Practice Access User Guide

Version 2.0

15th March 2022

Contents

An Introduction to Practice Access

Practice Access provides secure, remote access to your patient's clinical record including medical history, medication and test results. It also allows you to enter patient consultations while away from your practice and provides a business continuity solution. Data is regularly synchronised between the practice clinical system and **Vision360**.

You can access clinical data for patients registered at your own GP practice, or if used in a **Shared Care** Setting it can be configured to include patients from other practices.

You can only amend or delete clinical data added to **Practice Access** before it synchronises with the practice clinical system, the remainder of the record is view only:

Practice Access consists of five tabs:

Each tab displays entries for the selected patient, along with the ability to enter new information. You can use the column headers to sort the records that display.

The number of records that display is set at the bottom of the screen, you can select from 30, 40 or 50 per page. To display additional pages, either enter the page number or use the navigation arrows.

See **Logging in to Practice Access** on page **7** for details.

Prerequisites

The following are the minimum prerequisites for **Practice Access**:

Dependency	Version Required
Windows Desktop	Windows 7, 8.1 or 10
Browser	Internet Explorer version 9 and above.
N3	Access must be via a secure N3 connection, a token is needed for remote use. Practice Access cannot be used offline.
Access requirements	**Vision360** user name and password. Your user name is your NHS Mail email address. For **Vision 3** users your password is your existing password, for English sites this is your offline password.

The **Cegedim Healthcare Solutions** deployment team are responsible for enabling your practice and testing the data transfer.

Meadco ScriptX Plugin

You must install the **Meadco ScriptX Plugin** on each workstation to enable correct printing. If this is not done, an error message displays every time you log in.

> **Note** - You must be logged in as a System Administrator to install this utility.

To install the plugin:

1. Log into the **Vision360** in the usual way, see **Logging in to Practice Access** on page **7** for details.

2. If the Plugin is not installed on this machine, the **User Account Control** message displays:
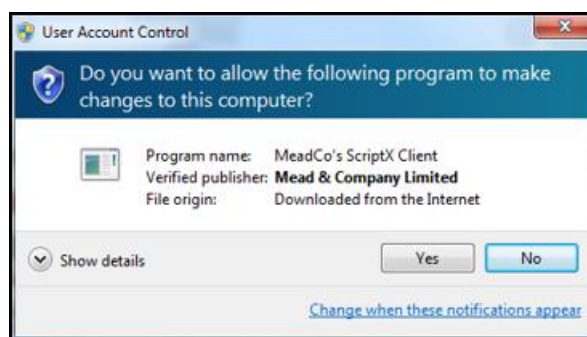
3. Select **Yes** to begin the install and follow the prompts on the screen.

> **Note** - If you do not have System Administrator rights, a **Copy Error** message displays. Select **Cancel** to close the error.

Data Synchronisation

Data synchronisation occurs between the original patient record, for example, **Vision 3** or **EMIS** and **Vision360** to ensure patient data is kept up-to-date. In the event of the practice system being unavailable the messages queue until access is available.

The patient's record is read only, with the exception of any entries added to **Practice Access** as part of the current consultation. Synchronisation automatically occurs approximately 20 minutes after data is entered, entries can only be edited / deleted up to this point.

After synchronisation, the data becomes read-only.

> **Note** - Prescriptions entries that have been printed cannot be edited or deleted.

> See **Editing Entries** on page **36** and **Deleting Entries** on page **37** for details.

Logging in to Practice Access

You can access **Practice Access** from **Vision360**. To log in to **Vision360**:

1. From your desktop, select **Vision360**, or open your browser and enter the web address provided by the **Cegedim Healthcare Solutions** implementation team.
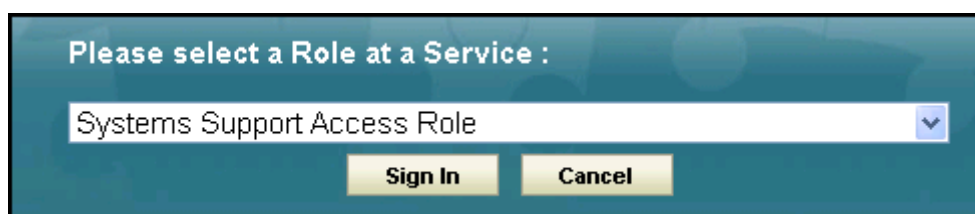
2. The **Vision360** login screen displays:

3. Enter your details in **User Name** and **Password**.

> 💡 **Training Tip** - Your **User Name** is your NHS email address, and for **Vision 3** users your password is your existing password, for English sites this is your offline password.

4. Select **Sign In**.

5. If you have more than one role, select from the available list, for administrative use, select **Systems Support Access Role**:

6. The **Vision360** home screen displays, the options available depend on your access rights.

7. Select **Practice Access** .

8. The **Patient Select** screen displays, see for details.

Once you have selected a patient, their record displays, and the **Patient Banner** displays demographic details and allergy status.
If the patient is deceased, the date of death and the patient age display in the **Patient Banner**.

See for details.

Selecting a Patient

Patient Select allows you to search using various criteria including surname, date of birth and unique patient number, for example, NHS number and CHI Number.

This can be accessed in two ways:

- **Practice Access** - You are prompted to select a patient when you select **Practice Access**.
- **Select Patient** - You can choose **Select Patient** from the **Vision360** home screen.

> *Note* - If you already have a patient open and you choose to select a different patient, the current patient record closes and you are prompted to save any unsaved data. This change of patient reflects throughout all open applications.

