

Patient Summary

Patient Summary allows you to enable your patients to view a subset of their medical record.

Once enabled, your patients can view their:

- **Allergies** - Drug and non-drug.
- **Medication Issued** - Acutes and repeats (including discontinued repeats).
- **Immunisations** - All **Immunisation** entries with a status of **Given**.

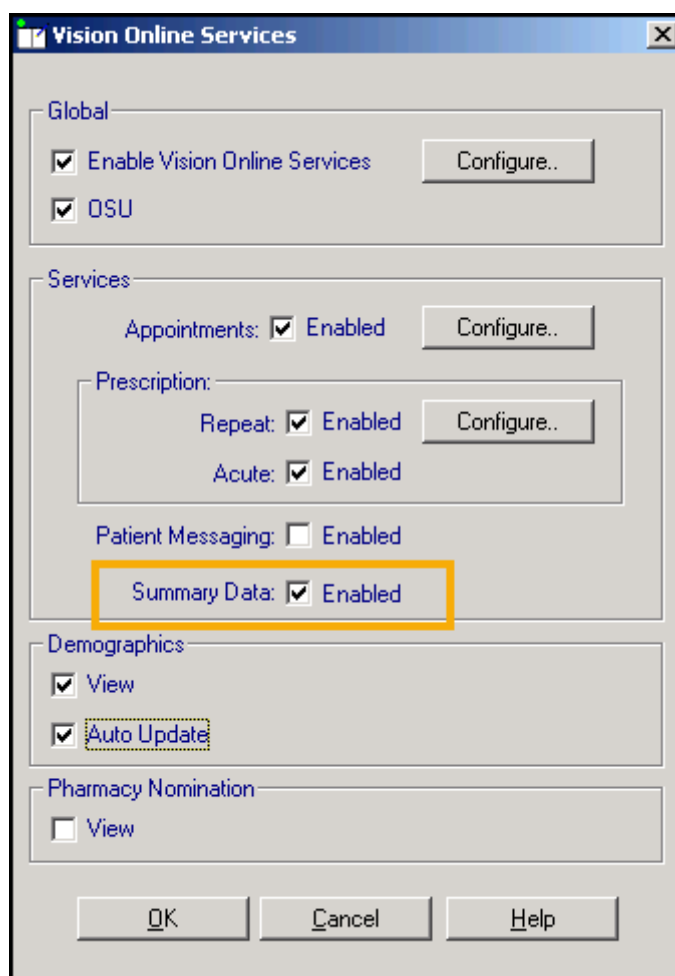
To set up and use this facility, please see the following:

- [Enabling Patient Summary Data](#) on page 2
- [Record Read Code for Access to Patient Summary](#) on page 3

Enabling Patient Summary Data

Summary Data allows patients access to their summary information. To enable **Summary Data**:

1. From **Vision 3 - Management Tools**, select **Control Panel - File Maintenance - Online Services**.
2. Tick **Summary Data**:



Vision Online Services

Global

☒ Enable Vision Online Services Configure..

☒ OSU

Services

Appointments: ☒ Enabled Configure..

Prescription:

Repeat: ☒ Enabled Configure..

Acute: ☒ Enabled

Patient Messaging: ☐ Enabled

Summary Data: ☒ Enabled

Demographics

☒ View

☒ Auto Update

Pharmacy Nomination

☐ View

OK Cancel Help

3. Select **OK** to save.



Note - Exact clinical terms must be recorded for each patient to gain access to their **Patient Summary** record online. See [Record Read Code for Access to Patient Summary](#) on page 3 for details.

Record Read Code for Access to Patient Summary

In order for your patients to view their **Patient Summary** once the functionality is enabled at your practice, you must add the following data to the patient record in the following order:

- **Step 1 - Patient identity verification** - See [Add Patient Identity Verification Details](#) for details, this step should have been completed when the patient was registered for online services.
- **Step 2 - England, Scotland and Northern Ireland only - Electronic record notes summary verification** - See [Recording the Read Code for Access to Patient Summary](#) for details.

It is Important to note -

- You must only record **93440 Electronic record notes summary verified** if the patient already has **91B..00 Patient Registration Data Verified** recorded. This is an NHS requirement and is the practice's responsibility to manage.
- It may take up to 24 hours from adding these codes until the patient can see their summary tab.
- Before going live with **Patient Summary**, you should check for patients who already have **93440 Electronic record notes summary verified** on their record, recorded in relation to something other than the online Patient Summary. For such patients, you can edit the record and change the Read code to another appropriate Read code, see [Patient Summary Clinical Audit](#) on page 4 for details.
- You can start to record and monitor Read codes for patients to access **Patient Summary** at any point, you do not need **Summary Data** enabled to do this.
- You may wish to review patient records before allowing patients to access their summary. You can track patients with or without this Read code using the Online Services Clinical Audit, see [Patient Summary Clinical Audit](#) on page 4 for details.

