Institute of IT Training
Gold Standard
Accredited Training Department

Patient Administration System

PMI (Patient Master Index) & Healthcare Wide Scheduling Contacts
<HC2>

Version 1

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Contents

1   GENERAL COURSE INFORMATION

COURSE TITLE	**HEALTHCARE WIDE SCHEDULING 2 (PMI & HC1)**
METHOD OF TRAINING	Classroom
DURATION	7 hours
PRE-REQUISITES	Basic IT skills, Admin Support

ABOUT THE COURSE

The PMI Record holds general demographic details about a patient/client and an outline of any episodes of care occurring at hospitals within the Portsmouth/IoW area and Community Contacts/Services. The course will enable students to have a basic understanding in using PAS including; searching for a patient/client, identifying specific information, updating records for existing patients with new information and recording Service Group referrals, contacts and the contact outcome.

OBJECTIVES

This course will enable the student to:

1.   State their personal responsibilities for Data Protection and the Caldicott Principles.

2.   Log on and off of the P.A.S. system.

3.   Find and select a patient/client.

4.   Find specific patient/client information

5.   Identify Episodes of care

6.   Revise existing patient/client demographic details

7.   Record a referral

8.   Record contacts

9.   View episodes and contacts.

10.   Revise referrals and contacts.

11.   Use the delete functions.

2   INFORMATION GOVERNANCE

Information Governance (IG) sits alongside the other governance initiatives of clinical, research and corporate governance. **Information Governance is to do with the way the NHS handles information about patients/clients and employees, in particular, personal and sensitive information.** It provides a framework to bring together all of the requirements, standards and best practice that apply to the handling of personal information.

Information Governance includes the following standards and requirements:

- Information Quality Assurance
- The NHS Confidentiality Code of Practice
- Information Security
- The Data Protection Act 1998
- Records Management
- The Freedom of Information Act 2000
- Caldicott Report December 1997

> *Further information can be accessed on the Trust Intranet. Click on* **Information Governance** *and* **Management Policies** *under the* **Governance and Policies** *heading.*

2.1   What can you do to make IG a success?

2.1.1   Keep personal information secure
Ensure confidential information is not unlawfully or inappropriately accessed. Comply with the Trust ICT security policy and Staff Code of Confidentiality. <u>Do not share your password with others. Ensure you "log out" once you have finished using the computer</u>. Do not leave manual records unattended. Lock rooms and cupboards where personal information is stored.

2.1.2   Keep personal information confidential
Only disclose personal information to those who legitimately need to know to carry out their role. Do not discuss personal information about your patients/clients/staff in corridors, lifts or the canteen

2.1.3   Ensure that the information you use is obtained fairly
Inform patients/clients of the reason their information is being collected. Organisational compliance with the Data Protection Act depends on employees acting in accordance with the law. The Act states information is obtained lawfully and fairly if individuals are informed of the reason their information is required, what will generally be done with that information and who the information is likely to be shared with.

2.1.4   Make sure the information you use is accurate
Check personal information with the patient. Information quality is an important part of IG. There is little point putting procedures in place to protect personal information if the information is inaccurate.

2.1.5   Only use information for the purpose for which it was given
Use the information in an ethical way. Personal information which was given for one purpose e.g. hospital treatment, should not be used for a totally separate purpose e.g. research, unless the patient consents to the new purpose.

2.1.6   Share personal information appropriately and lawfully
Obtain patient consent before sharing their information with others e.g. referral to another agency such as, social services.

2.1.7 Comply with the law

The Trust has policies and procedures in place which comply with the law and do not breach patient/client rights. If you comply with these policies and procedures you are unlikely to break the law.

Written by PHT Information Governance Manager, Nov 05

3   CONFIRMATION OF DETAILS PROCEDURES

To ensure that the Patient Administration System (PAS) contains up to date particulars of all patients being treated, staff must verify with patients their personal details. This should be undertaken when the patient is arriving at the hospital on admission or when attending for an outpatient clinic or other types of appointment.

The types of detail we must verify are those within the Patient Master Index (PMI) function within PAS and covers the following items:

- Patient Forename, Surname and Title
- Date of Birth
- NHS Number (If not one shown on screen)
- Address and Postcode
- Telephone Number – Home and Work numbers
- Name and Practice Address of GP
- Religion
- Marital Status
- Next of Kin
- Ethnic Group
- Military No (If applicable)

By checking the above details with the patient, we are ensuring the following:

- *   PAS contains the latest details for all our patients.
- *   Mistakes or "old" details can be amended.
- *   Information relating to the patient's well-being, such as Religion and Ethnic Group, can be used in patient care.
- *   Emergency contact details for relatives are up to date.

In some circumstances it will be difficult to verify the details highlighted above as the patient may not be coherent at time of arrival (e.g. emergency admission, A&E, etc). However, it is important that at the earliest opportunity, the details are verified and amended accordingly.

IMPORTANT

If details are amended, please remember to print a new set of labels, remove and destroy any incorrect labels from casenotes. We must not retain any labels that do not contain current details.

Many thanks for your cooperation.

Prepared by: ICT Information Manager
Issued: January 2003
Reviewed: March 2007
Version No: V1.2

4   KEYBOARD LAYOUT

4.1   Primary keys and their function

1.   **RETURN** or **ENTER**
     Must be pressed at the end of each entry you make. It tells the computer that you have finished typing the prompted keystroke.

2.   **BACKSPACE**
     Used to delete the last character typed. Repeated pressing deletes characters to the left. This key can only be used for correcting errors BEFORE pressing the RETURN/ENTER key.

3.   **DELETE (DEL)**
     Can be used as a BACKSPACE key. Can also be used in conjunction with arrow keys to re-enter a word to delete an individual character.

4.   **ARROW KEYS**
     Can be used to move selection highlight/cursor around the screen. They allow movement up, down, (left and right on menu only). Can also be used to re-enter a word, and to amend if necessary.

5.   **SHIFT**
     To produce the upper symbol of dual character keys and upper case letter characters.

6.   **CAPS LOCK**
     To produce upper case alphabetical characters only without having to use the shift key. Does not affect the upper symbol keys. Pressing key ON will display light on right hand side of keyboard or display words CAPS LOCK in corner of screen, dependant on the type of computer terminal being used. Pressing key again will release CAPS LOCK.

7.   **PAGE UP and PAGE DOWN**
     Used to move back and forward on lists, which extend further than the screen space allows. E.g. If display prompts 'do you want NEXT page', use the page down key, to go back again use the page up key.

8.   **NUMERIC KEYPAD**
     Numeric pad to right of keyboard. May be used instead of the number keys above the letter keys. Pressing NUMBER LOCK (NUM LOCK) key will display light on right hand side of keyboard above the numeric pad. Pressing key again will release NUMBER LOCK.

IMPORTANT NOTE:

CAPS LOCK MUST BE **OFF** WHEN LOGGING ON TO THE SYSTEM.
CAPS LOCK MUST BE **ON** ONCE YOU ARE LOGGED IN.

4.2   Function Keys - 'F' Key Set

 "F" key functions could be different depending on the program being used.

Use of 'F' keys within P.A.S. (Patient Administration System)

F1   =   Exit

F2   =   Delete Field

F3   =   Go To First

F4   =   Go To Field

F5   =   Go To Page

F6   =   Previous Field

         NB: Also used to change function set and change hospital code.

