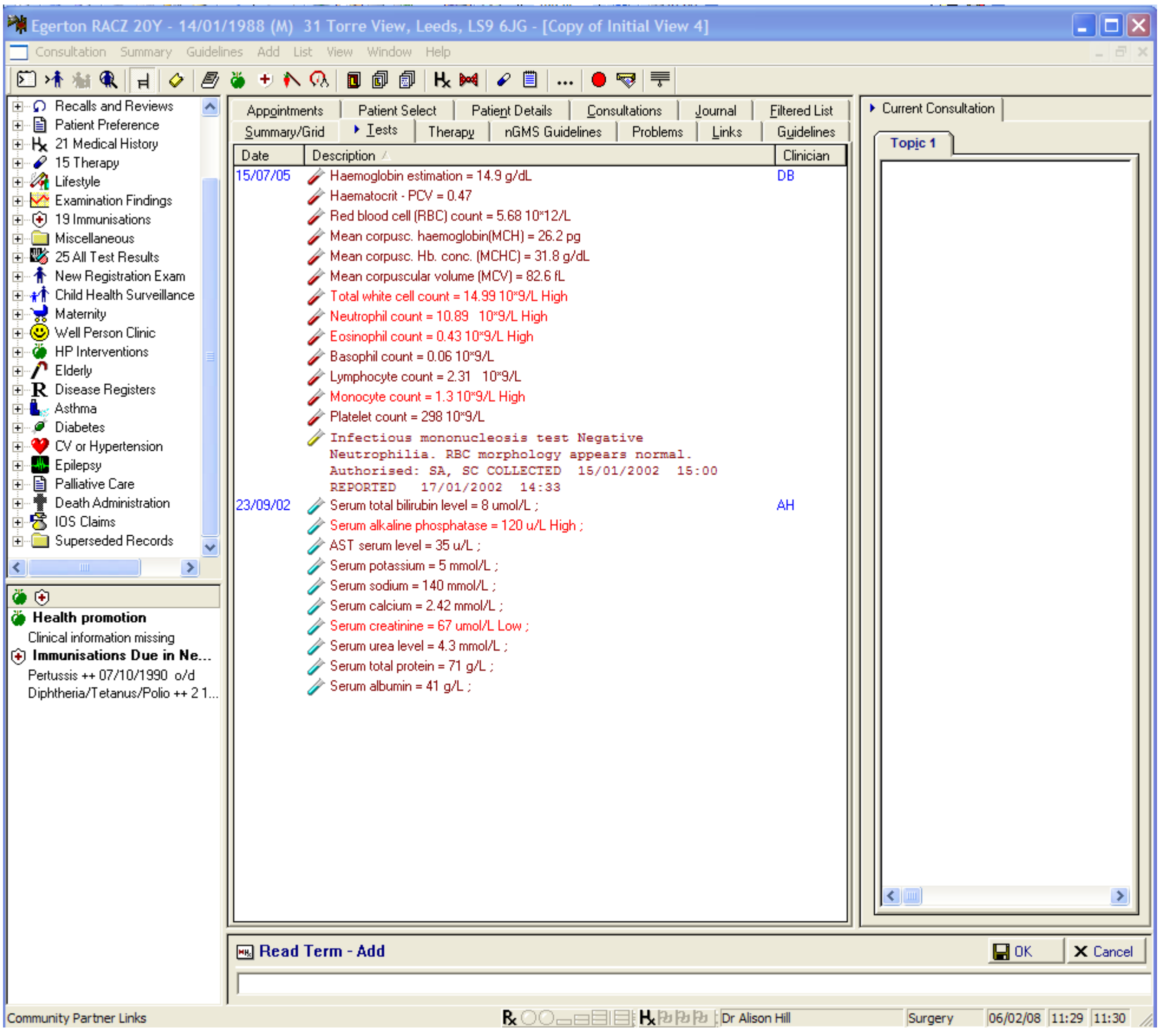
1. First select the patient and start a consultation.
2. Click on **Add** then **Test Results** to bring up a picklist: Diagnostic Imaging, Biochemistry (routine), Biochemistry (Hormones), Biochemistry (Other), Haematology, Microbiology, Serology, Other pathology, Diagnostic Tests.
3. If you are not sure which one to choose, click on **Help - Index**. Go to the **Search** tab and type in **test results** and press Enter. Select **Test results - which forms they appear on** and click on **Display**. Scroll down and you will find an alphabetical list of test results, so, for example, click on C to find cholesterol. Scroll down and look at the final bracketed heading at the end of the entry, e.g. **Cholesterol, serum 44P.. Blood lipids (Biochemistry - Routine).** So the form you want to select in step 2 above is Biochemistry - Routine. Exit from **Help** . Now you know the actual Read code which leads to the Serum Cholesterol - Add screen, you can also use the Adding a Read term (see page 16), entering #44P, instead of the method described below.
4. Having selected the correct form in step 2, go to the correct tab. For cholesterol, this is Biochemistry (Routine) followed by the Blood Lipids tab.
5. Right click while pointing to the **Cholesterol** line and select **Add**.
6. Enter the numerical result in **Value**.
7. Optionally, in **Read Term**, either leave this as 44P Serum cholesterol, or click on  and choose another entry, such as 44P3 Serum cholesterol raised.
8. Optionally, change the **Result Qualifier** from <None> to another, such as High.
9. The other entries are all optional. Click **OK**.
10. A **High Density Lipoproteins - Add** screen is displayed. Click on Cancel.
11. Close the main **Test Results** screen .
12. List all the patient's test results to date by clicking on the **Tests** tab of the Patient Record. See also List test results on page 47.

**Note** - Any results that have the Result Qualifier selected as Abnormal will be shown in red on the test results list.

## List test results

- To list test results, click on the **Tests** tab. Listings are chronological, but by clicking on the column heading of Description, you can resort the test results by type, or by Read code, or alphabetically by Description.
- Test results can also be listed by clicking on the **All Test Results** line on the left-hand navigation pane. All test results are listed under the **Filtered List** tab.
- If you first click on the + by **All Test Results** line, then click on, e.g. **Haematology**, the Filtered List shows only these specific haematology results.

**Note** - Any results that have the Result Qualifier selected as Abnormal will be shown in red on the test results list.

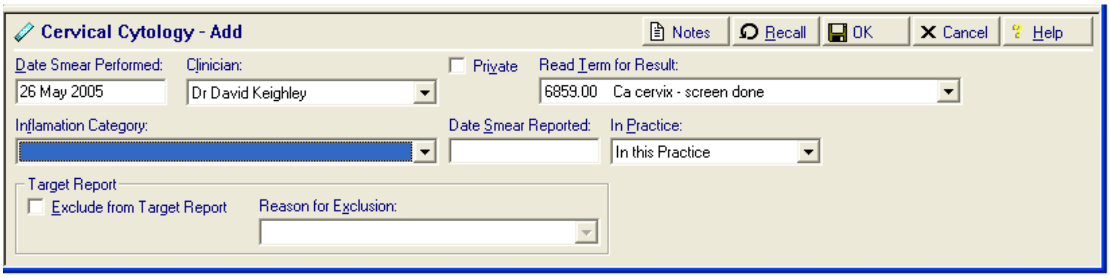



*Consultation Manager – Test tab selected*

## Add cervical cytology

This method first records that you have taken a smear. The idea is that when the result is through a few weeks later, you update this record with the actual result.

1. In **Consultation Manager**, select the patient .
2. Make sure a consultation is started (see page 9).
3. Click on the **Add** menu and select **Cytology**.
4. At the **Cervical Cytology – Add** screen, just press OK UNLESS you want to change the **Date Smear Performed** (defaults to today's date). Usually all the defaults can be accepted as displayed. **For this first smear entry, do not enter a recall record at this stage, or change the Read term**




*Cervical Cytology – Add screen*

## Update an Existing Smear Result when result arrives

1. When the result arrives, select the patient and start a consultation.
2. From the List menu, select Cytology. The topmost entry on a list - Ca cervix screen-no result yet is usually the one to be updated.
3. Right mouse click on this and select **Edit**.
4. Click on in Read Term for Result field. Click on the appropriate result from the displayed picklist. It is advisable to scroll up and choose from the 4K2 options, or if a vault smear, 4KA. This will ensure that searches are reliable and accurate. The following are Read codes acceptable for the nGMS contract:

| | |
|---|---|
| 4K22 Cervical smear: negative | 4K2C Smear NAD - no endocervical cells present |
| 4K22.11 Smear NAD: no endocervical cells | 4KA1 Vaginal vault smear negative |
| 4K23 Cerv.smear: mild dyskaryosis | 4KA3 Vaginal vault smear-atrophic |
| 4K23.11 CIN I - mild dyskaryosis | 4KA4 Vaginal vault smear abnormal |
| 4K24 Cerv.smear: severe dyskaryosis | 6856 Ca cervix screen - up to date |
| 4K24.11 CIN III - severe dyskaryosis | 6859 Ca cervix - screen done |
| 4K25 Cerv.smear:severe dysk.?inv.ca | 685B Ca cervix screen normal |
| 4K26. Cervical smear: ? gland neopl. | 685C Ca cervix screen abnormal |
| 4K27 Cervical smear:atrophic change | 685D Ca cervix screen + fee claim |
| 4K27.11 Atrophic change on cerv.smear | 7E2A2 Papanicolau smear NEC |
| 4K28 Cerv.smear: mod.dyskaryosis | 7E2A3 Vaginal vault smear |
| 4K28.11 CIN II - moderate dyskaryosis | ZV762 [V]Screening for malignant neoplasm of cervix |
| 4K29 Cerv.smear: borderline changes | |

