



# **Electronic Document and Records**

## Management System (EDRM)

# **Patient Electronic Record Module**

**User Guide** 

CCube Solutions | 13 Diamond Court | Opal Drive | Milton Keynes |MK15 0DU Main Office: +44 (0)1908 677752 | Fax: +44 (0)1908 679444 | Web: www.ccubesolutions.com

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## **1** Contents

1	Con	itents	. 2
2	Rev	isions and Distribution	.3
3	Intr	oduction	.4
4	Use	r Guide	.5
4	4.1	Patient Record Display Structure	.5
	4.2	Demographics Display	.8
	4.3	Alerts	.9
	4.4	Recent Activity	11
4	4.5	Break Glass	11
4	4.6	Case Notes	13
4	4.7	Timeline	14



## 2 Revisions and Distribution

Revision	Summary of Changes	Author	Date
0.1	Initial creation of document	Paul Glock	03/07/2015
0.2	Update for 4.1.134	Paul Glock	14/08/2015
1.1	Updates for Timeline in 4.1.135	Paul Glock	27/08/2015
1.2	Updates to Recent Activity	Paul Glock	02/10/2015
1.3	Update for List View	Paul Glock	02/10/2015
1.4	Update for Case Notes View	Paul Glock	05/10/2015
1.5	Check & proofread (User Guide only)	Ann Wrightson	14/10/2015
1.6	Add Case Notes Filters	Collins Manna	29/01/2016
1.7	Update for case notes filters	Collins Manna	29/01/2016
2.0	Update screen shots to version 4.2	Jon Waight	03/10/2017
2.1	Updates to new functionality Timeline,	Sarah Butler	21/11/2017
2.2	Language		12/12/2017
2.2	Update to new v4 functionality	Nichael Robertson	12/12/2017
2.6	General content and grammatical update	Andrew Phelps	07/02/2018
2.7	Alert Summary Window	Manish Panchmatia	19/04/2018
2.8	Workflow Status update / Screenshots	Michael Renwick	09/10/2018
	updated		
2.9	Video file support added	Michael Renwick	12/10/2018
3.0	Timeline updated	Michael Renwick	25/10/2018
3.1	Break Glass Update	Michael Renwick	01/11/2018



## 3 Introduction

The purpose of this document is to describe the Electronic Health Record (EHR) module within the CCube EDRM solution. This document is part of the overall CCube EDRM documentation;

(1) User Guide – The user guide explains how an end user can use the system. This describes configurations that may exist within a typical deployment. Customers are welcome to extract parts of this document to use within localised training documentation.

The EHR module forms part of the main user interface to a patient record, which provides facilities to find and view all documents in the record whether scanned or created electronically (such as letters and eForms). The display is configurable to support different users.



## 4 User Guide

The Patient Record can be opened from various other modules within the EDRM system. It is not possible to display a patient record without first having selected the patient elsewhere. The patient can be selected from any of the following modules;

- Patient search
- Appointments
- Pre-Admissions/In-Patient

For details on how to navigate and select a patient in those modules please refer to the corresponding module user guide.

## 4.1 Patient Record Display Structure

When a patient record is opened, the screen typically (subject to site configuration) contains three panels in addition to the blue menu bar at the left hand side of the screen.



Depending on configuration settings your patient screen may start out looking like the screen below, you can simply select the word "search" in the top left hand corner to expand your search options.



40	Search			Co Co Co Rootmans	MARRA A A A A A B DM
-	Mrs Pauline GALLOWAY, 21 Nov 1964, 1223334324			K K K K	
-		- ACTIVATION CONTRACTOR CONTACTOR			I
部			NOT ATTEMPT CARDIOPULM	IONARY RESUSCITATION	
int.	Mone Demographics Recard Activity		In the ment of cardiac or menioters areast		
<b>EO</b>	April Trest for showing in timeline last	The second secon	ascitation (CPR) will be made. All other treatme	ent should be given where appropriate.	
		Married Statements	o Pospilar No	Next of Kin / Emergency Contact	
n		Address of the second s		Relationship	
	Case Notes Ø Y	and a second sec			
14	ALERTS (3	Postor	de Date of Birth	Tel Nomber	
	Sub Chapter Date	Sector	Ion 1 Reason for DNACPR: Select as	appropriate from A - D	
0	ALENTS 01ANICO13		CPR has been discussed with this patient. It is again	et their wishes and they have the mental	
	ALERTS UNX52013		capacity to make this decision.		
-	La	1 March 1997	The right to refuse CPR in an Advance Decision only ap	ples from the age of 10.	
φ٥	CUNICAL NOTES (8)	c.	The outcome of CPR would not be of overall benefit	to the patient and	
	INVESTIGATIONS [2]	transfer	They last the capacity to make the decision	er	
	OPERATION SHEETS (1)	"NEW DO	this must be discussed with relevant other g been discussed with	Rolationship to patient	
1	TREATMENT CHARTS (2)	······································	CPR would be of no clinical benefit because of the fo	ollowing medical conditions	
			Even in situations in which CPB is not a	exected to be successful	
			etil good practice to explain to the patient and/or rela	evant others why CPR will not be attempted.	
		Trin h	an peer decreased with the partent because it would a	cause them unnecessary distress	
		Company of the second sec	g bees discussed with	Relationship to patient	
		Narra Narra	& Designation Nome &	Designation (Conter Synatre Prepared)	
		Organ	saton Organis	inter	
		Signal Signal	re Date Signatu	re Date	
		PERSONAL PROPERTY IN THE PERSON NEW YORK	ion 3 Review of DNACPR decision (if a	appropriate)	
			toview Date Full Name and Designation Signate	en Ditt sygdes Stat. Hanlass Date	
		T Card	AMBULANCE CREW INS	TRUCTIONS offer approximate tradement should be aborn	
		Any of	her specific instructions		
		("nontremannen")			