The **Patient Select** screen provides two search modes:

Quick Patient Search

To use the quick patient search:

1. From the **Patient Select** screen, in **Search Criteria** enter all or part of the patient's surname and forename and/or date of birth:
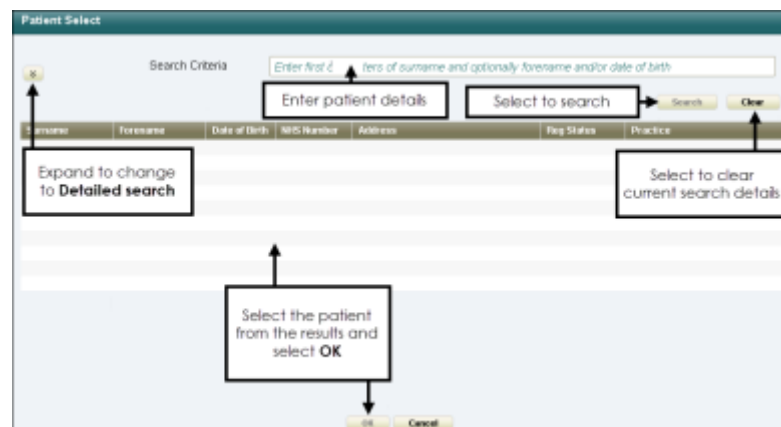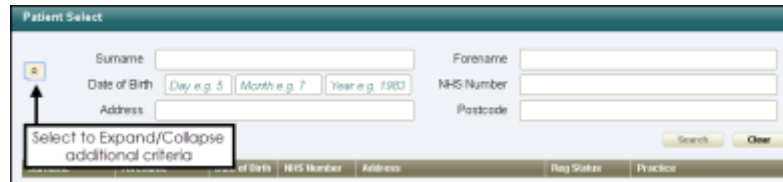
2. Select **Search**.

Detailed Patient Search
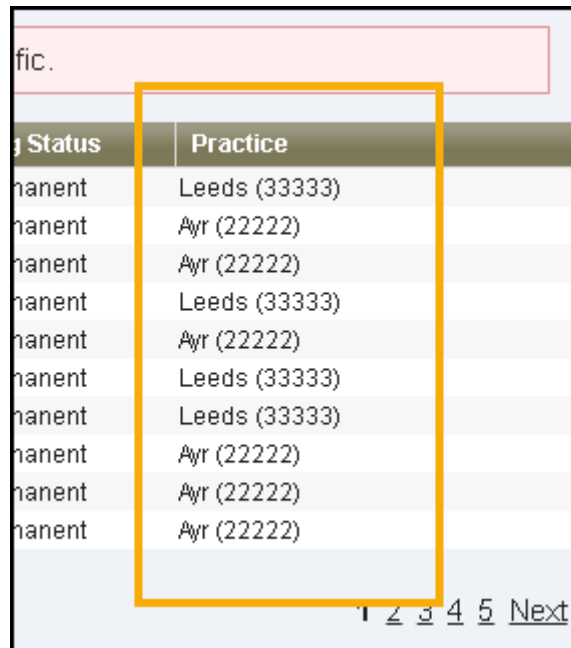
If you cannot find the patient required using the quick search, you can expand the search criteria:

1. From the **Patient Search** screen, select **Expand** to display more search options:

> 🖊 **Note** - To search by postcode, a minimum of two characters must be entered in Postcode.

2. Select **Search**.

3. A list of matching patients displays, highlight the patient required and select **OK**.

> 🖊 **Note** - If using **Practice Access** in a **Shared Care Setting**, the list includes the patient's registered practice.

4. The **Prescribing Decision Support Warning** screen displays, select **Accept** to acknowledge the warning and proceed:

5. If you are in a **Shared Care Setting**, you must select a consent reason to access the patient's record:

After selecting the consent reason, select **Show Patient Record**:
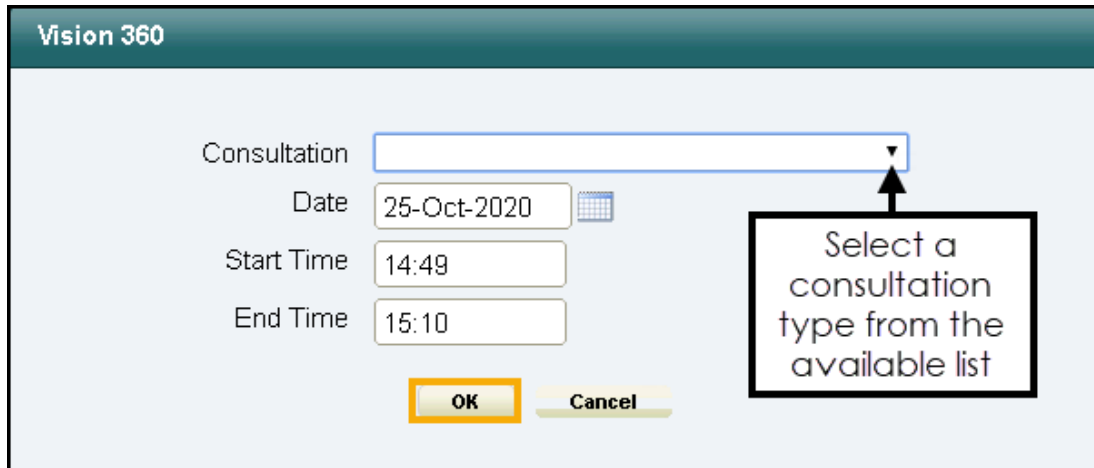
The patient record displays.