5. If the result shows inflammation, click on  in the **Inflammation Category** field and click on the appropriate entry from the displayed list.
6. In **Date Smear Reported**, you can use the abbreviated date format, T for today's date: press Enter for today's date, or –1D for yesterday, -3D three days ago and so on; or type in a date eg 3.4.04
7. The due date is not generated automatically, so click on 

to record this. The **Recall – Add** screen is displayed:
8. In **Recall Date**, field either in the format 3y (for three years) or 6m (for six months) or as an actual date. Note that if you enter the date in the 3y or 6m format, the actual date will only be displayed when you move to the next field or when you click on the OK button.
9. In **Read Term for Recall Trigger**, this will default to whatever the Read term result is on the front Cervical Cytology Add screen.
10. In **Read Term for Recall Reason**, this again defaults to the same Read code.
11. Click on the 

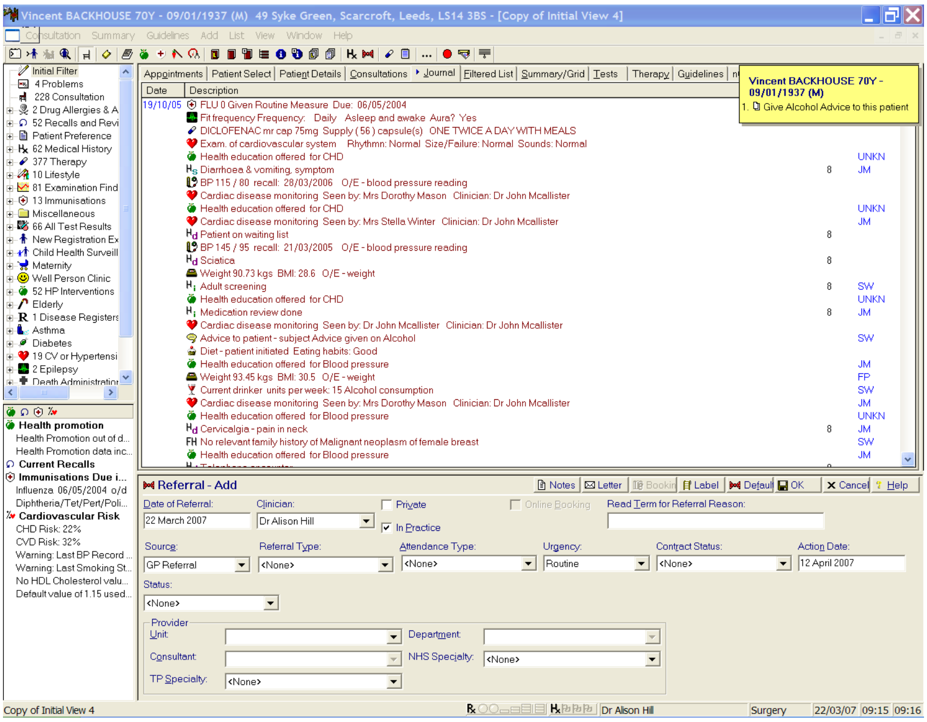
button to accept the recall record. The Recall icon is ticked.
12. Click on the 

button to accept the cytology record.

## Add a Referral

For practices using trial data pre-Go-Live, you should add at least one hospital (see page 61) before adding a referral.

1. Click on the **Referral** icon to display the **Referral Add** screen.
2. **Read Term for Referral Reason** – This is the condition for which the patient needs the referral, e.g. sciatica, dyspepsia.
3. **Referral Type** must be completed to appear in Referral Report. Optionally change: **Source, Attendance Type, Urgency, Contract Status**.
4. **Action Date** defaults to 3 weeks from the referral date so you can keep track of responses. This is the date by which you would expect treatment to have started. You can enter a time period here, for example, 7D for seven days, or 3M for three months, which will act as an offset date. Once a default referral is related to a patient, you can search on Action Dates in Searches, but there is no other action triggered once overdue.
5. Select the **Provider Unit, Department** and **Consultant** – these details will all merge on to the referral letter. The picklist depends on the organisations you have set up in File Maintenance and ticked as Provider Units.
6. Select the relevant **NHS Specialty** and **TP Specialty**.
7. If you want to generate a referral letter, click on the **Letter** icon (you need to have letter templates set up beforehand). Refer to Chapter 23 of the Vision 3 User Guide which explains how to do this.
8. Otherwise, complete the referral by clicking on **OK**.




*Consultation Manager with Referral – Add selected*

## Medical Insurance Report

A template allows Vision users to create a medical report for insurance purposes as a Word document. It automatically extracts data from the Vision database to produce a report that can then be edited.

1. From Consultation Manager, select the patient required, and open an Administration consultation.
2. From the **Add** menu, select Correspondence to display **Clinical Correspondence – Add**.
3. Select **Medical Report** in the Type of Letter field.
4. Under Summary enter Medical Report for Insurance Purposes and the name of the insurance Company requesting the report.
5. Click on the Letter button Letter .
6. Highlight the Insurance_Report.doc from the offered files on Select patient Template to Open and click on **Open**.
7. This will open the Insurance Report, and after a few seconds delay the hourglass will be displayed indicating that the report is been constructed by merging in the patient's data. The cursor shape will return to normal on completion of the report; this may take a while on patients with a lot of data.
8. The report will now need to be edited. Some of the sections in the report have Yes/No printed at the end; one of these will need deleting each time and then further comments added if necessary. The data that is imported from Vision can be edited and deleted as required. To alter text, highlight it and type the required text. To delete unwanted text, right click on the line, select Delete Cells and then Delete entire row. This then does not leave a blank line. To delete several rows, first highlight the rows, right click and select Delete Rows. To delete text, highlight it and use the Delete key.
9. To alter text, highlight it and type the required text. To delete text, highlight it and use the delete key
10. Print the report using the Print button from the top tool bar.
11. When the report is closed, a prompt will appear asking if you want to save changes for this report, for example, Do you want to save the changes to 00473000.CLI? . Remember this is just for this patient's report - it does not affect the template.
12. Click on **Yes** to save the changes made. A red tick will now appear on the Letter button Letter showing a Report has been created.
13. To save the record click on the **OK** button. To cancel the whole process, press the Cancel button.

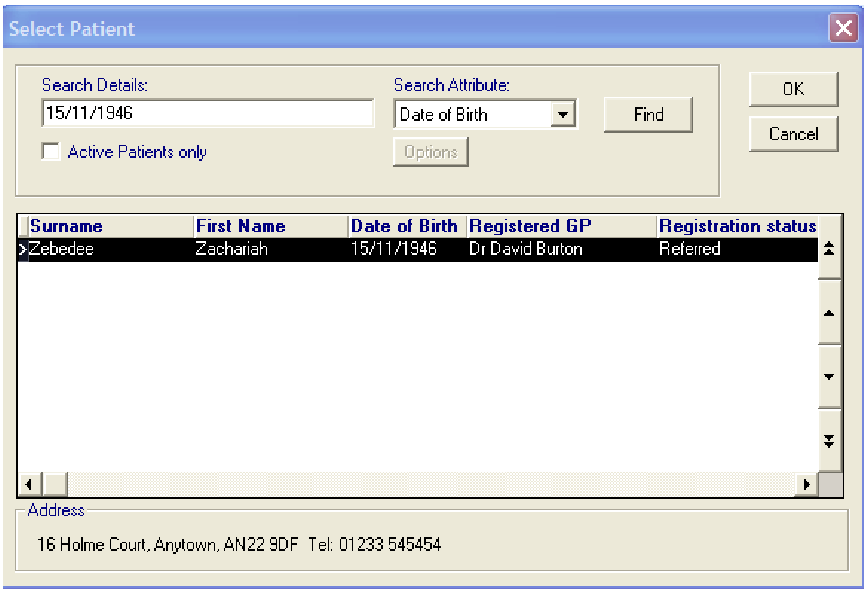
# In Registration


*Vision Front Menu*

## Register a patient

### *First check patient is not already on the patient register*

1. Select **Registration** from the Home menu on the Vision front menu.
2. Before adding a new patient, first check the patient is not already on the register. Click on the Select Patient icon  .
3. At the Select Patient screen, if you can see an Active Patients Only box, make sure that this is not selected.
4. Change the Search Attribute to Date of Birth, then enter the patient's date of birth in the Search Details field, and press Enter.