F7   =   View (Refreshes screen)

F8   =   HELP (explain and advice)

F9   =   SUPERHELP (selection lists)

F11   =   Multi-Select (Allows selection of more than one item in a list, certain functions only)

5   LOGGING IN TO PAS

Log in: prd: (if required)   <Return>

            Username: e.g. bloggsj   <Return>

            Password: _ _ _ _ _ _ _ _ _   <Return>

            Hospital: (as appropriate)

Your password lasts for 90 days; you will be warned that it is running out so you have time to think of a new one.

If you forget your password or need to reset it, please contact ICT Helpdesk on SJH 7703 2680.

Your Default Function Set is PMI - To change function set press the **F6** function key once and select HC1

```
   Function Set :HC1        HEALTHCARE WIDE CLINICIANS
        Function :
```

The HC1 (Healthcare Wide Clinicians) function set contains all of the basic functions and all of the functions specific to Healthcare Clinicians, all of the functions covered within this course can be found on this menu.

5.1 Logging Out

To log out of PAS return to the main menu screen and press the F1 key on the keyboard. This will log the user out of the system.

6 SEARCHING FOR YOUR CLIENT/PATIENT

6.1 LIST <LIS>

```
      Function Set :HC1       HEALTHCARE WIDE CLINICIANS
           Function :LIS█
                   PMI List

                    ┤Available Functions├
DAP - Delete Appointment          DCC - Delete Community Contact
DER - Delete Service Group Referral  DFU - DNA Follow Up
 DP - Document Print              DSD - Delete Service Group Discharge
EPI - Episode Enquiry            FBA - Follow up Book Appointment
HWL - Waiting List Add/Rev/Del/List  LIS - PMI List
MAH - Maintain Address History    MGH - Maintain GP History
MSH - Maintain Surname History     NI - Inpatient Name Enquiry
NID - DW Inpatient Name Enquiry   OCC - SG Clinical Coding
 PE - Patient Diary : By Patient  PEL - Patient Diary : By List
PLH - Patient Letter History      PMI - PMI Add/Revise
```

The function <LIS> is the means to establish if a patient has had past contact with NHS Services in Portsmouth or the Isle of Wight. If they have then all or part details will be found on the PMI (Patient Master Index), searches can be made using various combinations of patient demographic information, i.e. surname and forename initial, date of birth or approximate age and sex, or any combination. If no matches are found, a list of similar sounding names may be made available to you. To ensure entries are not duplicated, use casenote number only as a last resort.

1. From the Healthcare menu select function <LIS> and press <RETURN>.

2. To search for the patient always start by using the recommended SEARCH PROCEDURE of surname, forename initial, date of birth, sex .

   Press <RETURN>. A list of possible matches will be displayed, e.g.

```
                      P M I   L i s t
      Matching Patient Records  (Name Search)          20/04/07 13:35 QAH

  Seq   PAS No.   Name              Sex    DOB      Dth    Address

  79   01124001   ANGUS             F   01/12/1940   Flat
                    &ABBY                               21 High St
  80   01124001   ANGUS             F   01/12/1940   Flat
                    ABIGAIL                             21 High St
  81   23044203   ANNALS            M   23/04/1942   172 Northern Parade
                    FRANK                               PORTSMOUTH
  82   01017026   ANON              M   01/01/1970   13 Redlands Ln
                    ARTHUR                              EMSWORTH
  83   01016410   ANORY             M   01/01/1964   2 Sandcroft Ave
                    JACK                                RYDE
  84   02022202   ANOTHER_TR        M   02/02/1922

   (More Available)

 Select Patient, press <P> for previous page, or <Return> to continue   : █
```

Note: & symbol in front of a first name indicates this is a 'preferred name', # symbol in front of a surname indicates this is a 'previous surname' and a * symbol in the 'Dth' column indicates that this patient has been recorded dead.

3. Select correct patient from list by entering the appropriate Sequence Number found on the left hand side of the screen. Press <RETURN>. The patient's basic details will be displayed (see below). Check that they are correct and that you have the correct patient.

☞ **NOTE**: You must select the sequence number, even if only one patient is displayed on the screen.

```
                         P M I   L i s t
     Basic Details                              20/04/07 13:39 QAH

     ┌─────────────────────────────────────────────────────────────┐
     │                                                              │
     │                                                              │
     │  PAS No.    :01017026                                        │
     │  NHS No   :               Sts :RT                            │
     │  Military  :                                                 │
     │  Surname  :ANON                       Forenames  :ARTHUR     │
     │  DOB      :01/01/1970      37Y        Age    :        Sex  :M│
     │  Preferred Name :                     Work Ph :0771 457 6013 │
     │  Title    :MR                         Phone   :              │
     │  Address  :13 Redlands Ln                                    │
     │  *Full*   :EMSWORTH                                          │
     │           :Hants                                             │
     │           :                                                  │
     │  Postcode :PO10 7SN    Emsworth,Hants                        │
     │  HA CODE    Q38        SOUTH CENTRAL HA                      │
     │  Postal                                                      │
     │  Comment  :                                                  │
     │                                                              │
     │  Enter: 1-Details 1, 2-Details 2, 3-Case Notes, 4-Episodes, or <Return>  :█ │
     └─────────────────────────────────────────────────────────────┘
     ALL DETAILS MUST BE CONFIRMED AT EVERY CONTACT WITH THE PATIENT
```

4. For other details select from the taskbar at bottom of screen:-

   1. **DETAILS 1** - Displays General Practitioner (GP) Details, Next of Kin, Religion, Marital Status, NHS Number etc.

   2. **DETAILS 2** – Displays General Dental Practitioner (GDP) Details, Ethnic Origin, etc.

   3. **CASENOTES** - Displays casenote number(s), base location of notes and status (current or withdrawn).

   4. **EPISODES** - Displays all previous and current activity, attendances and episodes of care; eg: inpatient, outpatient and service group events, in reverse chronological order (most recent dates are at the TOP of the list).

Press F1 to exit <LIS>, or <Enter> to return to the Search screen.

☞ **NOTE**: If details need to be amended this maybe administered whilst recording a referral.

6.2 Recommended search procedure

The first search for a patient should always be by following the 'RECOMMENDED SEARCH PROCEDURE':

SURNAME, FORENAME (Initial only), DATE OF BIRTH & SEX

By using this method up to 90% of patients can be identified on the PMI.

6.3   Other search methods

If only **NAME AND DATE OF BIRTH** available, press <RETURN> until the cursor reaches the Surname field. Type in surname <RETURN>, forename initial <RETURN>, date of birth <RETURN> (past postcode field) to end of screen.

☛ **NOTE***: Remember when using a date of birth the +/- field will only search on the year of birth not on the day or month. The default in the +/- field is 3 years, overtype to change (0-9). You could convert the DOB to an approximate age. This will search on all dates within the range.*

If **NAME ONLY** available, press <RETURN> until the cursor reaches the Surname field. Type in surname and forename initial.

♡ **THINK***: Use various combinations of information to ensure you do a full search of the PMI, and identify the correct patient. If a patient has a preferred name different to their forename and it has been recorded on their PMI record you will still be able to find the patient using their preferred name in the forename field.*

☛ **NOTE***:   Do not search using the postcode even if this is combined with other details.*

CASENOTE NUMBER ONLY - type in the Casenote Number in the relevant field, press <RETURN>.

☞ **REMEMBER***: if searching by casenote number the system will find anything under this number, even if the casenote number has been withdrawn from use. You must access the 'casenote' selection of the patient record to check current 'live' number is used.*
Also, if searching by casenote number this will not show possible 'double' registrations, therefore search by casenote number should only be used in special circumstances.