The record navigation and search functions are split into 4 distinct areas: this Guide covers the EHR (Electronic Health Record) functionality, shown in the below screen shot as an ECG Monitor display;



The EHR (Electronic Health Record) functionality provides a number of summary views of the content of a patient record. The usual default appearance is as follows:

Demographics







## 4.2 Demographics Display

Three identifiers of the demographics will appear within a summary section of the record:

Title, forename and surname, date of birth and their NHS number



When a patient is marked as deceased a "Deceased" indicator will appear above the demographic panel.

☆Mrs Pauline GALLOWAY, 21 Nov 1964, 1223334324							
DECEASED							
₩	+	Q					
Quick Links		<u> </u>					
Less Demographics	Recent Ac	tivity 😽					
Sex Hospital Number Middle Name Address	Female 06297ZZ 15 Time Training Tra	ining Training PP1 PP1					
G.P No GP Available							



When the patient has no documents a message will appear indicating this;

☆Mr James MERCER, 14 Jan 1960, 9991115993							
Quick Links					L ⊠ E		
More Demo	graphics	*	Recent Act	ivity	~		
Create alerts							
A Hospital casenote not yet scanned.							
≣		9	æ		Ľ		
Case Notes	Case Notes S 🔻						

#### 4.3 Alerts

When a patient is first viewed, if the user has permission to see alerts and there are active alerts present, those alerts will be displayed in a pop-up window before the patient details are displayed;

Alerts			remaie
Alert Description	Deadline	Created By	On
Alert 5	20/07/2018	Clinician	28/03/2018
Alert 3	29/03/2018	Clinician	28/03/2018
Alert 4	22/12/2017	Clinician	28/03/2018
MRSA	02/10/2017	Clinician	31/10/2017
Alert2		Clinician	28/03/2018
Created Date	Docum	ent Count	
21/03/2018	2		
10/10/2017	1		
08/02/2018	2		
06/03/2018	8		
	Close	9	

Click "Close" to proceed or click on a document alert to open any corresponding document.



D	O NOT ATTE Yorkshire & I	EMPT CARDIOP Tumber Regional Form for	PULMONARY RESUSCITATION Adults and Young People aged 16 and over 12 June 2011
г	In the event of esuscitation (CPR)	of cardiac or respiratory ) will be made. All other	arrest NO attempts at cardiopulmonary treatment should be given where appropriate.
NH	S No	Hospital No	Next of Kin / Emergency Contact
Nar	ne		
Add	iress		Relationship
Pos	itcode	Date of Birth	Tel Number
Se	ction 1 Reaso	n for DNACPR: Se	ect as appropriate from A - D (see leverse) and MDT decisions must be recorded in the patient's notes.
A. [	CPR has been dis capacity to make	scussed with this patient. It this decision.	is against their wishes and they have the mental
			needelin e velid edveres desision

The alert viewer allows to quickly see a document relating to an alert. The user is able to scroll through the document, using the scrollbar or 'Close' the quick viewer. When closing the alert viewer, the previous 'Alert Summary' window will open.

Click 'Close' to close Alert Summary window. The patient Electronic Health Record will then be displayed.

The Alert Summary window will not appear again for the same patient, until the user logs out and back in. Alternatively, during a patient search the user can simply click the Alerts icon.

Search A									
Hospital Number									
NICS Number									
Forename	padra								
Sumane									
Date Of Birth	DOAM		12						
fex	- Pease	Select -							
Seath Real Single									
Roug No.	,	Kana	,	NP13 Number T	Date Of Birth	Address	6.P T	Precision	-
<ul> <li>12452534</li> </ul>		Mis Pauline DUDDY		1768066526	15 May 1909	15 Tens Training Training Training PD1 (PD1	David Smith	CCale Soldiers OP Practice	*▲
<ul> <li>2000064.</li> </ul>		Mts Pauline DANIELS		1144462929	17 Jan 1988	15 Tese Training Training Training PP1 (PP1	David Smith	CCube Solders GP Practice	\$
<ul> <li>11968475.</li> </ul>		Mts Paulee DONALDSO	*	ethiotics/tee	09-Jul 10/11	13 Time Training Training Training PP1 (PP1	David Smith	CCale Soldiers OF Practice	*
<ul> <li>0429722</li> </ul>		Mis Pauline GALLOWIN		1223004024	11 Nov 1968	15 Time Training Training Training PP1 (PP1)	David Smith	OCube Solutions OP Practice	* 🔺

This can be found in the additional options section.