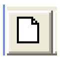


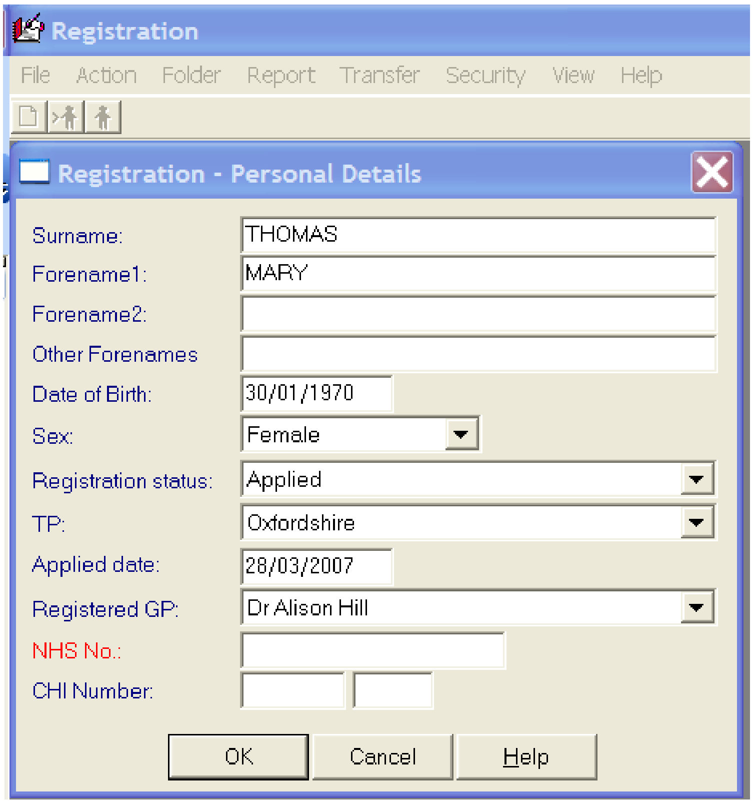

*Select Patient, Active Patient unchecked*

5. If their name does appear on the list, then they are, or were, registered. If registration has expired, re-register them by answering **Yes** to *This patient is no longer active – do you wish to continue?* Then in **Registration**, select **Action – Re-registration** and follow the prompts.

   If the message *A patient could not be found* is displayed, click **OK** to clear the message, and click on **Cancel** to exit from the **Select Patient** screen. Go to step 1 below to register the patient for the first time.

## *Add a new patient*

6. Once you have checked the patient is not already on your patient register, click on the Add Patient icon  to add a patient.
7. At the question: New, Selected or Existing?
   - If you select **Existing**, select another member of the same family in the same household, if you know one exists.
   - If there is no member of the same family to your knowledge, then answer **New**.
   - Select **Selected** if the last patient selected - and at the top of the screen - was a member of the same household – this means you can use the same address lines, and surname, if relevant.

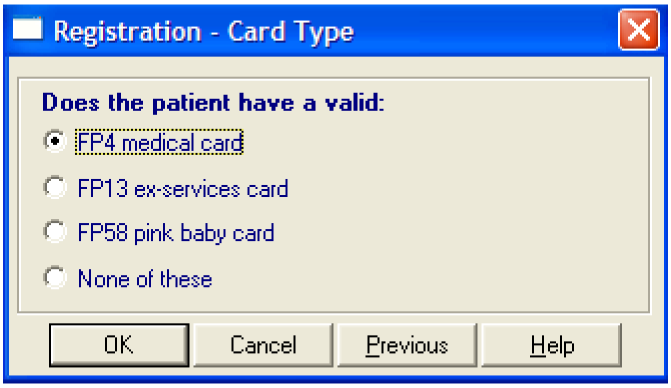



*Registration – Personal Details screen*

8. At the Registration Personal Details screen, the fields in red are mandatory: Surname, Forename, Date of Birth, Sex, TP (the Health Authority you are linked to), Registered GP and NHS No. These must be completed before the screen can be accepted. If you selected a family member before adding some details such as Surname will already be filled in.

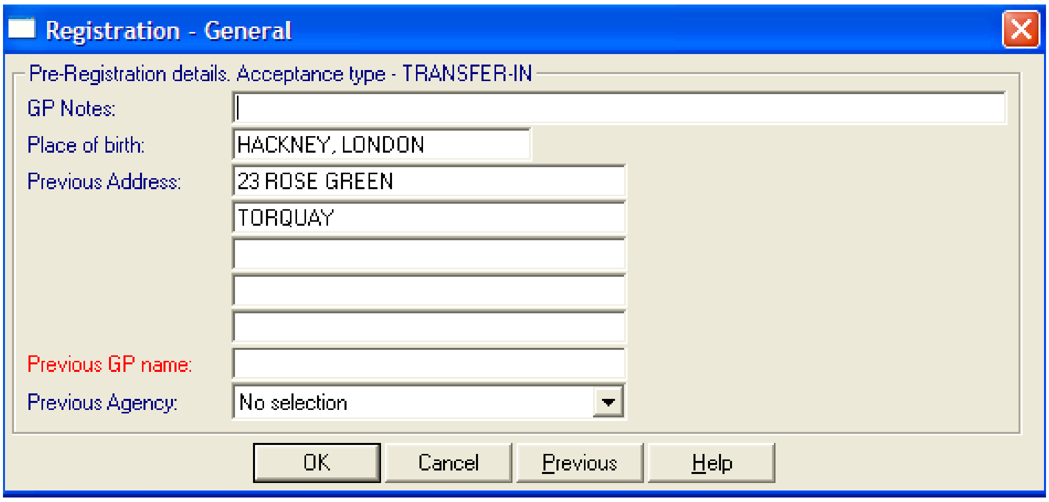
   Use the mouse or the Tab key to move from field to field.

   - **Forename2** and **Other Forenames** can be left blank if not known.
   - **Sex** – type M for male or F for female, Press Tab.
   - **Registration status** – Leave as Applied if this is a straightforward registration of a permanent NHS patient. Otherwise click on  and select appropriately from the picklist, e.g. temporary resident.
   - **TP (HB or CSA)** – Type the first letter of the appropriate Health Authority name, and use the down arrow until the correct one is shown. Press Tab.
   - **Registered GP** – Keep pressing the letter d until the correct GP is shown.
   - **NHS No** – This field is shown in red. Type the number in without spaces if known. It can be left blank for adults in England/Wales if not known, but is mandatory for new babies if you have a pink baby card.
   - When all details are complete, press Enter or click on the **OK** button.




*Registration - Card Type screen*

9. At the Registration Card Type screen, select from FP4 (NHS patient registering with medical card), FP13 ex-services, FP58 (pink baby card - remember, you need to enter the NHS No.), or None of these, e.g. if patient does not have a medical card, or has lost it.