Consultations

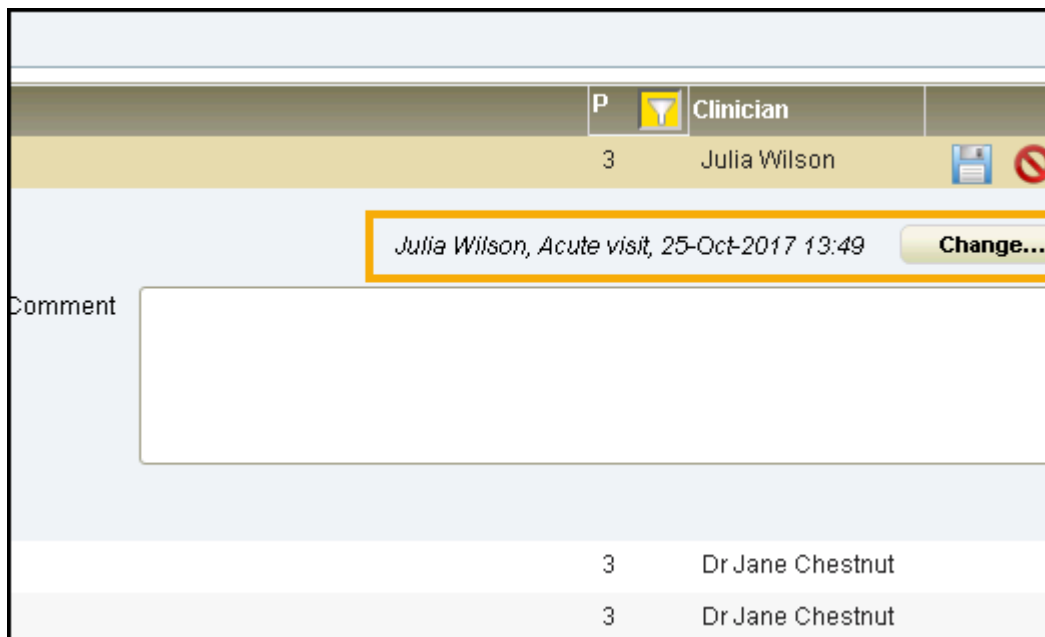A consultation automatically starts when you start adding data to a patient's record:

1. Once you select a patient, the **Consultation** screen displays:

   From **Consultation**, select the appropriate consultation type required from the available list, see **Consultation Types** on page **13** for details.

2. The **Date** and **Time** automatically default to the system date and time, update if required.

3. Select **OK** to save.

The consultation type displays at the top right of the data entry form:

Consultation Types

Practice Access supports the following consultation types:

Acute visit	Minor Injury Services
Administration	NHS Direct Report
Casualty Attendance	Night visit practice
Children's Home Visit	Night visit deputising service
Clinic	Night visit local rota
Co-op home visit	Nursing Home Visit
Co-op surgery attendance	Other
Co-op telephone advice	Out of hours non practice
Day Case Report	Out of hours practice
Discharge details	Repeat Issue
Emergency Consultation	Residential Home Visit
Follow-up/routine visit	Results Recording
GOS18 report	Surgery consultation
Home Visit	Telephone call from a patient
Hospital admission	Telephone call to a patient
Hotel Visit	Third Party Consultation
Letter from Outpatients	Triage
Mail from patient	Twilight Visit
Mail to patient	Walk-in Centre
Medicine Management	

Editing a Consultation Type

To change a consultation type, select **Change** alongside the consultation details and select a more appropriate type.

Note - A **Consultation Type** cannot be updated once a consultation is synchronised.

See **Selecting a Patient** on page **9** and **Data Synchronisation** on page **6** for details.

Journal Tab

The **Journal** screen displays a patient's complete medical record and allows you to add new records:

The **Journal** screen displays the following:

- **Date** - The date of the entry.
- **Description** - Displays a summary of the entry, to expand the entry, select the arrow.

> ✏️ **Note** - Repeat therapy items are prefixed with 'Repeat', for example, 'Repeat Zantac 50mg/2ml...' whereas any issues are prefixed with the issue number, for example, 'Issue 1 Zantac 50mg/2ml...'.

- **Priority** - Priorities are used to signify importance of clinical entries and are numbered from 0 - 9. The use of priorities varies between practices, but generally the following conventions are used:
  - **Priority 1** - Normally used for a chronic disease or significant illness.
  - **Priority 3** - General medical entries.
  - **Priority 0** - Sensitive items, these are hidden from view by default.

Priority Filter - The **Priority** column is abbreviated with the heading **P**, and has a filter you can use. Select **Filter** , choose the priorities to display and then select **Apply**:

- **Filter on** - Default option, displaying priorities 1 - 9.

- **Filter off** - All priority items display.

- **Clinician** - Displays the clinician that recorded the entry. Entries made in a **Shared Care Setting** display the **Shared Care** clinician.

Clinical data can be added from the **Journal** screen.

Adding a Medical History Entry

As well as being able to view a patient's record from the **Journal** screen, you can also record new medical history entries.

To record a medical history entry:

Note - If you are recording the first saved entry of this consultation with the patient, the **Consultation** screen displays. Complete as appropriate, see **Consultations** on page **12** for details.

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1. From the **Journal** screen, select **Add journal entry** and enter either:

   - **A Clinical Code** (preceded by #), or
   - **A Clinical Term** (minimum of two characters)

Training Tip - You can search on multiple words, for example back pain.

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2. Select **Search** 🔍 and the matching options display:

✏️ **Note** - The search does not currently include searching by hierarchy.

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3. Select the term required and the data entry form displays:
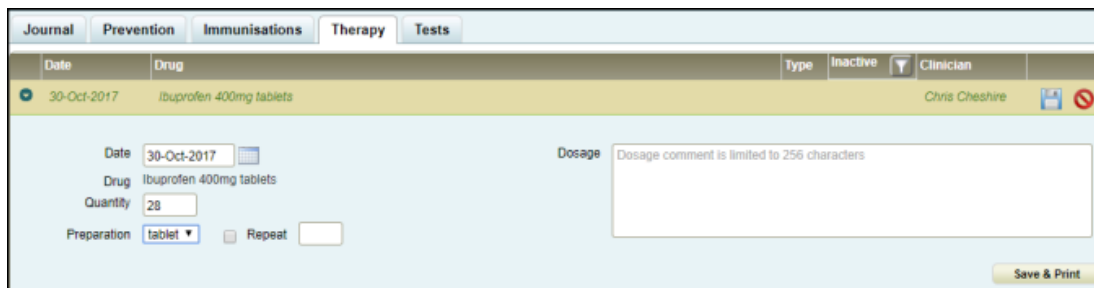

4. Complete as required:

- **Date** - Defaults to today's date, update as required.
- **Priority** - Select an appropriate priority for this entry.

