Vision Release DLM 710

Summary of Changes

December 2019

Consultation Manager

- **Test Results** - The following SDA results screens have been updated to include a numeric **Value**:
  - Faecal Occult Blood
  - Microscopy, Culture & Sensitivities
  - Film Report
  - Haemoglobin Variants
  - Haematology Screening Tests
  - Rubella Test
  - Chlamydia Test
  - Lipoprotein Electrophoresis
  - Blood Gases
  - Guthrie Test
  - Disaccharidase Tolerance Test
  - Cerebro-Spinal Fluid Examination
  - Synovial Fluid Examination
  - Pleural Fluid Examination
  - Ascitic Fluid Examination
  - Amniotic Fluid Examination
  - Histology
  - Other Diagnostic Imaging
  - Serum Amino Acids
  - Procedures, Specimens And Samples
  - Iron Studies
  - Microscopy For Malarial Parasites
  - Sickle Cell Disease Screen
  - Glandular Fever Test (Monospot)
  - Chemical Function Tests
  - Glucose Tolerance Test
  - Biochemical Screening Tests
  - Schilling Test - B12 Absorption
  - Pregnancy Test
  - Vomit Examination
  - Bone Marrow Examination
  - Sputum Examination
  - Calculus Examination
  - Mid-Stream Specimen Of Urine
  - Genetic Observations

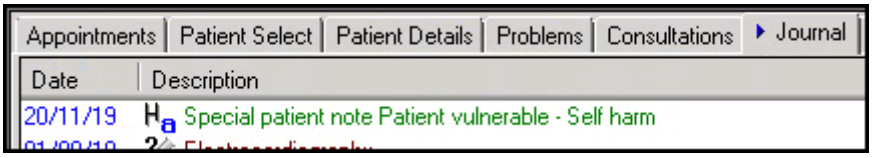
- **Immunisations** - The following immunisations have been updated:
  - **Meningitis ACW & Y vaccination declined** - Read code 657J500 now defaults to the **Immunisation Consent** SDA, any existing records with this code are automatically moved to the correct SDA as part of this install.
  - **BCG** - The inappropriate age warnings that display when you record a BCG have been removed and the **Reason** now defaults to **Special Risk Group**.
- **Co-ordinate My Care** (where available) - You can now see if a patient has a care plan from the patient record in Consultation Manager:
  -  **Patient has a CMC care plan, launch CMC to view and update the patient's plan** - Displays if a plan exists, select to trigger the plan.
  -  **This patient does not have a CMC care plan yet, launch CMC to create one** - Select to launch the portal and create a care plan.

Scotland only

Emergency Care Summary (ECS) and Key Information Summary (KIS)

The following changes have been made to the Emergency Care Summary (ECS) and Key Information Summary (KIS) functionality as part of this release:

- **Special Note** - The following changes are part of the DLM 710 update:
  - When you add a **Special Note** to a patient, it is now added to the patient record as a **Medical History** entry with a Read code of **9bK5.00** *Special patient note*. As part of this update, the most recent existing **Special Note - Notepad** record for each patient is automatically converted to the correct format. The original Notepad record is not deleted:



  - If a **Special Note** has an expiry date, a **Recall** is added to the patient record.
- **DNACPR** - **Has DNACPR Form** has been removed to avoid ambiguity. The following option is still available:
  - **Resuscitation status** - Select from:
    - **1R00.00** For attempted cardiopulmonary resuscitation, or
    - **1R10.00** Not for attempted CPR (cardiopulmonary resuscitation).

Note - Existing entries for **1R0..00** For resuscitation and **1R1..00** Not for resuscitation, are still valid for ECS and included in the extract.