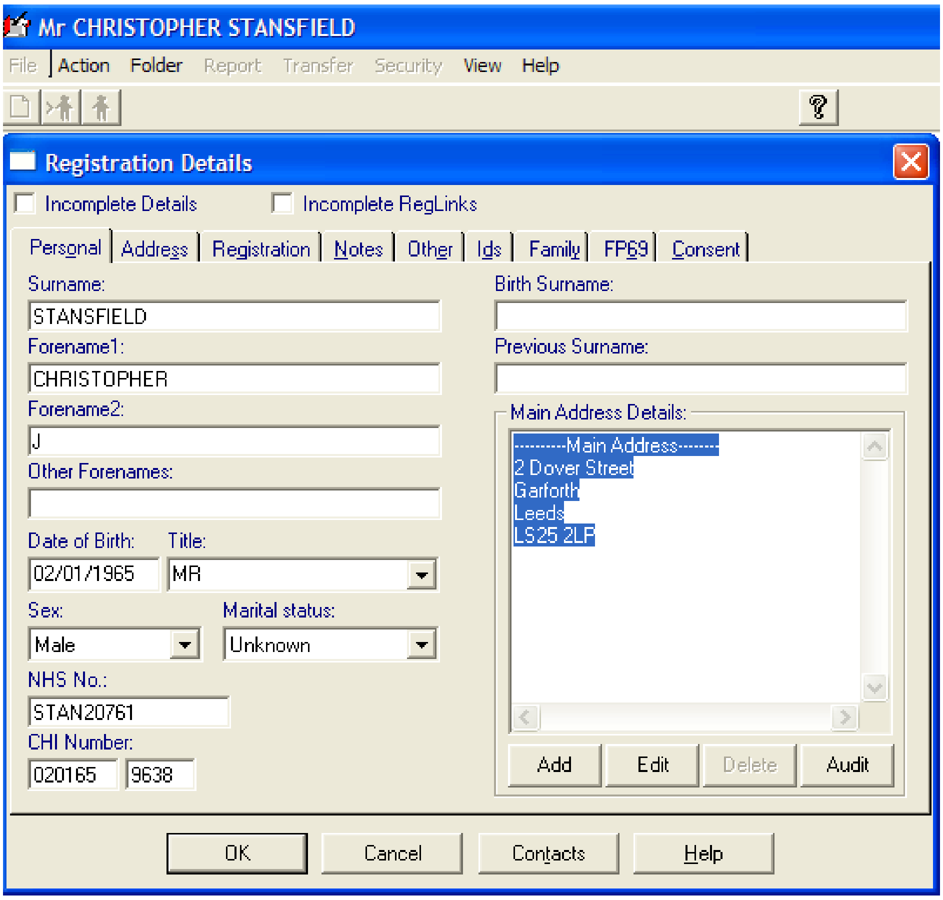



*Registration – General screen*

10. At the Transfer-in screen, if FP4, complete the mandatory fields in red to allow the new registration to go through to the Health Authority. The fields on this screen differ, depending on what Card Type you selected.

**Remember** – Do not press Enter until all details are filled in on the screen. Use the Tab key or the mouse to move from field to field.

## *Personal Details*



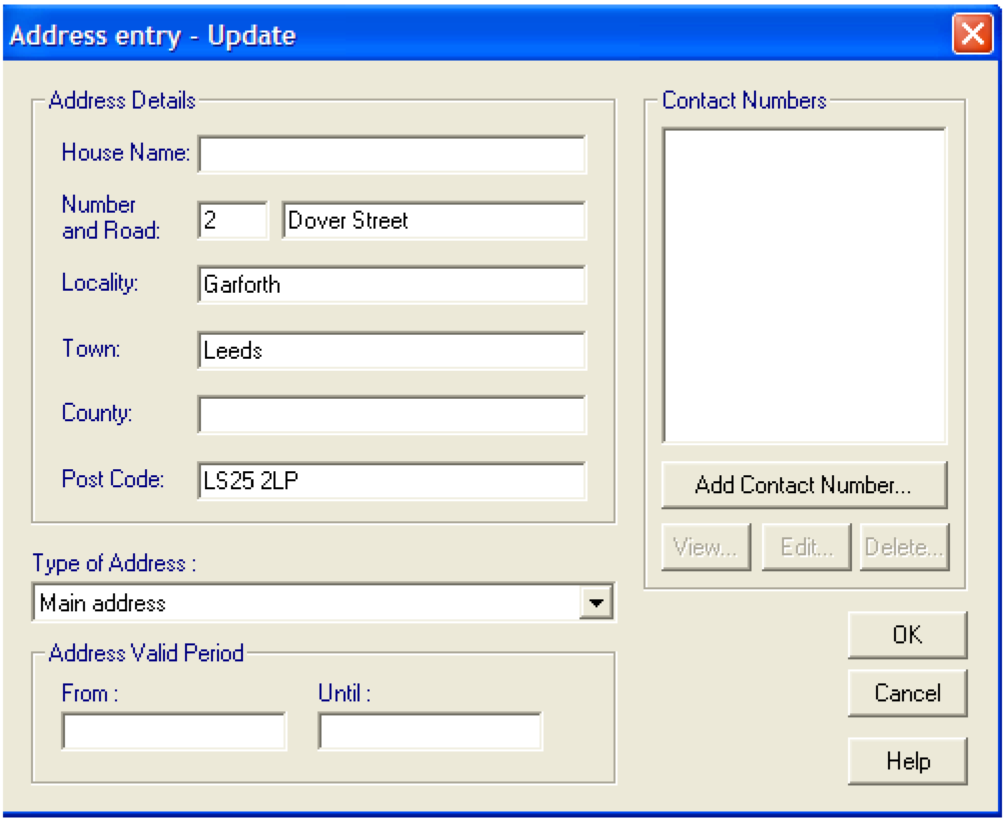

*Example of Registration Details – Personal tab*

11. Registration - Personal: If at this stage you want to go back and change anything on a previous screen, select **Action – Acceptance** which returns through the above screens.
12. If you pre-selected another member of the same family before adding this new patient, the address may already be filled in.

> **Note** - If the address is already filled in, this is the minimum you need to do to register a patient. You can click OK to save the details now and accept that you have entered **Incomplete details**, which can be completed later.

## *Adding an address*

13. To add the main address, when you first reach the main Registration – Personal screen, the focus (cursor) is on the **Add** button beneath the Main Address window, if no main address is present. Just press Enter to go into the Address Add screen.




*Address entry - Update*

14. At the Main Address Add screen, either the House Name or Number and Road must be completed:

- **House Name** – can be left blank, but should include any flat number or name of a property if there is one (eg Flat 1A, or Rose Cottage)
- **Number and Road** – can include the property number and road/street name, e.g. 21 High Street would have 21 in Number, and High Street in Road. If House is blank, Road must be entered, otherwise, Road is optional. If you type the first two or three letters of the road name, and this road has previously been entered for another patient, you may see a scroll arrow  listing roads from which you can select. This inserts the remainder of the address, including the postcode.
- **Town, County** and **Postcode** must be completed. Locality is optional.
- **Postcode** – Make sure the postcode is correct. This may fill in from the road name.
- Click **OK** to confirm the address to enable the Add Contact Number button.

### *Adding contact numbers*

15. Enter the patient's home phone number on **Add Contact Number**. Select Telephone – Home in Type of Contact Number. Click **OK**. Further numbers can be added from the Address tab.

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**Note** - The home telephone number added on the Main Address entry screen (Contact Number – Add) is attached to the address. Personal contact numbers (mobiles etc) can be added from the Address tab under Contact Nos and are attached to the patient's record.

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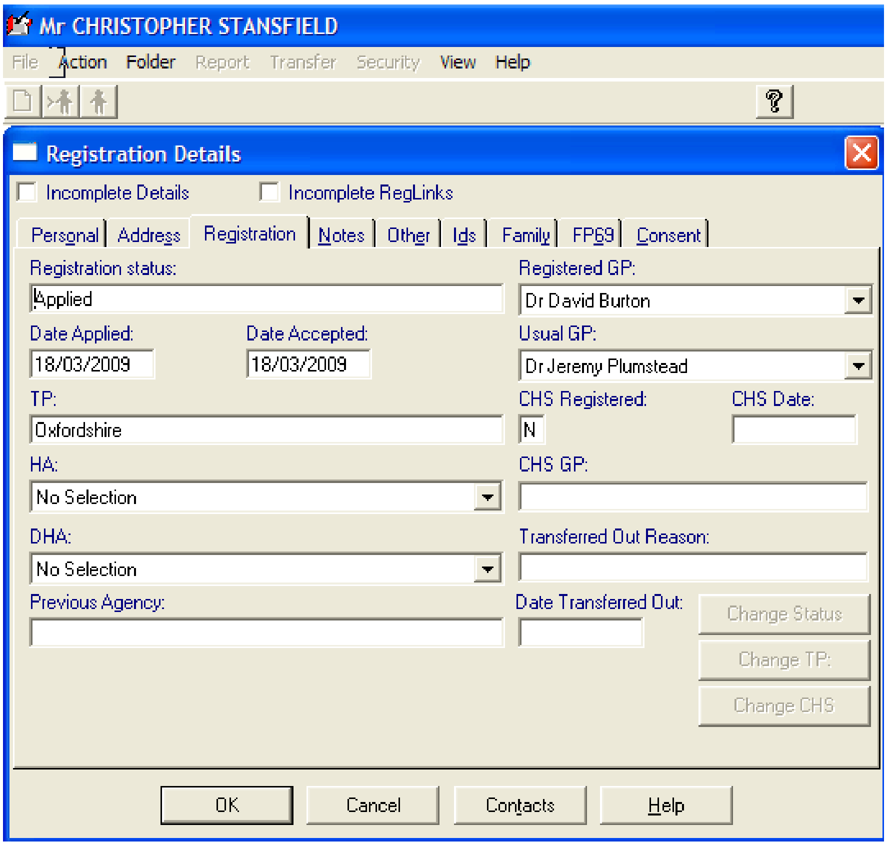
Click on **Close** on the Address entry screen to exit back to the patient's Registration details.

### *Registration details*




*Example of Registration Details*

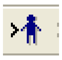
16. On the Registration tab, select the Usual GP if different from the Registered GP.
17. If you know you can claim rural mileage for this patient, click on the Other tab and enter a figure in RPP Mileage.
18. Check the Dispensing box if the patient will be a dispensing patient.