PAS NUMBER ONLY - type in the PAS Number in the relevant field, press <RETURN>.

NHS NUMBER ONLY – type in the NHS Number in the relevant field, press <RETURN>.

MILITARY NUMBER ONLY – type in the Military Number in the relevant field, press <RETURN>.

6.4 Help list

When searching for a patient if you cannot find them using the 'Recommended Search Procedure' remember to try various combinations of information.

1.   Part surname - e.g. LEW for LEWKOWICZ.

2.   Double-barrelled name - could be reversed, e.g. Warwick-Brown, Brown-Warwick.

3.   Similar sounding names - e.g. Walters - Waters, Shepherd - Sheppard.

4.   Forenames such as Kathryn, Katherine or Catherine. Is initial entered correctly?

5.   Could Forename and Surname be reversed - e.g. Thomas Paul, Paul Thomas

6.   Male and female versions of names such as Lesley / Leslie, Frances / Francis, Lee / Leigh / Lea. If the name has been spelt wrongly, another user may have amended the sex field to try to match the name, so you could try leaving the sex field   blank.   (F2   to   delete   field).

    Do not assume sex by forename, e.g. Kim, Charlie, Lee could be male or female.

7.   Children could be registered as M-I (Male Infant) F-I (Female Infant) if they were not named at birth, or forename could have been changed after birth registration.

8.   Child could have a different surname from parent.

9.   Remember the Age +/- search only checks either side of the YEAR of the date of birth. Therefore, try checking on age only search. (Default is 3 years).

ALWAYS BE AWARE OF THE SEARCH OPTIONS YOU HAVE.

EVERY EFFORT MUST BE MADE TO AVOID DUPLICATED ENTRIES.

REMEMBER: *A patient's casenotes on a shelf in Health Records does not help in the care of the patient - so search thoroughly.*

7 PATIENT EPISODE ENQUIRY <EPI>

This function will make available to you detailed episode information on:-

    a) INPATIENT ADMISSIONS
    b) WAITING LIST EPISODES.
    c) OUTPATIENT REFERRALS.
    d) WARD ATTENDER EPISODES.
    e) ACCIDENT & EMERGENCY ATTENDANCES - front screen only
    f) SERVICE GROUP REFERRALS

1.   Log on in the usual manner.

2.   Search for patient in the <LIS> function. Select patient using sequence number (on left side of screen). Press F1 to exit back to the menu.

3.   Select function <EPI> from the menu and press <Return>. Type 'L' (for last patient selected) in any of the top 5 fields, this will bring the patient selected in <LIS> to the Episode Enquiry screen, eg:

```
                      E p i s o d e    E n q u i r y
     Select Episode                                    14/01/05 14:31 QAH
    ┌Name├
    ┌ FROST, JACK                                      PAS No. 09072301  ┐


     No Status       Date     Cons   Spec Hosp Ward Cat Casenote      WL-Cd A/P
     -- --------     -------- ------ ---- ---- ---- --- ------------  ----- ---

     1  SG           22/08/04 Cli:SMM     SGp:IMT  NHS Q486239

     2  OP REG       01/06/04 MEL    140  SMHI     NHS IW154875

     3  WA ATT       22/10/03 MIM    110  QAH  ORT NHS Q486239

        A&E ATN      19/08/03          QAH

     4  DSCH INCPT   17/08/03 MIM    110  QAH  D1  NHS Q486239

     <More available>
     Select/Continue  : ███████
```

4.   For more detailed information of any episode, select your episode by sequence number, press <RETURN> and further episodic information will be displayed.

5.   If the patient has not had any episodes, the screen will provide the message:

                        NO RELATED EPISODES FOUND

6.   Press F1 to exit <EPI>.

8   EPISODE STATUS DESCRIPTION

IP ADM	-	Current Inpatient
IP SUSP	-	Patient out on home leave
DSCH INCPT	-	Inpatient Discharged - Coding Incomplete
DSCH CMPLT	-	Inpatient Discharged - Coding Complete
DIED INCPT	-	Inpatient Died – Coding Incomplete
DIED CMPLT	-	Inpatient Died – Coding Complete
A+E ATN	-	Accident & Emergency Attendance
WL ACTV	-	Patient on Inpatient Waiting List
WL DEFER	-	Patient on Deferred Inpatient Waiting List
WL SUSP	-	Patient on Suspended Inpatient Waiting List
WL CANC		Patient Cancelled from Inpatient Waiting List
CEA	-	Cancel Treatment - Elective Add.
		CEA may appear under the status on some episodes, this is to indicate the patient was Admitted and Discharged without having had treatment and is placed back on the Waiting List.
PRE ADM TCI	-	Pre-Admission - To Come In - Date Offered
PRE ADM CANC	-	Pre-Admission Cancelled
PRE ***	-	Pre-Admission Date Past - Patient Not Admitted
OP REG	-	Outpatient Appointment Episode
OP DSCH	-	Discharged from Outpatients
WA ATT	-	Ward Attender – Attended
WA EXP	-	Ward Attender – Expected
WA CNC	-	Ward Attender – Cancelled
WA DNA	-	Ward Attender - Did Not Attend
WA WLK	-	Ward Attender - Walked In
WA ***	-	Attendance Date Passed - Outcome not Recorded
SG REG	-	Service Group Referral
SG DSCH	-	Discharged from Service Group
SG	-	Indicates a Patient Contact attached to the Service Group Referral
IP SUMM	-	Isle of Wight Use Only (Inpatient Summary)
OP SUMM	-	Isle of Wight Use Only (Outpatient Summary)

9   APPOINTMENT ENQUIRY <APE>

Appointment Enquiry will display ALL the patient's Outpatient and Service Group appointment and waiting list activity. Waiting List activity will be displayed at the top of the list followed by Appointments. The list is displayed in date order with the most recent event at the top of the list.

```
              A p p o i n t m e n t   E n q u i r y
    Select Appointment                        14/01/05 14:55 QAH
  ┌─│Name│──────────────────────────────────────────────────────┐
  ┌┘ FROST, JACK                              PAS No. 09072301   └┐
  ┌─────────────────────────────────────────────────────────────┐
  │   Status Department    Date     Day  Time   Clinic  Appt With Type │
  │   Site                          By   Date/Time      Rev Date/Time    CAB │
  │                                                                  │
  │ ███████████████████████████████████████████████████████████████ │
  │ 1          Outpatients  16/01/02 WED  10:00  FCM RMA  FCM RMA    FU │
  │    QAH                           DVJ 15/01/02 15:28              │
  │ 2  CNC H  Outpatients   23/11/99 TUE  10:00  DJB MAX2 DJB MAX2   FU │
  │    QAH                           DVJ 09/11/99 09:28    DVJ 09/11/99 09:43 │
  │                                                                  │
  │                                                                  │
  │                                                                  │
  │                                                                  │
  │                                                                  │
  │                                                                  │
  │                                                                  │
  │                                                                  │
  │  Select  :███                                                   │
  │                                                                  │
  └─────────────────────────────────────────────────────────────┘
```

Please note that Appointments are recorded differently to Contacts and Contacts will not display in the Appointment Enquiry function.
For function 'CPE – Patient Contact Enquiry' please see section 12.

For more detailed information select the appointment by using the sequence number or by moving the highlight bar to the appropriate appointment and press <Return>.

☛   **NOTE:** You will only be able to select those appointments for the speciality for which you have booking access. If selected, the appointment details will be viewed on the screen e.g. transport details, comments etc.