✏️ **Note** - Priorities are a way of allocating an importance to an entry, chronic and serious conditions are usually a Priority 1, and general entries a Priority 3, but this may depending on the practice.

- **Comment** - Enter any comments to support this record.
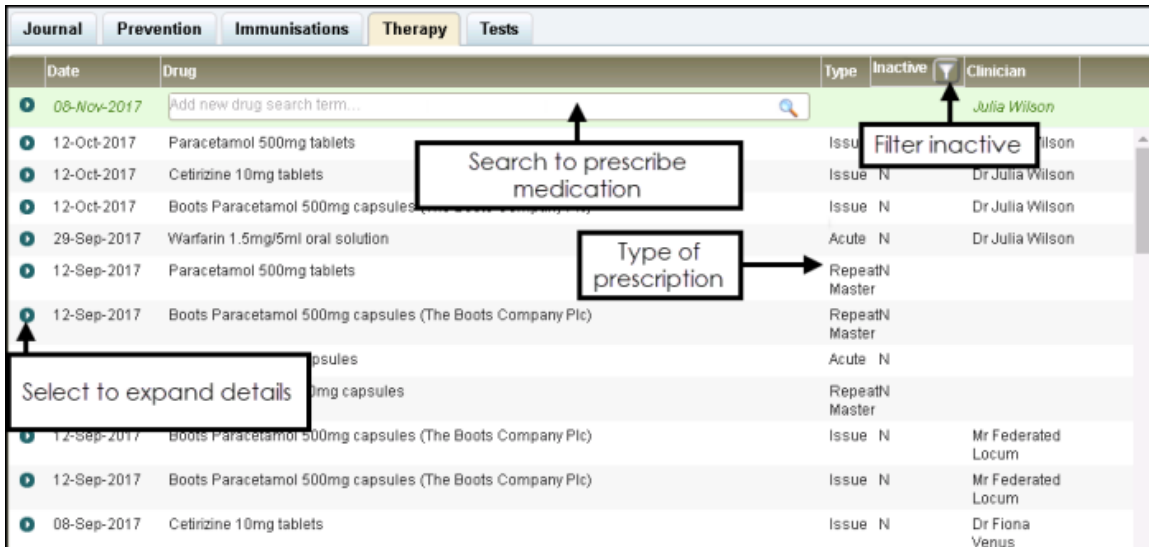
5. Select **Save** 💾 to save and close the entry.

Therapy Tab

The **Therapy** screen displays a patient's medication history and allows you to record new medication:

The **Therapy** screen displays the following:

- **Date** - The date of the entry.

- **Drug** - Displays the medication prescribed, to expand the entry, select the arrow.

- **Type** - The therapy type recorded:

    - **Acute**

    - **Repeat Master**

    - **Issue** - Individual issue against a repeat master.

- **Inactive** - Displays whether a medication is inactive or not. Select **Filter** to hide inactive items.

- **Clinician** - Displays the clinician that recorded the entry. Entries made in a **Shared Care Setting** display the **Shared Care** clinician.
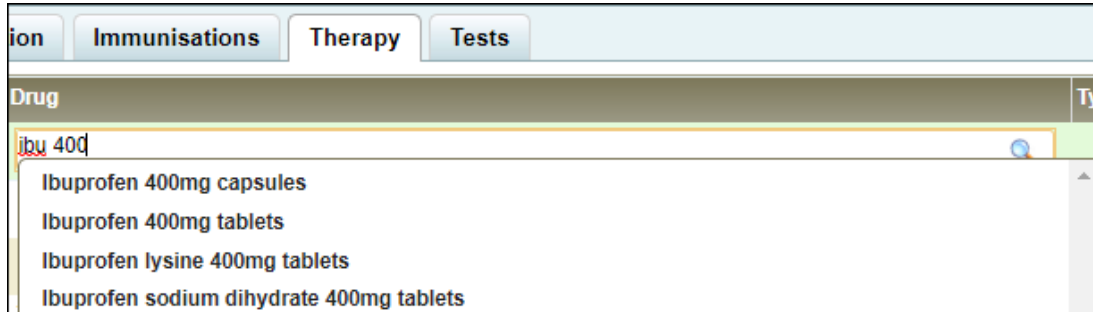
Note - If you are recording the first saved entry of this consultation with the patient, the **Consultation** screen displays. **Complete** as appropriate, see **Consultations** on page **12** for details.

To record medication:

1. From the **Therapy** screen, enter the drug details required in **Add new drug** search term and select **Search** :

> 💡 **Training Tip** - You can search on a combination of drug name and strength.

2. Select the medication and the **Therapy** form displays:

Complete as required:

- **Date** - Defaults to today's date, update as required.
- **Quantity** - Enter the quantity required.
- **Preparation** - Update the preparation if required.
- **Repeat** - Tick to turn this into a **Repeat Master** if required and enter the number of issues you are authorising.

> ✏️ **Note** - Leave **Repeat** unticked if this is an acute.

- **Dosage** - Enter the dosage required.