### *Saving the Registration record*

19. If the field ☑ Incomplete RegLinks at the top of the screen is checked, some details are missing. Click back through the tabs for a red mandatory field, such as the Main Address, which has not been completed. Try and enter that if possible. You can also select Action - Aceptance to check for other missing details.
20. If you see ☑ Incomplete Details, this usually indicates that the NHS number is missing. Note that this is not mandatory at this stage (except for new babies) but should be completed if known.
21. To save the new registration, click on the OK button. You will be warned if the patient has incomplete details. If possible answer No and enter the missing details. Otherwise complete these at a later time.
22. If the registration is complete, Registration Links practices will generate an Acceptance Transaction to the HA. The Registration screen of the newly added permanent patient remains “frozen” and cannot be amended until approval is sent electronically by the HA in a few days. In the meantime, if you try to edit this patient’s record, you will be unable to as it is view only.

## Change a patient's address

### *Single patient is moving address a changing phone number, but staying with the practice, the same GP and the same HA*

1. In Registration, click on the Select Patient icon  and select the patient who is changing address.
2. On the Personal tab, click on the **Edit** button under Main Address Details.
3. Make the amendments necessary on this screen and click **OK**.
4. If the home telephone number has changed as well, click on the phone number by Home under contact Numbers on the right-hand pane.
5. Select **Edit** under Add Contact Number.
6. On the Communication Numbers - Update screen, make the amendment.
7. Click **OK**.
8. Click **OK** from Address entry - Update.
9. Click **OK** on the main Registration screen.

### *The whole family is moving within the practice area*

If one member in a household has details amended for the address, phone number, rural mileage, dispensing and capitation, using **Amend Household** you can automatically update details of the other patients within the same household to match these, without having to type each in.

1. In Registration, click on  and select one member of the family who is changing address.

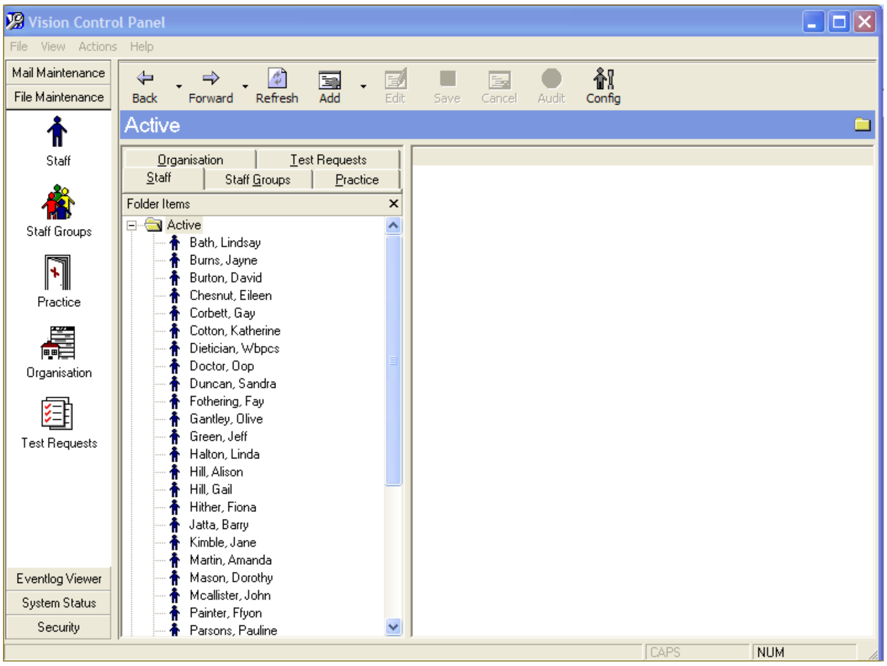
2. On the Personal tab, click on **Edit** under Main Address Details and amend their address.
3. If the home telephone number has changed as well, click on the phone number by Home under contact Numbers on the right-hand pane.
4. Select **Edit** under Add Contact Number.
5. On the Communication Numbers - Update screen, amend and click **OK**.
6. Click **OK** from Address entry - Update.
7. Select the Registration - Family Details screen of the patient. The selected patient is marked in the left margin =>.
8. Then highlight all (or a selection) of the other patients within the household who are moving to that address by clicking on each patient name.
9. Click on **Amend Household**.
10. This will amend the household details of the selected patients to match those of the patient you selected - Registered address and any phone numbers associated with this address, dispensing status, capitation supplement, walking units, blocked/special route marker, rural mileage, DHA and HA.
11. Click on **OK** to start the amendment (or Cancel to abandon).

# Add a Hospital in File Maintenance

Add any NHS Trusts, hospitals and other local medical services or clinics to which you might make a referral. In addition, include their departments (e.g. ENT) and consultants (e.g. Dr Smith). If they have Provider Unit ticked, this will then provide a picklist on the Referrals-Add screen in **Consultation Manager**. In Registration, you can also record a patient's hospital number.

1. Select **Control Panel** from Management Tools on the Vision front menu.

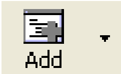

*Vision Front Menu with Management Tools selected*

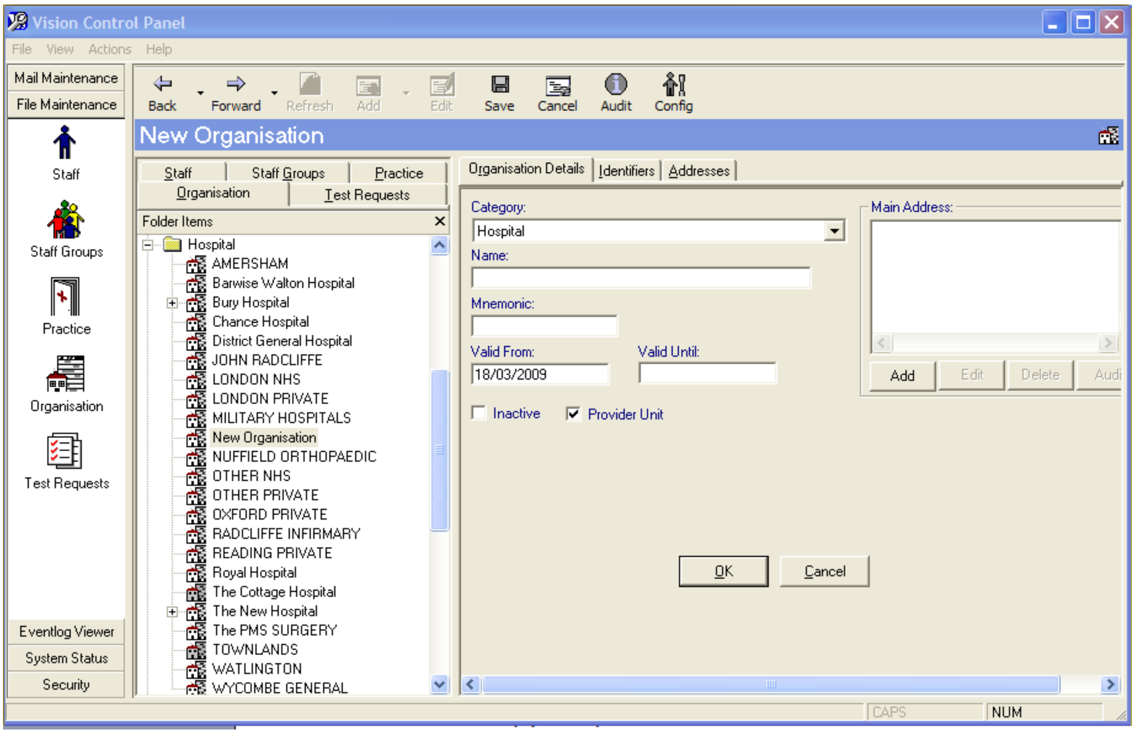


*Control Panel*

2. Then select **File Maintenance**.

3. Click on the **Organisation** icon  to list existing organisations.

4. To add a hospital, click on the yellow folder by either **NHS Trust** or **Hospital** on the list of organisations so that it is opened , then click on the **Add** icon .




*Control Panel – File Maintenance – Hospital expanded*

## Organisation Details

5. Make sure **Category** has either **NHS Trust** or **Hospital** selected.

6. **Name** - Type in the full name of the NHS Trust or hospital e.g. Bedford Hospital NHS Trust.