10   MANAGING REFERRALS AND CONTACTS

COMMUNITY CONTACT BY CLINICIAN <CCC>

10.1 Adding a referral

This function will allow the entry of the Service Group Referral onto P.A.S. Before proceeding with this function you should ALWAYS search for and check the patient's details in function LIS.

The Referral Screens will be tailored for your departmental needs. Development of the Healthcare function is ongoing therefore additional fields may be added to the referral Screens.

Whilst adding a referral you will get the opportunity to add or revise demographic details if necessary. To add a referral you must know the clinician or generic area code; and who the client/patient has been referred to. Some areas such as Physiotherapy are an exception to this rule as they have a temporary code of Unknown Physio.

1.   From the Healthcare Menu select CCC- Community Contact by Patient.

```
Training system                        /dev/pts/175          16/02/07 15:42


        Function Set :HC1        HEALTHCARE WIDE CLINICIANS
           Function :CCC
                     Community Contact by Clinician

                        ┤Available Functions├
  AAD - Record Attendance and Disposal    ABT - Appointments Block Transfer
  ACR - Cancel Clinic and Reschedule      ALR - Allocate Chair
  APE - Appointment Enquiry               BWL - Waiting List Book Appointments
  CAB - Cancel and Rebook Appointment     CAP - Cancel Appointment
  CBK - Clinic Booking Summary            CC0 - Community Contact by Patient
  CCA - SG Code Clinic Attendance         CCC - Community Contact by Clinician
  CCD - Clinician Diary                   CCE - Cancelled Clinic Enquiry
  CEQ - Clinic Enquiry                    CMG - Clinic Management
  CMH - Clinic Management (by Date)       CNE - Clinician Enquiry/Update
  CPE - Patient Contact Enquiry           CTE - Maintain Treatment Episode


  Press 'NEXT' for next page

```

HC1 – Available Functions

2. At Clinician Code enter the clinician or the agreed generic code that you are recording the patient/client activity for.

```
        C o m m u n i t y   C o n t a c t   b y   C l i n i c i a n
    Clinician Contact                                16/02/07 15:43 QAH

  Clinician Code      :TRAIN7    TRAIN,7
```

Clinician Contact Screen

3. Recall your patient using the last patient command (L).

```
        C o m m u n i t y   C o n t a c t   b y   C l i n i c i a n
       Patient Selection Details                      20/02/07 12:55 QAH

                            ┤Select Patient├
  PAS Number      :L            Casenote No    :
  NHS Number      :             Old NHS No     :
  Military Number :
  Surname         :
  Forenames       :

  Date of Birth   :                  Age    :        Years +/-   :

  Sex             :             Postcode   :
```

Patient Selection Details Screen

4. Revise the Basic Details if required.

```
        C o m m u n i t y   C o n t a c t   b y   C l i n i c i a n
     Basic Details                                    16/02/07 15:44 QAH

   Do you wish to revise the following ? :NO

   PAS No.    :06055932
   NHS No     :                Sts :RT
   Military   :FJFDDS
   Surname    :PIKE                       Forenames  :JANICE
   DOB        :06/05/1959      47Y        Age    :            Sex    :F
   Preferred Name :                       Work Ph :023 9256846
   Title      :MRS                        Phone   :023 9278 5319
   Address    :30 Westways
   *Full*     :HAVANT
              :Hants
              :
   Postcode   :PO9 3LN      Havant,Hants
   HA CODE     Q38           SOUTH CENTRAL HA
   Postal                                Maintain Postal Address    :
   Comment    :JSP TRAINING PATIENT                       Enter?  :
```

Basic Details Screen

5. If there is not a current referral for your Service Group, you will be asked if you wish to create one. To proceed enter Y.

```
        C o m m u n i t y   C o n t a c t   b y   C l i n i c i a n
    Basic Details                                    16/02/07 15:44 QAH

    Do you wish to revise the following ? :NO

    PAS No.   :06055932
    NHS No    :               Sts :RT
    Military  :FJFDDS
    Surname   :PIKE                    Forenames  :JANICE
    DOB       :06/05/1959    47Y       Age    :              Sex    :F
    Preferred Name :                           023 9256846
    Title     :MRS          ┌─────────────────┐ 023 9278 5319
    Address   :30 Westways   │ Create Referral? : ■ │
    *Full*    :HAVANT        └─────────────────┘
              :Hants
              :
    Postcode  :PO9 3LN      Havant,Hants
    HA CODE    Q38          SOUTH CENTRAL HA
    Postal                            Maintain Postal Address    :
    Comment   :JSP TRAINING PATIENT                      Enter?  :
```

6. At Case Note Details Screen use F9 and select the current Case Note (Super help Screen). If there is no current case note number telephone Health Records Library Registration or if your department hold new case note folders issue a new number. If you keep your own department notes only ie Physio, Cardiac Rehab the Location Code will be no Case Notes Issued (NCI).

```
        C o m m u n i t y   C o n t a c t   b y   C l i n i c i a n
    Command and Case Note Details                    16/02/07 15:44 QAH
  ┌┤Name├────────────────────────────────────────────────────
  │ PIKE, JANICE                              PAS No. 06055932
  └──────────────────────────────────────────────────────────


    Casenote No  :  ■■■■■■■■■■
```

Command and Casenote Details Screen

7. Amend the first Registration Details Screen if necessary, with the patient's Registered Dentist, Registered General Practitioner, Next of Kin etc.

```
        C o m m u n i t y   C o n t a c t   b y   C l i n i c i a n
    Registration Details                             16/02/07 15:45 QAH
  ┌┤Name├────────────────────────────────────────────────────
  │ PIKE, JANICE                              PAS No. 06055932
  └──────────────────────────────────────────────────────────

    Blood Group O Rh Negative       Allergies TEST         TEST
                                    Recorded      03/07/2006 By  B9E
    Patient Needs? NO

    Patient's GDP is MR J KELLY            Do you wish to view? :NO■
    Patient's GP is  DR HA BAGSHAW         Do you wish to view? :NO
    Next of Kin is   GREG & ADRIANNE PIKE  Do you wish to view? :NO


    Do you wish to revise the following patient details? :NO

    Religion      :CE     CHURCH OF ENGLAND     Carer Support  :
    Marital Status :D     DIVORCED      Place of Birth :PORTSMOUTH
    Ethnic Group  :1      BRITISH


    Occupation    :COMPUTER TRAINER         School    :
    Occn(Spouse)  :
```

8. Amend the second Registration Details Screen if necessary.

    It is very important to reflect the source of your referral.