3. Select **Save** to save and close the entry.

> ✏️ **Note** - Medication entries that have been printed cannot be edited or deleted.
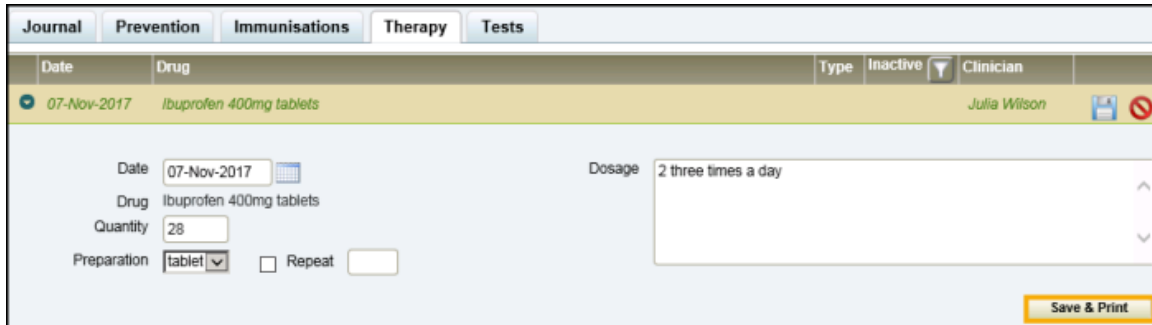
Printing Acute Prescriptions

If you are using **Practice Access** in a **Shared Care** Setting, you can print acute prescriptions.

> ✏️ **Note** - Your organisation can select to disable this option.

Once you have completed the prescription details, simply select **Save and Print**:

> ✏️ **Note** - Medication entries that have been printed cannot be edited or deleted.

Reprinting Acute Prescriptions
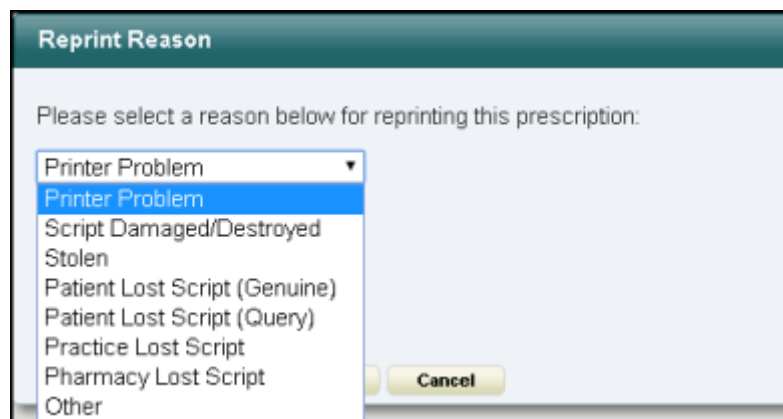
If you are using **Practice Access** in a **Shared Care Setting**, you can reprint acute prescriptions that have been added during the current open consultation.

To reprint a prescription:

1. From the **Therapy** screen, select the acute to reprint.

2. Select **Reprint**:

3. The **Reprint Reason** screen displays, select an appropriate reason from the list:

> ✎ **Note** - If you select **Other**, enter the reason into **Comments**.

4. Select **OK** and the prescription reprints.

> ✎ **Note** - You cannot reprint acute items which have been synchronised with the patient record. You can only reprint items which have been added in the current open consultation.

Canceling a Prescription

You can cancel acute prescriptions that have been added during the current open consultation.
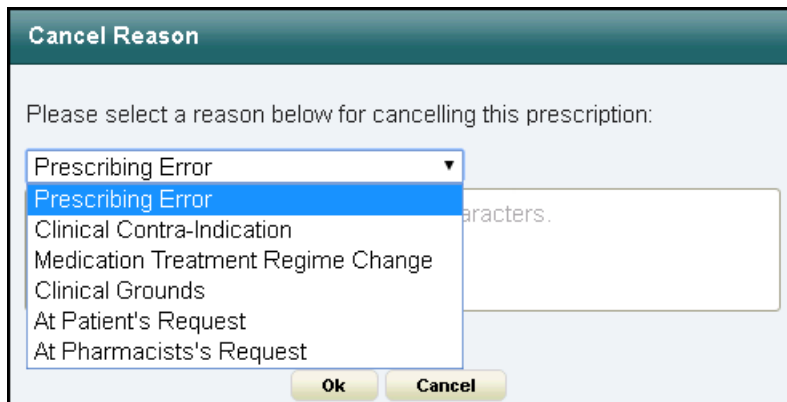
To cancel a prescription:

1. From the **Therapy** screen, select the acute to cancel.
2. Select **Cancel Prescription**:
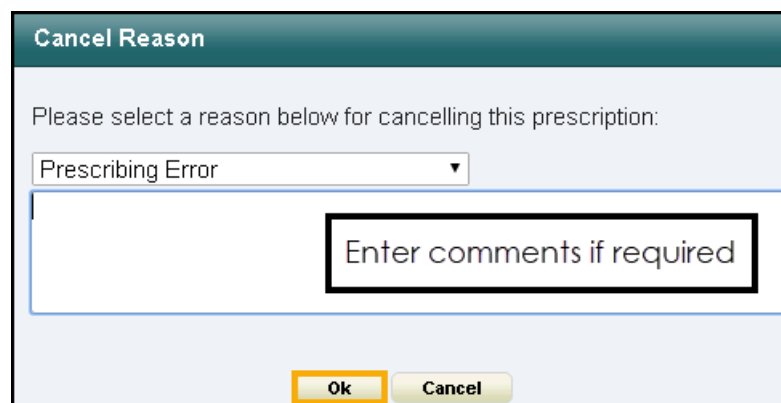
3. The **Cancel Reason** screen displays, select an appropriate reason from the list:

4. Optionally, enter any comments and select **OK**.
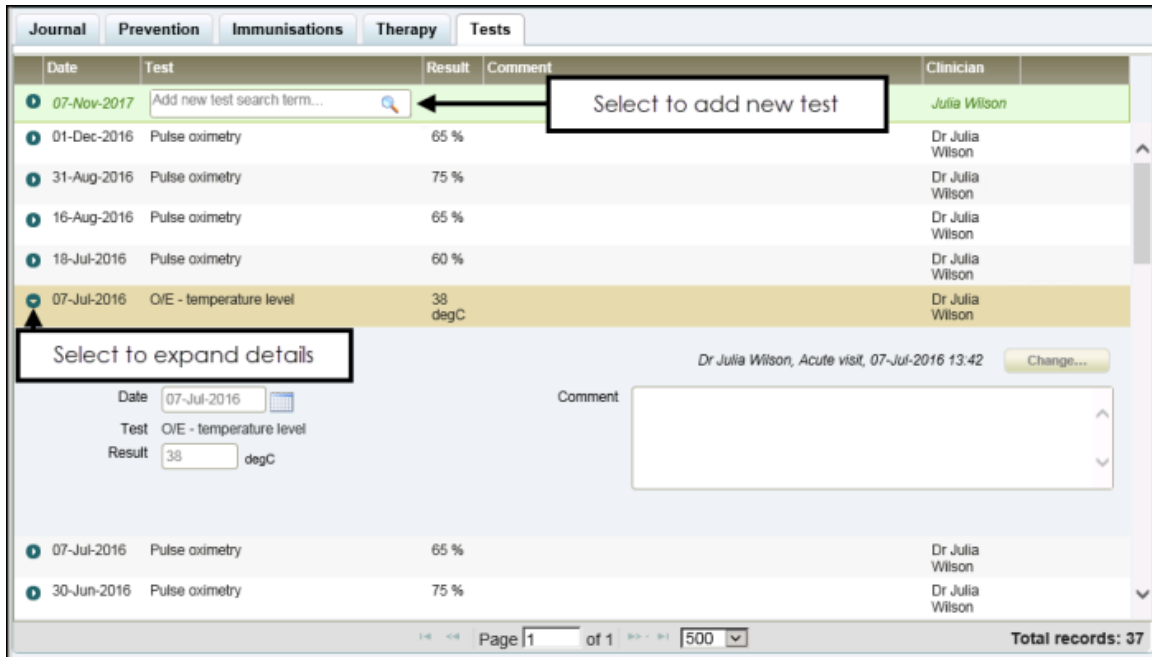
The entry no longer displays. The audit trail reflect these changes.

> ✏️ **Note** - The cancel and reprint options are only available while the consultation is open.

Tests Tab

The **Tests** screen displays a patient's test results and allows you to record new test results:

The **Test** screen displays the following:

- **Date** - The date of the immunisation.
- **Test** - Displays the test type, to expand the entry, select the arrow.
- **Result** - The result of the test where appropriate.
- **Comment** - Any text recorded.
- **Clinician** - Displays the clinician that recorded the entry. Entries made in a **Shared Care Setting** display the **Shared Care** clinician.
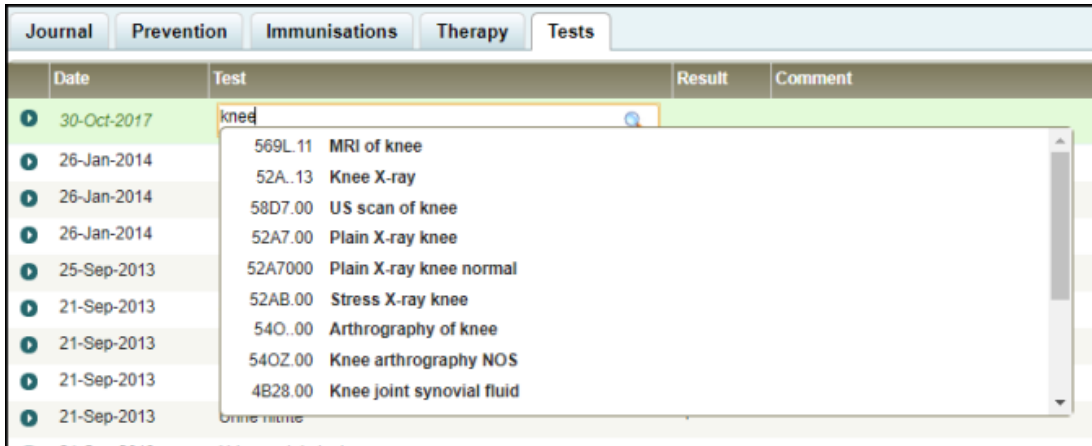
> **Note** - If you are recording the first saved entry of this consultation with the patient, the **Consultation** screen displays. Complete as appropriate, see **Consultations** on page **12** for details.

To record new test:
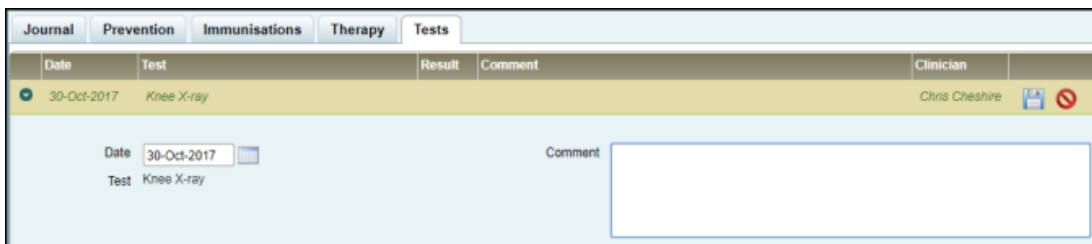
1. From the **Tests** screen, select **Add new test search term** and enter either:
   - **A Clinical Code** (preceded by #), or
   - **A Clinical Term** (minimum of two characters)

2. Select **Search** [🔍] and the matching options display:

3. Select the term you want to add and the appropriate test displays:

Complete as required:

- **Date** - Defaults to today's date, update as required.
- **Result** - Enter the result where available.

   🖊 **Note** - The units for the test result reflect the selected test and display alongside **Result**.