Patient Summary Clinical Audit

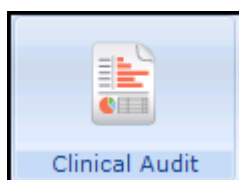
To help with tracking **Patient Summary** status, we have created a **Clinical Audit** published as part of the **Admin for SCR, Pt Online Services and Care.Data audits**. Using this audit, you can identify and address patients with or without the necessary Read codes to view their summary.

The latest **Admin for SCR, Pt Online Services and Care.Data audits** can be downloaded from [Admin for SCR and Patient Facing Services](#) in the **Clinical Audit Help Centre**.



Note - Downloading this audit replaces any existing versions of it.

Useful Audit Criteria



From **Clinical Audit** - **Admin for SCR, Pt Online Services and Care.Data audits - Patients Facing Services** open the **Identity and Email Verification** section:

Identity and Email Verification [Version 22, 17/03/2017]	
8035	Total Practice Population
0	Pts registered for Patient Facing Services
0	Patient Demographic Data Verified recorded In Practice (91B..)
0	Online patient summary verified by clinician EVER (93440) - ONLY these pts WILL have access to their summary when enabled
0	Online patient summary verified by clinician EVER recorded In Practice
0	Online patient summary verified by clinician EVER NOT recorded In Practice
0	Online patient summary NOT verified by clinician EVER
0	Patient Demographic Data NOT Verified by Practice (91B..)
0	Online patient summary verified by clinician EVER (93440)
0	Online patient summary verified by clinician EVER recorded In Practice
0	Online patient summary verified by clinician EVER NOT recorded In Practice
0	Pts registered for Patient Facing Services with NO Patient Demographic Data verified and NO Online patient summary verified by clinician (In Practice or elsewhere)
0	Pts registered for Patient Facing Services with 93440 added BEFORE 91B.
0	Pts registered for Patient Facing Services with an email address selected in the Online Services tab
0	Online Services email address verified
0	Online Services email address NOT verified
0	Pts registered for Patient Facing Services without email address selected in the Online Services tab
0	Pts registered for Patient Facing Services - CREATED - account has been created
0	Pts registered for Patient Facing Services - REGISTERED - username and password set up
0	Pts registered for Patient Facing Services - ACTIVE - account activated via confirmation email
0	Pts registered for Patient Facing Services - LOCKED - account is temporarily locked due to 5 unsuccessful logins

These audits are designed to enable you to check on the status of patients across your practice and to ensure, where relevant, the correct clinical terms have been recorded in the correct order.



See [Navigating Clinical Audit](#) in the **Clinical Audit Help Centre** for further details if required.

What Can My Patients See?

When logged into their online services account, providing your practice has met all the prerequisites, see [Enabling Patient Summary Data](#) on page 2 for details, your patients have a My Medical Summary option:



The following data is available for your patients to view, the number in brackets next to the section title is the number of records in the section:

- **Allergies**
- **Medication History:**
 - **Repeat Medications**
 - **Unavailable Repeat Medications**
- **Acute Medications**
- **Immunisations**



Note - Patients can only view their summary details, they cannot add or edit information.

Allergies

The **Allergies /Alergeddau** (Welsh) section displays any drug and non-drug allergies. The following information displays about each allergy listed:

- **Date** - Date allergy recorded.
- **Allergy** - Non-drug Allergy name, for example, Peanut allergy and or Drug Allergy name, for example, Penicillin (note that form and strength do not display).
- **Reaction** - Either Intolerance, Allergy or Adverse Reaction.



Note - For practices using GP2GP, any unprocessed degraded drug allergies do not display in the **Allergy** list for the patient to see. They should be processed by the practice as soon as possible.

Medication History

Your patients have three medication options:

- **Repeat Medications** - This displays issues in the last 12 months. If you have no repeat medications 'You have no recorded current repeat prescriptions' displays.
- **Unavailable Repeat Medications**- Displays repeat prescriptions that are inactivated in **Vision 3** but have been issued in the last 6 months. Some items display in the **Unavailable Repeat Prescriptions** list as well as the **Repeat Prescriptions** list which can cause confusion. These are likely to be old inactive repeat masters which have been updated/replaced for the next repeat cycle. If there are no unavailable repeat medications 'You have no recorded expired repeat prescriptions from the last 12 months' displays.
- **Acute medications** - Displays issues made in the last 12 months. The following information displays for each medication:
 - Last issued date of the prescription
 - Drug name
 - Quantity
 - Dosage instructions added by the prescriber including any text added in the dosage box when adding a prescription.



Note - Any prescriptions issued outside the practice within the specific timeframes, for example, hospital prescriptions, also display.

Immunisations

The **Immunisation** section displays those recorded in the **Immunisation** Structured Data Area (SDA) with the status of **Given**.