    GP – This will default to the client's/patient's registered GP details' from the previous screen. If the referring GP is not the registered GP, please amend with referring GP details; use F9 to locate GP code.

```
            C o m m u n i t y   C o n t a c t   b y   C l i n i c i a n
      Registration Details                              16/02/07 15:45 QAH
    ┌Name├──────────────────────────┐┌─────────────┤Valid Codes├─────────┐
    │ PIKE, JANICE                   │CNN  Consultant Non-Written Referral Request
    │                                │CON  Consultant Written Referral Request
    │ Do you wish to revise any of th│DC   Dental CON Written Referral Request
    │ Agreement       :              │DCN  Dental CON Non-Written Referral Request
    │                                │GDN  GDP Non-Written Referral Request
    │ Commission Ref :               │GDP  GDP Written Referral Request
    │ Referred by     :GP            │GP   GP Written Referral Request
    │ GP Code         :830968    Org Co│GPN  GP Non-Written Referral Request
    │ Surname         :BAGSHAW       │OPT  Optician
    │ Title           :DR      Initia│OTH  Other
    │                                │SLF  Self Referral
    │ Address         :280 HAVANT ROAD└──────────────────────────────────┘
    │                 :DRAYTON              Do you wish to view? :NO
    │                 :PORTSMOUTH
    │                 :HANTS
    │ Postcode        :PO6 1PA
    │ Phone           :023 92374022
    │ Reason For Change        :
```

Registration Details Screen 2

Referred By Choices

Con – The code for Referrals from an Internal (within your Trust) or Tertiary Consultant (from outside your Trust). At Consultant Code F9 to search for an Internal Consultant code or enter NSC for a Tertiary Consultant.

```
                    C l i n i c i a n   D i a r y
      Registration Details                           01/06/05 15:06 QAH
    ┌Name├─────────────────────────────────┐
    │ TRIAL, MANNIE                         PAS No. 01018604
    │
    │ Do you wish to revise any of the following details  :YES
    │ Agreement       :                         Episodic Address
    │                                            1 Westways
    │ Commission Ref :            Line :         HAVANT
    │ Referred by     :CON                       Hants
    │ Cons Code       :
    │ Provider Code  :                   Postcode    PO9 3LN    Q17
    │
    │
    │                              Temporary Address is not recorded
    │                              Do you wish to view? :NO
    │
    │
    │
    │ Reason For Change       :
```

Occupational Health –Select <**OTH**>

```
                    C l i n i c i a n    D i a r y
   Registration Details                          01/06/05 15:06 QAH
 ┤Name├
  TRIAL, MANNIE                               PAS No. 01018604

  Do you wish to revise any of the following details  :YES
  Agreement       :                              Episodic Address
                                                 1 Westways
  Commission Ref :                 Line :          HAVANT
  Referred by    :OTH                            Hants

                                       Postcode     PO9 3LN   Q17


                              Temporary Address is not recorded
                              Do you wish to view? :NO



  Reason For Change       :
```

Patient Referral Screen 1

9. The Patient Referral Screen will reflect the choice made on the previous registration Screen. Complete the screen with factual information. The referral date must reflect when the referral was received by your Service.

☞ **NOTE:** Referral Source must reflect the correct code. Use F9 to view options**.**

```
        C o m m u n i t y   C o n t a c t   b y   C l i n i c i a n
   Patient Referral                             16/02/07 15:47 QAH
 ┤Name├
  PIKE, JANICE                                PAS No. 06055932

  Service Group     :IMT        INFORMATION AND TECH
  Lead Clinician    :TRAIN7     TRAIN,7


  Referral date/time :01/02/2007 09:00
  Referral Source    :GP         GENERAL PRACTITIONER

  Referral Type     :NEW
  Patient Category  :NHS         NHS PATIENT INFORMAL
  Priority          :ROUTINE


  Predicted Outcome  :
```

☞ **NOTE:** Predicted Outcome is not a required field press enter to bypass.

REFERRAL CODES

Referral By	Con/GP Code		Patient Referral screen ref by & ref name field
GP	GP		Accept default
Internal Consultant	CON	Cons Code F9 search on the surname of the internal clinician.	Accept default
Tertiary Consultant	CTR	NSC (Non-Specified Consultant)	Over type with Non PHT Consultant details.
Occupational Health	OTH		OCH
Social Worker	OT		SW

10. The Referral Diagnosis/Outcome and Severity Codes will be provided for you on laminated cards, (these codes reflect your data pen codes). F9 will show codes that are used throughout the two Trusts (Acute & Community) and not just for your Service.

```
        C o m m u n i t y   C o n t a c t   b y   C l i n i c i a n
      Patient Referral                          16/02/07 15:47 QAH
  ┌┤Name├─────────────────────────────────────────────────────────
  │ PIKE, JANICE                                    PAS No. 06055932
  │
  │           Referral Diagnosis/                Severity
  │           Diagnosis Outcome
  │
  │ Primary    :OTMH  OTHER - MENTAL HEALTH       :
  │            :
  │ Subsidiary :                                  :
  │            :
  │ Secondary  :                                  :
  │            :
  │            :                                  :
  │            :
  │ Comment   1 :
  │          2 :
  │ Referral Outcome   :
  │ Enter?  :Y
  │ └──────────
```

Patient Referral Screen 2

10.2 Adding a contact

There are two types of Contacts: Face to Face or Indirect (Perhaps a telephone discussion with patient / client or perhaps a Multi Disciplinary Team Meeting etc). A Contact may be added for the past, present or future.

```
          C o m m u n i t y   C o n t a c t   b y   C l i n i c i a n
          Patient Contact                             16/02/07 15:50 QAH
      ┌Name├
      │ PIKE, JANICE                                   PAS No. 06055932
┌─────

       Command            :ADD
       Planned Contact Date/Time :14/02/2007 14:00
       Actual Contact Date/Time  :14/02/2007 14:00   Contact Duration  :
       Contact Type       :FACE TO FACE
       Location           :CH     CLIENTS HOME


                   Contact Diagnosis/             Severity
                   Diagnosis Outcome
       Primary     :OTMH  OTHER - MENTAL HEALTH    :
                   :
       Subsidiary  :                               :
                   :
       Secondary   : ███                           :
                   :
```

Patient Contact Screen 1

```
          C o m m u n i t y   C o n t a c t   b y   C l i n i c i a n
          Patient Contact                             20/03/07 15:47 SJH
      ┌Name├
      │ PIKE, JANICE                                   PAS No. 06055932
┌─────

       Command            :ADD
       Planned Contact Date/Time :21/03/2007 10:00   Contact Duration  :
       Contact Type       :INDIRECT
       Location           :
                      ┌────────────────┤Valid Codes├────────────────
                      │ CANCELLED     Previously planned contact has been cancelled
                      │ FACE TO FACE  Face to face contact between clinician and patient
                      │ INDIRECT      Related to Patient but Between Clinician & Others

       Primary     :1111  DIAGNOSIS DESCRIPTION    :
                   :
       Subsidiary  :                               :
                   :
       Secondary   :                               :
                   :
```

☞ **NOTE**: The Attend/DNA field is not used. The Activity and Contact Outcome Codes provide the stats required.

```
      C o m m u n i t y   C o n t a c t   b y   C l i n i c i a n
      Patient Contact                              16/02/07 15:50 QAH
  ┌Name┤
    PIKE, JANICE                                   PAS No. 06055932

    Clinician     :TRAIN7   TRAIN,7               14/02/2007 14:00
    Team          :
    Attend/DNA    :

    Activity                            Activity Time
  :ASSI    ASS.INIT.                    :00:15
  :TG      TREATMENT GIVEN              :00:15
  :                                     :
  :                                     :
  :                                     :
   Other Service Group Clinicians
  :
  :

   Contact Outcome      :ONG  ON GOING

                        :C    Complete
  ┌─────────────────┐
   Enter?  :Y ▮
  └─────────────────┘
```

Patient Contact Screen 2

11 EPISODE ENQUIRY VIEW <EPI>

If you wish to view Service Group details in episode enquiry, select the appropriate SG REG. The referral details will be displayed on the screen; press return through these details to view a list of the Contacts.