- **Comment** - Enter any comments to support this record.
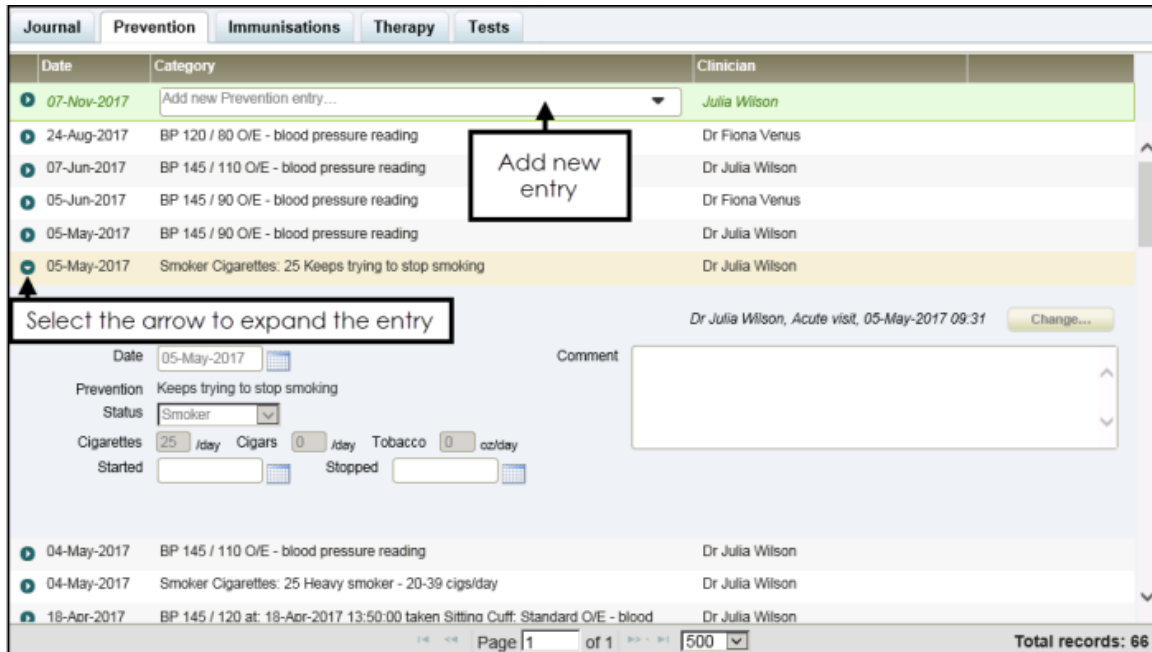
   🖊 **Note** - Some options may not be available depending on the test selected.

4. Select **Save** [💾] to save and close the entry.

Prevention Tab

The **Prevention** screen displays a patient's specific life style and examination data and allows you to record new prevention entries:
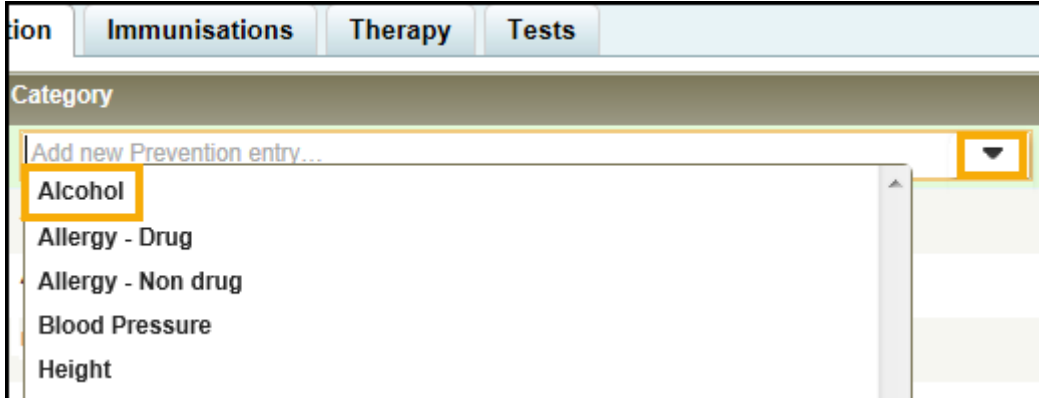

You can view and record the following from the **Prevention** screen:

✏ **Note** - If you are recording the first saved entry of this consultation with the patient, the **Consultation** screen displays. Complete as appropriate, see **Consultations** on page **12** for details.

Alcohol

To record alcohol consumption:

1. From the **Prevention** screen, select the **Add new Prevention** entry list and select **Alcohol**:

2. The **Alcohol** form displays:

Complete as required:

-   **Date** - Defaults to today's date, update as required.
-   **Drinker** - Select the appropriate status.
-   **Units/Week** - Enter the weekly units
-   **Started/Stopped** - Enter **Started** and **Stopped** dates if appropriate.
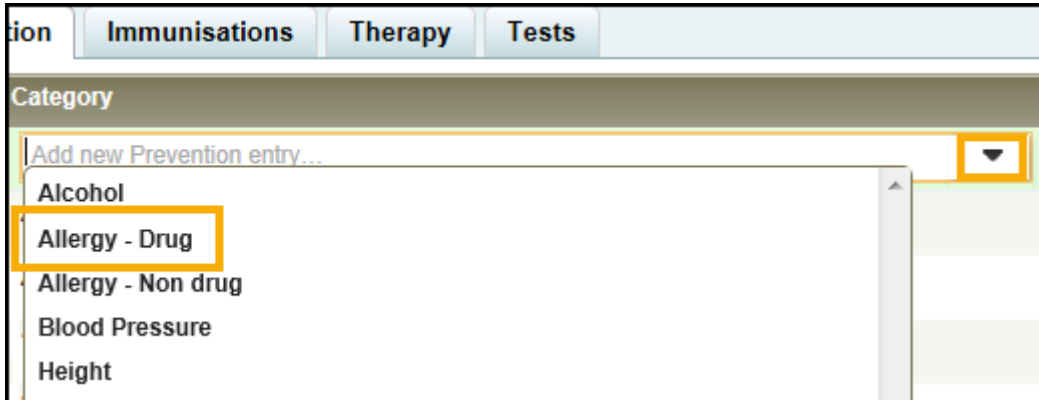-   **Comment** - Enter any comments to support this record.