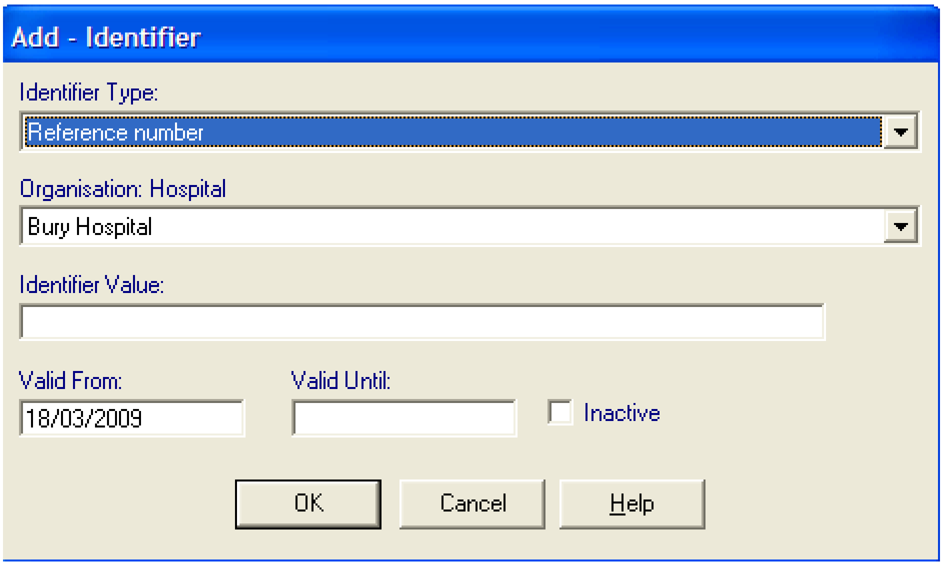
7. **Mnemonic** - A short name, up to 5 characters, which has to be unique, and which refers to the organisation, for example, BEDFO for the above NHS Trust.

8. **Provider Unit -** Make sure this box is ticked so the hospital or NHS Trust appears on the picklist in Referrals in **Consultation Manager**.

## Identifiers (optional)

9. Enter an organisation code for the hospital in **Identifiers**. (Practices using trial data can skip this step if they do not know the hospital code). Click on the **Identifiers** tab.

10. Click on **Add**.
11. At the **Add - Identifier** screen:
    - **Reference Number** - Select either Reference number for a hospital, or NHS Trust Code if a NHS Trust, or non-NHS Trust code.
    - **Organisation** - Disabled if you picked NHS Trust code in Reference Number, but enabled for you to select the hospital from the picklist.
    - **Identifier Value** - Enter a Reference number of the organisation code. For NHS Trusts, for example, eg RC1.
    - Click **OK**.




*Add – Identifier screen*

### *Address and Contact Numbers*

12. From the **Organisational Details** tab, click on **Add** under **Main Address**. Use the Tab key to move from field to field (or Shift-Tab to move to a previous entry).
13. In **Road**, type the first two letters of the road then click on  for a picklist of roads already in Vision. If none, then just type the road name in free text.
14. The **Town** field must be filled.
15. **Postcode** is the usual postcode format, up to 8 characters. Leave the **Type of Address** defaulting to Main address.
16. Click **OK** when you have entered the address which then enables **Add Contact Number**.
17. Click on **Add Contact Number**. Type in the contact number, and then select the Type of Contact Number - Telephone Business. Click **OK**.
18. Click **Close** to return to the front **Organisation Details** screen.

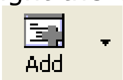
### *Save Details*

19. Click **OK** to save the details. This completes adding the NHS Trust or Hospital.
20. Now go on and add the departments and consultants that you may make referrals to.

## Add Department to a Hospital

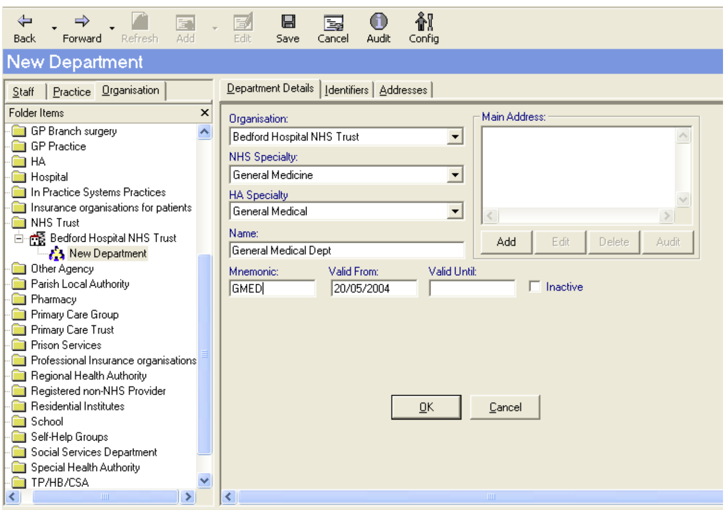
Departments can be added within each Organisation and these departments can then have staff (Person) such as consultants attached to them. This is particularly relevant if hospitals have been entered as *Organisations* in order to record referrals:

1. In Control Panel, select **File Maintenance**.
2. Click on 

 or the Organisation tab to list existing organisations.
3. Under NHS Trust or Hospital, click on  to expand the list beneath, and highlight the line to which you want to add departments, then click on the Add icon 


### *Department Details*

4. On the new **Department** screen, the **Organisation** is filled in automatically.
5. **NHS Speciality** - Select from the picklist.
6. **HA Speciality** - Select from the official list of 17 specialties, shorter than the NHS Speciality list and used for Referral Report purposes.
7. **Name** - Enter the name of the department in free text, for example, Cardiology Dept. Keep the Department names consistent because they are listed alphabetically on Referral Add in **Consultation Manager**, i.e. do not sometimes use Department of Cardiology, Dept of Cardiology, Dept. of Cardiology.
8. **Mnemonic** - This is a mandatory and unique entry, up to 5 characters, for example CARD (for cardiology).
9. **Valid From** - Optionally, enter a date as the start date of the association of the Department with the practice. Leave blank Valid Until.




*Control Panel – File Maintenance – Organisations – Hospital – Department*

### *Address and Contact Numbers (optional)*

10. From the Organisational Details tab, click on **Add** under Main Address.
11. Enter free text on the **Address entry - Add** screen. The **Town** field must be filled. Use the Tab key to move from field to field (or Shift-Tab to move to a previous entry). **Postcode** is up to 8 characters including the space following a valid postcode format. **Type of Address** defaults to Main address.
12. Click **OK** when you have entered the address. This then enables **Add Contact Number**.
13. Click on **Add Contact Number**. First type in the contact number, then select the **Type of Contact Number** - **Telephone Business**. Click **OK**.
14. Click **Close** to return to the front **Organisation Details** screen.

### *Identifiers*

15. Click on the **Identifiers** tab.
16. **Identifier Type** - The two options are **Mail Manager – Related Department** and **Mail Manager - Hospital Department**. Any hospital department relaying electronic pathology results (eg Haematology, Chemical Pathology) should have the correct Identifier type and Identifier Value. These appear on pathology messages, in order for these messages to match up. You may need to contact the path. Lab to find out what these codes are
17. **Organisation** – This should default to the organisation that the department belongs to.
18. **Identifier Value** - Enter here the actual reference number, or code, which can be alphanumeric.
19. **Valid From and Valid To dates** - Optional dates for a date range that this reference number is valid. Leave blank if required.
20. **Inactive** - Only check this box if the currently displayed identifier is inactive.
21. Click on **OK** to save the entry.

### *Save details*

22. Click **OK** on the main **Department Details** screen.
23. This completes adding the department to an NHS Trust or Hospital.
24. Now go on and add the further departments for that NHS Trust or Hospital.
25. You can then add consultants or other staff within that department that you may make referrals to.

## Add a Consultant to a Hospital Department

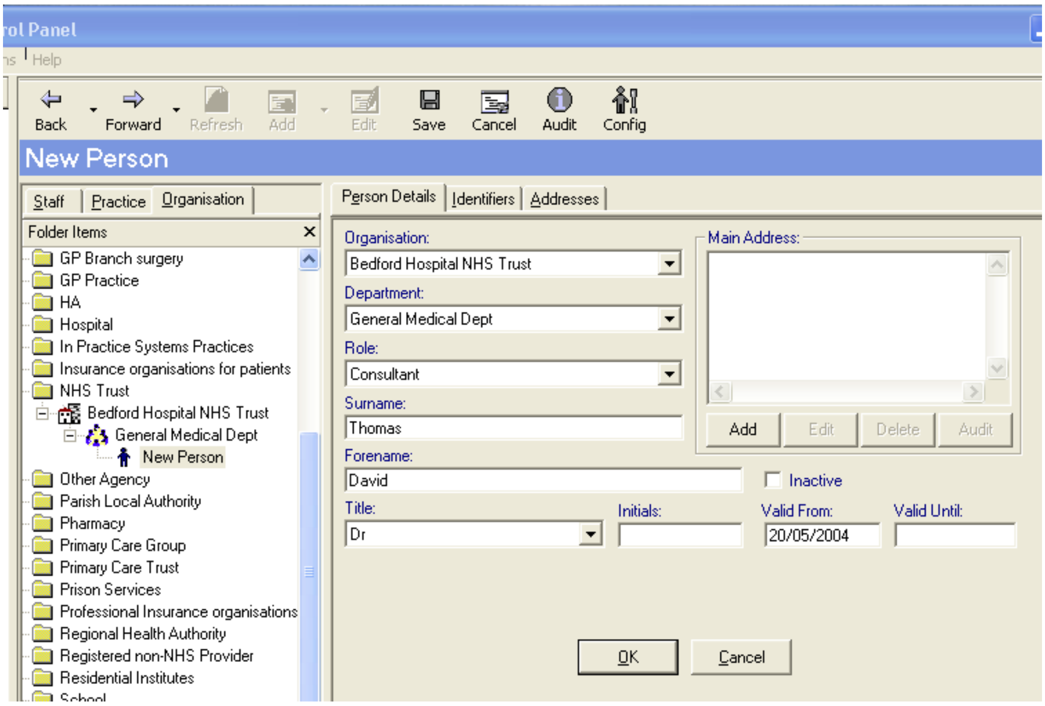
You can enter a consultant attached to a hospital department. This means that referral letters can be personalised.