#### 4.4 Recent Activity

The recent activity window will appear when a patient has documents that are not finalised. This is provided for eForms and Letters.

By default the Recent Activity window will appear expanded. The expand and collapse control can be used to alter the display:



When a patient with these documents is viewed the recent activity screen will appear displaying separate lists for the eForms and Letters.

Clinician	т Туре	▼ Status	▼ Edit
Charles Bucket	Tes	CREA	$\bowtie$

The user can select the row to open the letter or eform in read only view or click on the edit icon to make amendments.

#### 4.5 Break Glass

"Break Glass" is a general term used to describe the process of requesting access to documents that would otherwise be restricted. This is to enable access to documents where there is an urgent clinical requirement.

Top level categories can be configured so users have to use the Break Glass feature in order to view documents in those categories. The Break Glass option will only appear when documents are present that cannot be seen or opened by the user.



A record that has restricted access will be shown with a padlock icon adjacent to the locked category name, as seen below.



-
•

Clicking on the break glass padlock icon will prompt the user to type in a reason and their password;

You have selected the "break glass" function that allows you to override the security built into the system.							
The system administrator will be notified that you have overridden security and this should only be done if you are sure it is necessary.							
Reason Urgent access required due to clinical risk							
Please pro	ovide your password to continue.						
Password	••••••						

Then click "BREAK GLASS" to unlock the protected case note categories.

The system administrator is then notified and the restricted categories will be unlocked. Documents in the restricted categories can then be viewed.





#### 4.6 Case Notes

The case notes tab is ordinarily the default display when a patient record is opened. It shows all categories visible to this user, and orders the categories alphabetically.

≣		9	æ				
ALERTS							
Sub Chapter Date							
ALERTS			01/09/2013				
ALERTS			01/05/2013				
H 4 1	<b>F</b>			1	- 2 of 2 items		
CLINICAL I	CLINICAL NOTES						
CORRESP	CORRESPONDENCE						
OPERATIO	OPERATION SHEETS						
TREATMEN	NT CHARTS				•		

#### Default Loading (Alphabetically)

#### 4.6.1 Case Note Display Structure

When viewing a case note document category, the appearance will be as indicated below.

The sub-category and scan date will appear in the view. The user can use the paging buttons at the bottom of the view to scroll to subsequent pages;

CLINICAL NOTES [6]	
Sub Chapter	Date
Catheter Clinic	15/09/2012
Diabetes	11/05/2013
Gen Surgery	15/09/2013
Oral Surgery	15/09/2013
Plastic Surgery	12/04/2013
Urology	15/10/2011
H 4 1 <b>F</b> H	1 - 6 of 6 items



## 4.7 Timeline

The Timeline gives a different view of the documents grouped into 6 time bands. The date ranges shown in each column can be adjusted by a System Administrator.

Timeline 🛛						© 🔻
0-7 days	8-31 days	1-6 months 2 1 3 4	7-12 months	1-2 years 3	>2years	1 6
CLINICAL NOTES	CLINICAL NOTES	CLINICAL NOTES 2 2 C			ALERTS 1	
<ul> <li>CARDIOLOGY 1</li> </ul>	CARDIOLOGY	CORRESPONDENCE			CLINICAL NOTES	4 <b>1</b> C
12/12/2017 1	11/12/2017 1	<ul> <li>OPERATION SHEETS</li> </ul>			CONSENT FORMS	20
		OPERATION SHEETS			CORRESPONDENCE	1
		06/09/2017 1			<ul> <li>INVESTIGATIONS</li> </ul>	Ð
		20/10/2017 1			MATERNITY 12	
		06/11/2017 1			<ul> <li>MONITORING</li> </ul>	
			-		OPERATION SHEETS	3 🚺
					• OTHER 1	
					SENSITIVE DOCUME	NTS 1
					TREATMENT CHART:	s 🚺

Expanding the Categories reveals the Sub-Categories which can be further expanded to display document dates.

Clicking on the top Category node will display the sub-categories.



Clicking on the Sub-Category node will display the creation dates for documents in that sub-category.



When a Document Date is selected the timeline will collapse and the viewer will appear.



Clicking on the Expand box at the right of the timeline tab will expand the timeline back to full screen.



Navigation between the timeline segments can be done by clicking on the arrows at the top of the timeline.





Within a segment a user can select to display documents at the category, sub-category or document level

#### 1-2 years

- CORRESPONDENCE
- CLINICAL NOTES
- ALERTS
- INVESTIGATIONS
- OPERATION SHEETS
- TREATMENT CHARTS

Category Level

#### 1-2 years

- CORRESPONDENCE
- CLINICAL NOTES
- ALERTS
  - ALERTS
- INVESTIGATIONS
- OPERATION SHEETS
- TREATMENT CHARTS

## 1-2 years

- CORRESPONDENCE
- CLINICAL NOTES
- ALERTS
  - ALERTS

# 01/05/2013

01/09/2013

- INVESTIGATIONS
- OPERATION SHEETS
- TREATMENT CHARTS

Sub-Category Level

Date Level