☞ **NOTE:** SG - Service Group a with Contact activity attached. The Date is the first contact date not the date that the referral was received by the Service.

```
                         E p i s o d e   E n q u i r y
      Select Episode                                    20/02/07 15:12 QAH
   ┌─┤Name├─
   │  PIKE, JANICE                                    PAS No. 06055932
   └─                                                                    ─┘

   No Status        Date      Cons   Spec Hosp Ward Cat Casenote      WL-Cd A/P
   -- --------      --------  ------ ---- ---- ---- --- ------------  ----- ---

   1  SG            14/02/07 Cli:TRAIN7    SGp:IMT   NHS J006055

   2  WL ACTV       01/11/06 GEH     110   QAH       NHS Q257981       GEHWL

   3  OP REG        07/08/06 ITAJ    110   QAH       NHS Q257981       ITAJOWL

   4  OP REG        04/07/06 MJW     100   QAH       NHS Q257981

   5  SG REG        11/05/06 Cli:JONHC1    SGp:SPNT NHS Q257981

   <More available>
   Select/Continue  : ███████████
```

Referral Details:

```
                         E p i s o d e   E n q u i r y
      Service Group Referral Details                    20/02/07 15:16 QAH
   ┌─┤Name├─
   │  PIKE, JANICE                                    PAS No. 06055932
   └─                                                                    ─┘

   Service Group       :IMT       INFORMATION AND TECH
   Lead Clinician      :TRAIN7    TRAIN,7
   Patient Category    :NHS       NHS PATIENT INFORMAL

   Referral Source     :GP        GENERAL PRACTITIONER

   Referral Type       :NEW
   Referral date/time  :01/02/2007 09:00
   Priority            :ROUTINE

   Discharge Date/Time :
   Reason              :
   Discharge Outcome   :
                                                       <Press Return> ███
```

Contact Details:-

```
                         E p i s o d e   E n q u i r y
      Appointments within Episode                       20/02/07 15:16 QAH
   ┌─┤Name├─
   │  PIKE, JANICE                                    PAS No. 06055932
   └─                                                                    ─┘

      Status Department    Date      Day  Time   Clinic  Appt With Type
      Site                           By   Date/Time       Rev Date/Time   CAB

            IMT            19/02/2007 MON  09:00          TRAIN7   FACE TO FACE
            IMT            14/02/2007 WED  14:00          TRAIN7   FACE TO FACE
                          ** End of List **
```

12 CONTACT ENQUIRY FUNCTIONS

12.1 Patient Contact Enquiry <CPE>

This function will allow you to view the patient's contacts in the following ways:-

```
INDIVIDUAL REFERRAL    An Individual Referral
ALL REFERRALS          All Community Referrals
SERVICE GROUP          All Referrals for a Service Group
TREATMENT EPISODE      All Referrals for a Treatment Episode
```

12.2 Patient Contact Enquiry by Individual Referral <CPE>

1. Select CPE & search for the patient that you wish to view the Contacts for.

2. Select the Service Group Episode for the contacts that you wish to view.

3. A list of contacts for that Service Group will be displayed.

```
  Status Department    Date     Day  Time   Clinic  Appt With Type
  Site                           By   Date/Time        Rev Date/Time       CAB

         CARDIAC REH  31/05/2005 TUE  14:45           CJS      FACE TO FACE
         CARDIAC REH  24/05/2005 TUE  14:45           CJS      FACE TO FACE
         CARDIAC REH  20/05/2005 FRI  14:45           CJS      FACE TO FACE
         CARDIAC REH  17/05/2005 TUE  14:45           CJS      FACE TO FACE
         CARDIAC REH  10/05/2005 TUE  14:45           CJS      FACE TO FACE
         CARDIAC REH  06/05/2005 FRI  14:45           CJS      FACE TO FACE
         CARDIAC REH  03/05/2005 TUE  14:45           CJS      FACE TO FACE
         CARDIAC REH  22/04/2005 FRI  14:45           CJS      FACE TO FACE
         CARDIAC REH  19/04/2005 TUE  14:45           CJS      FACE TO FACE
         CARDIAC REH  25/02/2005 FRI  09:30           DJC      FACE TO FACE
                            ** End of List **
```

12.3 Patient Contact Enquiry by all Referrals <CPE>

The date range will default to the earliest and most recent activity recorded. A comprehensive list of all Service Group contact activity will be displayed.

1. Select CPE
2. Select Patient
3. Select All Referrals

A list of contact across all the service group referrals will be displayed.

```
                        Across Service Groups
                Contacts between 12/09/1997 and 16/03/2005
      Date       Event Typ Locn    SGrp Clinician  Activity

      17/05/02 PCONT F2F SC0020 SNC   103133      SN004 HEARING RECEPT
                                                  SN190 BACK TO CORE PROGRAMME
      15/04/02 PCONT F2F SC0020 SNC   103133      SN004 HEARING RECEPT
                                                  SN113 SN/SW
      31/08/01 PCONT F2F HC0470 DEN   200136      CGXCR EXAMINATIO/CONSULTATION/RE
      30/08/01 PCONT F2F HC0470 DEN   200136      SN999 CONTACT NOT POSSIBLE
      19/03/01 CONT  F2F GP0126 VHC   105319      HV039 CHS 36 MONTH REVIEW
      02/02/01 CONT  F2F HC0470 DEN   113011      CGXCR EXAMINATIO/CONSULTATION/RE
      23/01/01 CONT  F2F GP0126 VHC   105319      HV039 CHS 36 MONTH REVIEW
      10/08/00 CONT  F2F HC0470 DEN   111971      CGXCR EXAMINATIO/CONSULTATION/RE
                                                  CPOHI OHI
      07/12/99 CONT  F2F HC0470 DEN   111971      CP0DA DIET
Select   :█
```

☛ **NOTE**: The different SGrp, listing Dental (DEN), School Health Service (SNC) & Health Visitor (VHC) Activity.

12.4 Patient Contact Enquiry by Individual Service Group <CPE>

This will allow you to display activity for a specific Service Group.

1   Select CPE
2   Select the Patient
3   Select the option Service Group
4   Select the Service Group Code (using F9 if code not known)

Contacts for the specific Service Group will be displayed, in this example DEN – Dental.

```
                      For Service Group DEN – DENTAL
                Contacts between 07/12/1999 and 16/03/2005
      Date       Event Typ Locn    SGrp Clinician  Activity

D    Change date range
O    Change option
R    Request Report
     16/03/05 PCONT F2F HC0470 DEN   TRAIN9      CGFML FAMILIARISATION
                                                 CPFRS FISSURE SEALANTS
                                                 CGRDG RADIOGRAPHS
     10/01/05 PCONT F2F HC0470 DEN   201391      CGXCR EXAMINATIO/CONSULTATION/RE
     14/10/04 PCONT F2F HC0470 DEN   201391      CP0DA DIET
                                                 CPFRS FISSURE SEALANTS
     19/08/04 PCONT F2F HC0470 DEN   200449      CGXCR EXAMINATIO/CONSULTATION/RE
                                                 CGFML FAMILIARISATION
                                                 CPSAP SCALE & POLISH
     Select   :█
```

13 RECORD CLINICIAN ACTIVITY <RAC>

Many teams record group sessions with just a number of patients rather than face to face contacts for each patient seen. Some clinicians may do Health Promotion Work etc. with classes of school children it is not appropriate to put a referral on for each child with a face to face contact so these are collected as group numbers for commissioners.