1. In **Control Panel**, select **File Maintenance** and click on the Organisation icon 


2. Add a consultant (person) to a department by first clicking on  to expand the list under NHS Trust or Hospital, and then their departments. Highlight the department to which you want to add a consultant. Right click and select **Add Person**.

### *Person Details*

3. The **Organisation** and **Department** are filled in automatically if you are adding a consultant to a department.
4. **Role** - Pick **Consultant** for a hospital consultant so the name can be merged in a referral letter.
5. **Surname, Forename**, and **Title** - All three fields can be merged into a referral letter.
6. **Initials** are mandatory and are used as an identifier.




*Control Panel – File Maintenance – Organisations – Hospitals – Departments – New Person screen*

### *Address and Contact Numbers (Optional)*

7. Click on **Add** under **Main Address**.
8. Enter free text on the Address entry - Add screen. The Town field must be filled. Use the Tab key to move from field to field (or Shift-Tab to move back). **Type of Address** defaults to Main address.
9. Click **OK** when you have entered the address. This then enables **Add Contact Number**.
10. Click on **Add Contact Number**. Type in the contact number, and then select the Type of contact number - Telephone Business. Click **OK**.
11. Click Close to return to the front **Organisation Details** screen.

### *Identifiers (Optional)*

12. Click on the **Identifiers** tab, and click on **Add**.
13. In **Identifier Type**, select **Consultant Code** (or if a nurse, their NMC Pin). In Identifier Value, type in the code - the consultant code is 8 characters, six numeric characters (their GMC code) with the addition of the C prefix and a last check digit. It can used as a merge field on referral letters.
14. Click **OK**.
15. Click back on the **Person Details** tab and click on **OK**.

# Appointments

This section is primarily for those practices looking at their trial data prior to the Vision Go-Live day. It should help you familiarise yourself with the setting up of the Appointments system, and the way to book appointments. Remember that anything you do on trial data will not be saved or converted to your live system.

To set up Appointments you need to be a System Administrator with full system rights, this is set up in **Control Panel – File Maintenance** (see User Guide 04 Control Panel)

## Set up Appointments

### *Set up Owners*

Owners are staff, including GPs, nurses and any other staff or clinics who will be booked using Appointments.

1. From the main Vision menu, select **Appointments**.
2. Select **Book Owners** from the **Maintenance** menu.
3. Click on **Add Staff**.
4. Click to highlight a member of staff. Any staff on this picklist must already be set up in Control Panel - File Maintenance - Staff.
5. No. of weeks ahead - Type in 12 (i.e. 3 months). This is the number of weeks ahead that the appointment book will be made up with appointments slots for this owner. The maximum 80 weeks is allowed but in reality, you would probably choose 12 - 16 weeks.
6. Click on **OK**.
7. Click on **Add Clinic**.
8. Type in a description, for example, Minor Surgery.
9. Alias - type in up to four characters that describe the clinic, e.g. MSUR. This cannot be edited later.
10. In Number of weeks ahead, type 12.
11. Click on **OK**.

### *Set up Slots*

You can have different sorts of appointment slots in an appointment book - ordinary slots, emergency slots, book only 24 hours in advance etc.

1. Click on **Plan - Slot Type**.
2. Click on **Add**.
3. Description - Type in a description, for example, Emergency.
4. Warning Message - Press Tab to move to Warning Message. Type in a suitable reason, for example: Book only on the day.
5. Number of days that slot can be booked prior to the appointment date: 0

6. Colour - To assign a colour to this Slot Type on the appointment page, click on the colour window to display a palette of colours. Click on a red colour to signify emergency slots and click on **OK**.
7. Click on **Ad**d to add another slot type.
8. Add another slot called 24 hours. Warning message: Book only the day before, and Number of days that slot can be booked prior to the appointment date: 1. Click **OK.**
9. Click on **Add** to add another slot type.
10. Add another slot called Minor surgery. Warning message: Minor surgery only and Number of days that slot can be booked prior to the appointment date: 30. Click **OK**.
11. Click **Close**.

### *Set up a Session type*

Sessions are the surgeries or clinics, made up of appointment slots. Session types are the sorts of sessions, such as morning surgery, evening surgery.

1. Click on **Plan - Session Type**.
2. Click on **Add**.
3. **Description** - Type in Morning surgery.
4. Make sure Clinical is ticked. A clinical session type means that patients can be selected from the patient register and booked into this session.
5. Click on **Add**.
6. **Description** - Type in Evening surgery.
7. Make sure **Clinical** is ticked.
8. Click **Close**.

### *Add a new session and its slots*

A session is a definition of a period of time - for example, 120 minutes - which describes an appointment book session, and includes the way appointment slots within that session are arranged, for example, in ten minute slots. For example: Dr A has a session type of Morning Surgery, duration 120 minutes, start time 0900, with ten minute appointment slots.

The following instructions will add three sessions: morning surgery, evening surgery and a minor surgery session.

1. Select **Plan - New Session***.*
2. **Type**: Click on  and choose morning surgery from the list of Session Types*.*
3. **Owner**: Click on  and choose from the list of Owners.
4. **Description**: Enter a description of this new session, e.g. Dr DK AM surgery
5. **Default Start**: Type in, e.g., 0900 as the time this session begins. Use the 24 hours clock, e.g. 0900
6. **Duration**: Enter in minutes the time the surgery usually lasts, e.g. 120 minutes.

7. **Slots per hour** – Click on and select the number of appointment slots there should be per hour. For example, 6 slots per hour would mean six 10-minute appointments.
8. Active is selected, by default, and assumes that this format of session is currently in use.
9. You can optionally choose a colour for your session header. Click on the colour bar to display a palette and select a colour.
10. There is a choice of Black or White for the Text Colour. This is the text that appears on the session header, for example, black text shows up better against a yellow session header.
11. Click on **Distribute Slots**. You can define how the appointment slots and blanks are arranged during the session, either automatically or customised.
12. Click on in Slot Type at the top right to display the options and select Emergency.
    - Move your cursor over to the list of appointment slots on the left-hand side. The cursor changes to a thick white cross.
    - Then just click on each appointment time you want to define as this special slot type, for example, the last appointment of the session if it is an emergency slot. The time slot will be updated in the colour defined for the special slot type and the description of the slot type will be displayed.
13. Repeat step 11 for the **24 hours** slot type, moving that into one of the slots on the appointments session.
14. Click **OK**, then **OK** again at the Define Session screen. This completes adding the morning surgery session.
15. Reselect **Plan - New Session**
16. **Type**: Click on and choose **evening surgery** from the list of Session Types.
17. **Owner**: Click on and choose from the list of Owners.
18. **Description**: Enter a description of this new session, e.g. Dr DK PM surgery
19. **Default Start**: Type in, e.g., 1600 as the time this session begins.
20. **Duration**: Enter in minutes the time the surgery usually lasts, e.g. 90 minutes.
21. **Slots per hour:** Click on and select the number of appointment slots there should be per hour. For example, 8 slots per hour would mean eight 7.5-minute appointments per hour.
22. If you want to choose a colour, repeat steps 9 and 10 above.
23. Click on **Distribute Slots**.
24. Click on **Arrange** then **Yes** to the message that is displayed. This puts blanks in at regular intervals throughout the session.
25. Click on in **Slot Type** at the top right to display the options and select **Emergency** as in step 10 above.
26. Repeat the Slot Type insertion for **24 hour**.

27. Click **OK**, then **OK** again at the Define Session screen. This completes adding the evening surgery session.
28. Reselect **Plan - New Session**
29. **Type**: Click on and choose **morning surgery** from the list of Session Types.
30. **Owner**: Click on and choose from the list of Owners.
31. **Description**: Enter a description of this new session, e.g. Minor Surgery
32. **Default Start**: Type in, e.g., 1000 as the time this session begins.
33. **Duration**: Enter in minutes the time the surgery usually lasts, e.g. 90 minutes.
34. **Slots per hour:** Click on and select the number of appointment slots there should be per hour. For example, 2 slots per hour would mean two 30-minute appointments per hour.
35. If you want to choose a colour, repeat steps 9 and 10 above.
36. Click on **Distribute Slots**.
37. Click on in **Slot Type** at the top right to display the options and select Minor Surgery as in step 10 above.
38. Click on **OK**.

### *Set up a Personal Plan*

You can now start building up the appointments book. From Personal Plan, a Monday-Friday plan is displayed. Choose the owner (GP or staff), and add the sessions to make up that owner's plan for a working week.

1. Select **File - Open - Personal Plan** or click on.
2. Click on in the box on the top right to display the Owners and select an owner.
3. Session List: Click on, the Session List icon.
4. Click on **All** by the Owner box in the Add Session to Plan window. This now displays all the sessions you have added. You can add sessions set up for one owner to another owner's appointment book, as long as the Session Description, Start Time, Duration and slot distribution of the session is the same for both owners.
5. Add a session to a weekday: Click on one of the sessions, e.g., morning surgery, holding the left mouse button down, and drag the mouse to the square on the plan, (the icon changes to a suitcase), for example, the first cell under Monday. Release the mouse button at the square. Click **OK** at the Confirm Details screen (though you can vary the Start time if you want). The session will now be displayed in the plan square.
6. If this same owner has a similar morning surgery on Tuesday, Wednesday, Thursday and Friday, you can copy the Monday morning session - hold the Control key down, hold down the left mouse button, and drag the mouse to the next cell and release the left mouse and the Control key.
7. Remove Session: If you want to remove a session, click on the session, and then click on the Remove button at the bottom of the screen. *Are you sure*

*you want to remove the [session name] from the plan?* Confirm the removal with Yes

**Note -** Sessions do not have to be added in chronological order; because they will automatically adjust themselves according to the start time. So you can drop an earlier session on top of another, and the later session will move down a square.

8. Continue to drag other sessions from the session list: for example, this owner has evening surgery on Monday Tuesday, Thursday and Friday. He also has a minor surgery session on Wednesday.
9. Click on  to clear the Session List.
10. Click **OK**.

### *Extend Books*

Extend Books is used to generate Appointment Slots, i.e. how far ahead appointments are available for booking in each owner's appointment book. You will need to run this weekly to create the future appointment slots.

1. Select **Books - Extend Books**.
2. Answer **Yes** to the message: *You cannot extend books unless all forms have been closed. Do you want all forms to be closed? Yes/No.* Although you can run Extend Books while other users are using the system, the Extend Books process will take longer, and others may find the system is slowed.
3. Once the Extend Books screen is displayed, click on **All Books** to select all the owners.
4. Click on **Extend**. The Appointment Slot Generator will be displayed briefly, showing progress of each selected book.

## Making Appointments

There are two views of the appointments book:

- The **Reception View** shows appointments by weekday, for several owners at a time.
- The **Book View** shows appointments for a single owner (a GP, nurse or clinic) at a time, giving a much wider detailed view of each appointment, its duration, status and any comment. There is a column - Notes - to show if the records have been pulled from the shelf.

### *Make an appointment today*

1. Select **File - Open - Book**.
2. Click on  in the window to the right of the weekday tabs and select the owner, e.g. Dr DK. You should see an appointments book with appointments slots for today's date, with the correct weekday tab is selected.
3. Click on the **All Day** button if you want to see the whole day, am and pm session together. Otherwise click on AM or PM for the morning or afternoon session.

4. Bearing in mind that you cannot make an appointment in the past, double click on an appointment slot.
5. At the Select Patient screen, select a patient (see page 8).
6. On the Appointment Booking Form, you can optionally add free text in Comments for extra information about the appointment: e.g., Blood pressure check.
7. Click **OK**. The appointment slot is filled with the patient's name.

### *Make an appointment tomorrow*

1. Select **File - Open - Book**.
2. Click on  in the window to the right of the weekday tabs and select the owner, e.g. SYS.
3. Click on the weekday tab after today, for example, if today is Monday, click on the Tuesday tab.
4. Double click on an appointment slot.
5. At the Select Patient screen, select a patient.
6. On the Appointment Booking Form, you can optionally add free text in Comments for extra information about the appointment: e.g., Blood pressure check.
7. Click **OK**. The appointment slot is filled with the patient's name.
8. Click on the **Today** button to return to today's appointments.

### *Make an appointment in the future using the calendar*

1. Select **File - Open - Book**.
2. Click on  in the window to the right of the weekday tabs and select the owner, e.g. SYS.
3. Click in the date window at the extreme bottom left of the Book view to bring up a calendar.
4. Highlight the date you want and click **OK**.
5. This moves the appointments book on to that date.
6. Double click on an appointment slot, and select the patient for the appointment.
7. Click **OK** on the Appointment Booking Form.
8. Click on the **Today** button to return to today's appointments.

## *Find a specific appointment slot using Search Slots*

You can search for a specific appointment slot for any owner.

1. Select **Specific Slots** from the Search menu.
2. **Who**: Either click in the All Staff box if you want to search all appointment books; or click to highlight each owner - GP, staff or clinic - you want to include in the search.
3. **Day**: Leave the tick in Any for all days. You can also highlight one or more of the required weekdays to include in the search - to select specific days, hold the Control key down and click on the days you want to choose.
4. **Slot Type**: Leave the tick in Any for all Slot Types.
5. **Start From Today**: You can specify a day by time period to start the search list from that date, if for example, the appointment is to be in 2 weeks' time, click on  in the Weeks box and select 2. Note you can only search as far as the appointment book is made up.
6. **Session Type**: Either leave the tick in Any to select all session types, or specify one session type. For example, tick the Minor Surgery session.
7. **Duration** - Leave the tick in Any.
    - If you would like to specify an **End Date**, tick the Stop Search After box and fill in the date you do not want to search past. Use dd/mm/yyyy for date.
8. Click on **Search** to start the search.
9. As the list starts appearing on the Free Slots screen, you can click on the Stop Search button if you see the appointment slot you want. You do not have to wait until the search has finished.
10. Double click on the appointment slot you want or single click and click on **Book**.
11. Select the patient.
12. The Appointment Booking Form is displayed. Click on **OK**.
13. A confirmation screen is shown of the patient's name, the appointment time, day and date and GP. Click on OK. The patient's appointment has been automatically inserted in the correct session, but the page will remain at today's date.
14. Click on **Close** on the Free Slots screen.

## *Cancel an appointment*

1. From either the **Reception** or **Book** View, select the appointment session by the relevant GP, staff or clinic, and the required date.
2. **To cancel a single booking:** Click on the appointment slot so that its frame become emboldened.
3. Click on **Appointments - Cancel Booking**.
4. You will be warned if you try and cancel an appointment in the past, though you may continue with **Yes**.
5. On the **Confirm Cancellation and Select Reason** screen, click to select a cancellation reason from the displayed list, and click on **OK**. A default cancel

reason can be set up in **Maintenance - System Constants** but can be overridden at this point.

6. Note that if you do not select a cancellation reason, and use **Cancel** on the **Confirm Cancellation** and **Select Reason** screen, you will warned: *If you don't select a reason, the appointment will not be cancelled. Do you want to continue? Yes/No.*

# Exit from Vision front menu

On the Modules menu, there is a Close All Modules option that shuts down all open Vision modules.

> **Important** - You need to ensure that all users are properly signed out of Vision every night. INPS records show that on average, 15-20% of sites fail to sign all users out. This prevents practices from receiving updates through Download Manager and will stop the overnight re-index running. Please ensure all of your users know of the need to properly sign out of Vision and close down their workstations every night. It will also result in an invalid backup.

**Please**:

- Don't leave a patient record up on screen if you leave the workstation. Other Vision users can only view details for that patient while you are editing it. Note that a screensaver will be triggered after a certain period of time, or can be invoked with Ctrl-Alt-F12.
- You must log out of Vision when you are not using it, both for security reasons and in order for the daily backup to complete cleanly.

**Close each Vision module down when you have finished and return to the Vision Front menu**:

- Click on the  at the top right of the screen;
- or click on *File*, then *Exit;*
- In **Consultation Manager**, click on Consultation, and then click on **Exit Consultation Manager**.
- In Patient Groups, click on **Group**, and then **Exit.**

To exit from **Vision Front** menu, click on the top left exit ; or select **Modules – Exit**.

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