1. **Select RAC**
2. **Clinician Code** – Enter Code or F9 to search
3. **Date** – Date of event
4. **Time** – Time session is to take place
5. **Activity** – Enter Code or F9 to search
6. **Duration** – Length of Session
7. **Location** – Where the event will take place
8. **Group No's** – How many client / Patients are attending the Group Session.

```
              R e c o r d   C l i n i c i a n   A c t i v i t y
      Clinician Activities                          19/03/08 13:44 QAH

    Clinician Code      :TRAIN7     TRAIN,7

    Date                :19/03/2008
                                                        Group
    Time   Activity                          Durtn  Loctn  No's
   :13:00 :BCC      BACK CARE CLASS         :01:00 :PHY  :10
   :14:00 :GT05     GROUP THERAPY 0-5       :02:00 :HZ   :5
   :      :                                 :      :      :
   :      :                                 :      :      :
   :      :                                 :      :      :
   :      :                                 :      :      :
   :      :                                 :      :      :

      Enter?  :Y
```

To Revise – RAC and overwrite.
To delete – RAC and F2 details.

The activity displays in CCD Clinician Diary:

```
                    C l i n i c i a n   D i a r y
          Daily Diary View                          19/03/08 13:54 QAH

 MISS 7 TRAIN                       Wednesday 19 March 2008      Incomplete (I)
    Times     Patient/Activity/Clinic                 Event Type Locn  Status

  09:00-10:00  BCC    BACK CARE CLASS                    GROUP      PHY
  10:00-12:00  GT05   GROUP THERAPY 0-5                  GROUP      BCR
  13:00-17:00  Clinic:TRN7                                          NGQA
 L  Last date with activity 18/03/2008 (or press '-' for 18/03/2008)
 N  Next date with activity 20/03/2008 (or press '+' for 20/03/2008)




    V : Change Diary View     R : Diary Report   F : Refresh   Q : Quiet
    A : Clinician Activity    P : Select Patient       S : Shrink
```

Select activity to list details or to revise or delete.

```
                    C l i n i c i a n   D i a r y
          Daily Diary View                          19/03/08 13:54 QAH
                                                    ┤Valid Codes├
 MISS 7 TRAIN                       Wednesday 19 March 2 DELETE   DELETE RECORD
    Times     Patient/Activity/Clinic             Eve LIST    LIST RECORD
                                                    REVISE   REVISE RECORD
  09:00-1 ┤Clinician Activity├
  10:00-1  TRAIN7    TRAIN,7                    19/03/2008
  13:00-1
 L  Last   Command     :LIST
 N  Next
           Time        :10:00
           Activity    :GT05    GROUP THERAPY 0-5
           Durtn       :02:00
           Loctn       :BCR     Breast Care Reception
           Group No's  :5
```

14 REVISION OF AN EXISTING REFERRAL <SGR>

1. Select SGR
2. Select the patient for whom you are revising the referral for.
3. Revise the Basic Details if Required.
4. Select the SG REG that you wish to revise.
5. At the Command prompt F9 and select the option to Revise the patient Record.

```
                    S e r v i c e   G r o u p   R e f e r r a l
        Command and Case Note Details                    23/12/05 11:10 QAH
       ┌Name┤                                          ┌Valid Codes├
       │ TRIAL, MANNIE                            │LIST    LIST PATIENT RECORD │
       │                                          │REVISE  REVISE PATIENT RECORD│
       │ Command      :  ▓▓▓▓▓
```

15 REVISION / LISTING OF AN EXISTING CONTACT <CCC>

1. Select CCC.
2. Select the patient whose contact you wish to revise.
3. Select the SG REG for your Service Group that has the contact attached that you wish to revise.
4. At the Command prompt F9 and Select the option to revise.

```
         C o m m u n i t y   C o n t a c t   b y   P a t i e n t
         INFORMATION AND TECH Patient Contact              28/02/07 13:55 QAH
    ┌─Name├─                                          ┌─┤Valid Codes├─
    │ TRIAL, MANNIE                                   │ADD     ADD RECORD
    │                                                 │LIST    LIST RECORD
    │ Command               :▓▓▓▓▓▓                   │REVISE  REVISE RECORD
    │ Planned Contact Date/Time :
    │ Actual Contact Date/Time  :              Contact Duration  :
    │ Contact Type          :
    │ Location              :


                  Contact Diagnosis/             Severity
                  Diagnosis Outcome
    │ Primary      :                              :
    │              :
    │ Subsidiary   :                              :
    │              :
    │ Secondary    :                              :
```
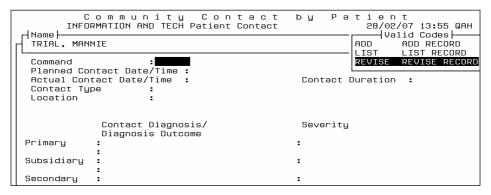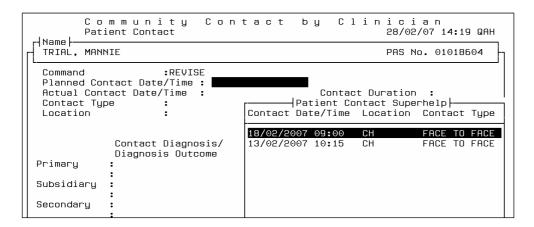
5. At the Planned Contact Date/Time F9 and select the contact that you which to Revise/ List.

```
         C o m m u n i t y   C o n t a c t   b y   C l i n i c i a n
         Patient Contact                                 28/02/07 14:19 QAH
    ┌─Name├─
    │ TRIAL, MANNIE                                    PAS No. 01018604

    │ Command               :REVISE
    │ Planned Contact Date/Time : ▓▓▓▓▓▓▓▓▓▓▓▓
    │ Actual Contact Date/Time  :              Contact Duration  :
    │ Contact Type          :       ┌─┤Patient Contact Superhelp├─
    │ Location              :       Contact Date/Time  Location  Contact Type

                  Contact Diagnosis/   18/02/2007 09:00   CH        FACE TO FACE
                  Diagnosis Outcome    13/02/2007 10:15   CH        FACE TO FACE
    │ Primary      :
    │              :
    │ Subsidiary   :
    │              :
    │ Secondary    :
    │              :
```
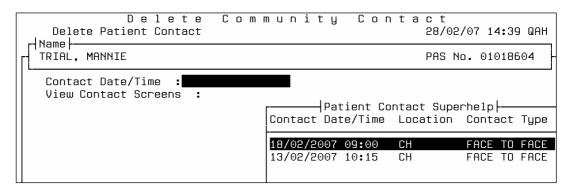
16 DELETING A CONTACT <DCC>

1. Select DCC.
2. Select the patient whose contact you wish to delete.
3. Select the SG REG for your Service Group that has the contact attached that you wish to delete.
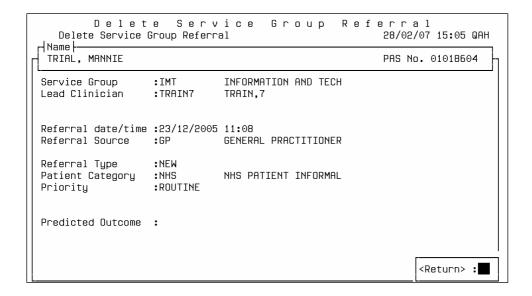4. F9 at Contact Date/Time to select the Contact that you wish to delete.

```
              D e l e t e   C o m m u n i t y   C o n t a c t
     Delete Patient Contact                         28/02/07 14:39 QAH
   ┌─┤Name├─────────────────────────────────────────────────────────────
   │ │ TRIAL, MANNIE                                 PAS No. 01018604    ├
   │ └
      Contact Date/Time  :▮▮▮▮▮▮▮▮▮▮▮▮▮▮
      View Contact Screens  :
                                  ┌──────┤Patient Contact Superhelp├──────
                                  │ Contact Date/Time  Location  Contact Type
                                  │
                                  │ 18/02/2007 09:00   CH        FACE TO FACE
                                  │ 13/02/2007 10:15   CH        FACE TO FACE
```

5. Only state Yes at View Contact Screens if you wish to view the details of the Contact prior to deletion.
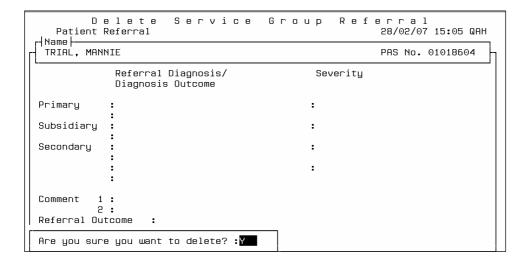6. At the prompt are you sure you wish to delete enter Y.

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17   DELETING A SERVICE GROUP REFERRAL <DER>

1. Select DER.
2. Search for and select the patient that you wish to delete the Service Group Referral for.

3. Select the Episode for the Service Group Referral that you wish to delete.

4. The next two screens will show you the details of the referral that you are about to delete.

```
          D e l e t e   S e r v i c e   G r o u p   R e f e r r a l
     Delete Service Group Referral                      28/02/07 15:05 QAH
   ┌Name├
    TRIAL, MANNIE                                    PAS No. 01018604

    Service Group      :IMT       INFORMATION AND TECH
    Lead Clinician     :TRAIN7    TRAIN,7


    Referral date/time :23/12/2005 11:08
    Referral Source    :GP        GENERAL PRACTITIONER

    Referral Type      :NEW
    Patient Category   :NHS       NHS PATIENT INFORMAL
    Priority           :ROUTINE


    Predicted Outcome  :



                                                      <Return> :█
```

5. You will be asked if you are sure that you wish to delete. Only delete if the referral was recorded in error.

```
          D e l e t e   S e r v i c e   G r o u p   R e f e r r a l
     Patient Referral                                   28/02/07 15:05 QAH
   ┌Name├
    TRIAL, MANNIE                                    PAS No. 01018604

               Referral Diagnosis/            Severity
               Diagnosis Outcome

    Primary     :                              :
                :
    Subsidiary  :                              :
                :
    Secondary   :                              :
                :
                :                              :
                :

    Comment   1 :
              2 :
    Referral Outcome   :
    Are you sure you want to delete? :Y█
```
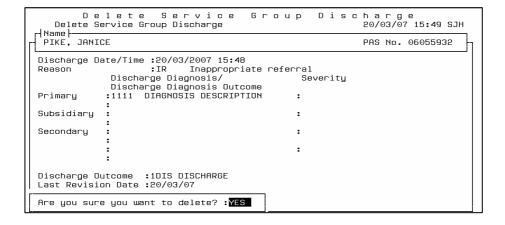
18 DELETING A SERVICE GROUP DISCHARGE <DSD>

A Service Group Episode is discharged when the Contact Outcome is completed with a Discharge Code.

A Discharge Episode Status reads SG DSCH, opposed to an open Service Group Referral which status reads, SG (if a Contact is attached) or SG REG (if a clinic appointment is attached).

```
1   SG DSCH     20/03/07 Cli:CP      SGp:IMT   NHS J006055
```

1. Select DSD.
2. Search for and select the patient that your wish to delete the Service Group Discharge for.

3. Select the Episode for the Service Group Discharge that you wish to delete (SG DSCH).

4. You will be asked if you are sure you wish to delete.

```
        D e l e t e   S e r v i c e   G r o u p   D i s c h a r g e
    Delete Service Group Discharge                  20/03/07 15:49 SJH
  ─┤Name├─
  ┌ PIKE, JANICE                                    PAS No. 06055932 ─┐

   Discharge Date/Time :20/03/2007 15:48
   Reason             :IR    Inappropriate referral
              Discharge Diagnosis/          Severity
              Discharge Diagnosis Outcome
   Primary    :1111  DIAGNOSIS DESCRIPTION     :
              :
   Subsidiary :                                :
              :
   Secondary  :                                :
              :                                :
              :
   Discharge Outcome  :1DIS DISCHARGE
   Last Revision Date :20/03/07

   Are you sure you want to delete? :YES
```

19 FAULT REPORTING

Contact ICT Service Desk:

Email	ict.servicedesk@porthosp.nhs.uk
Phone	023 9268 2680 or SJH (7703) 2680.

Some of the reasons you may need to contact the ICT Service Desk:

EQUIPMENT FAILURE
SOFTWARE PROBLEMS
SCREEN FREEZES
PASSWORD NON-ACCEPTANCE *

You will need to give the Service Desk certain information, so always ensure you have the following information available. They may need to know:

Your Username.

The KB Number of the equipment. This is found on a small label (usually red or blue) stuck to the equipment.

The function set and function you were working in.

The patients details e.g. casenote no.

Exactly what you were attempting to do, e.g. log on, admit patient, register patient.

19.1 Out of Office Hours

Contact the ICT Service Desk and leave a message on the answer machine. They will deal with the problem as soon as they can. Alternatively email them.

If you feel there is a major system problem contact the switchboard for them to contact the engineer on call.

20 HELP WITH USING PAS

If you have only just attended the course and feel you may need additional support, help or advice, you can contact the ICT Training Office.

* If you have not used PAS for more than 12 months you will be required to re-attend your training.

Email	ict.training@porthosp.nhs.uk
External Phone	023 9228 6000
Internal Phone	QAH (7700) 5867

21 ICT TRAINING CANDIDATE APPEALS PROCEDURE

- Candidates who are unhappy with any aspect of the end of course/test assessment decision should first discuss the problem with the ICT Trainer at the time of receiving the result.

- The reasons must be made clear by the candidate at this time.

- If the candidate is still unhappy with the result further discussion should take place involving the ICT Training Team Leader or ICT Training Senior Trainer within 3 days of the course/test date.

- The ICT Training Department will keep a record of such discussion together with date and outcome.

- Where necessary the 1st marker will be asked to re-mark and the marking checked by the ICT Training Team Leader or Senior Trainer.

- It should be noted that if the candidate was borderline double marking should already have been undertaken.

- If this does not provide satisfaction the candidate may raise a formal appeal.

- Appeals will only be accepted if made in writing (not e-mail) to the ICT Training Audit & Quality Manager within 10 days of the candidate receiving their result, outlining clearly the circumstance of the appeal.

- The 1st & 2nd markers will meet with the Training Audit & Quality Manager to consider if there are any aspects that should be taken into account in the candidates performance.

- In some circumstances the candidate may be offered a re-test (eg hardware or software problems).

- If this is not the case and the result remains unchanged and the Training Audit & Quality Manager is unable to resolve the impasse then the candidate may write to the ICT Training Manager (within 5 days of receiving the 3rd result) who will consider all evidence and circumstances of the appeal also taking into consideration responsibilities to the Trust and Data Protection Act to make a final decision.

ICT Training. QAH. May 2005

22 MANUAL VERSION CONTROL/LOG

Manual	Healthcare Wide Scheduling – HC1 Contacts	
Version	VN2.2	
Date	March 2008	
Revisions		Page
New	Confirmation of Details	3-1
New	Record Clinician Activity <RAC>	9-1
New	Support	18-1

Manual	Healthcare Wide Scheduling – HC1 Contacts	
Version	VN2.1	
Date	February 2008	
Revisions		**Page**
Updated	Formatting and text refinements (unlisted as content and meaning unchanged)	All