    Note - Some options may be disabled depending on status chosen.

3. Select **Save** to save and close the entry.

Allergy - Drug

To record a drug allergy:

1. From the **Prevention** screen, select the **Add new Prevention** entry list and select **Allergy - Drug**:

2. The **Allergy - Drug** form displays:
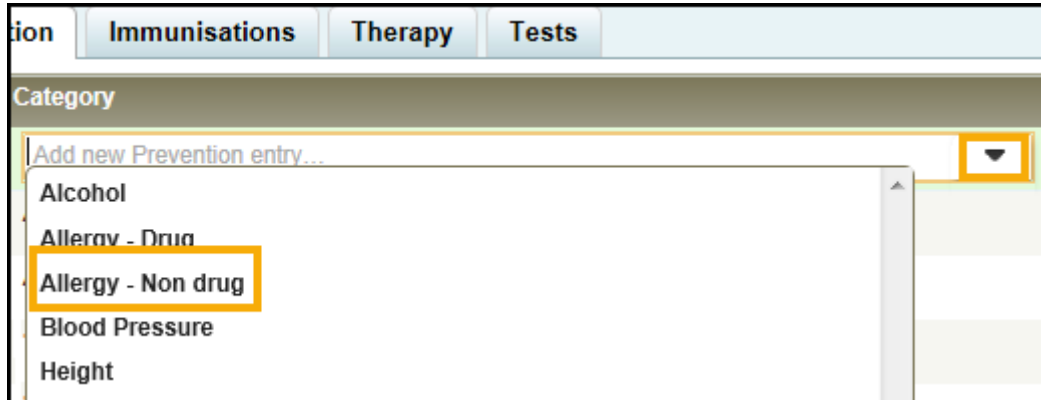

   Complete as required:

   - **Date** - Defaults to today's date, update as required.

   - **Drug** - Enter the drug name and select **Search** . Select the drug from the list.

   - **Severity/Certainty** - Select as appropriate.

   - **Comment** - Enter any comments to support this record.

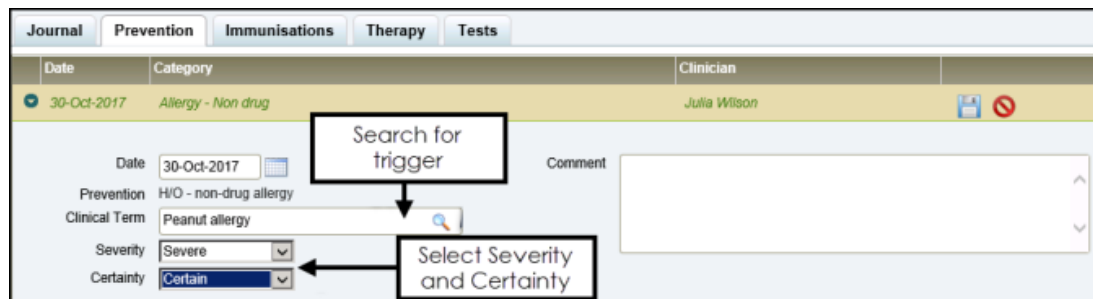3. Select **Save** to save and close the entry.

Allergy - Non-drug

To record a non-drug allergy:

1. From the **Prevention** screen, select the **Add new Prevention** entry list and select **Allergy - Non drug**:

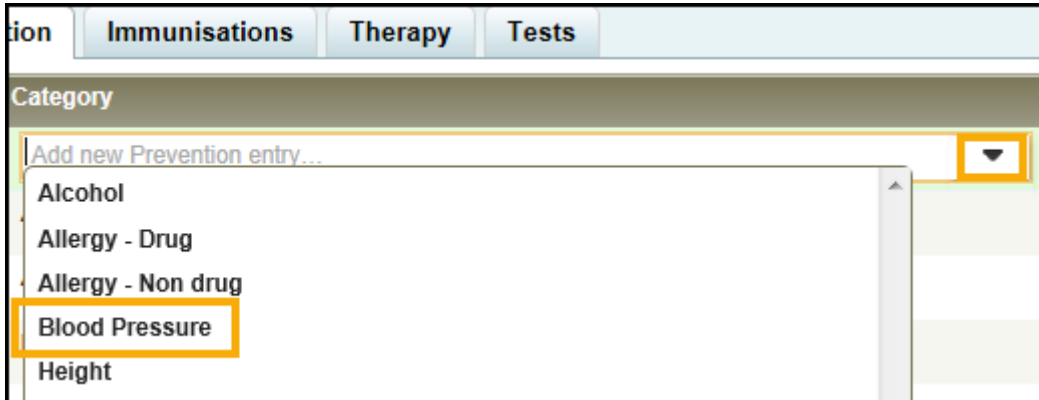2. The **Allergy - Non drug** form displays:

Complete as required:

- **Date** - Defaults to today's date, update as required.
- **Clinical Term** - Enter the details of the allergy trigger and select **Search** . Select the term required from the list.
- **Severity/Certainty** - Select as appropriate.
- **Comment** - Enter any comments to support this record.

3. Select **Save** to save and close the entry.

Blood Pressure

To add a blood pressure reading:

1. From the **Prevention** screen, select the **Add new Prevention** entry list and select **Blood Pressure**:

2. The **Blood Pressure** form displays:
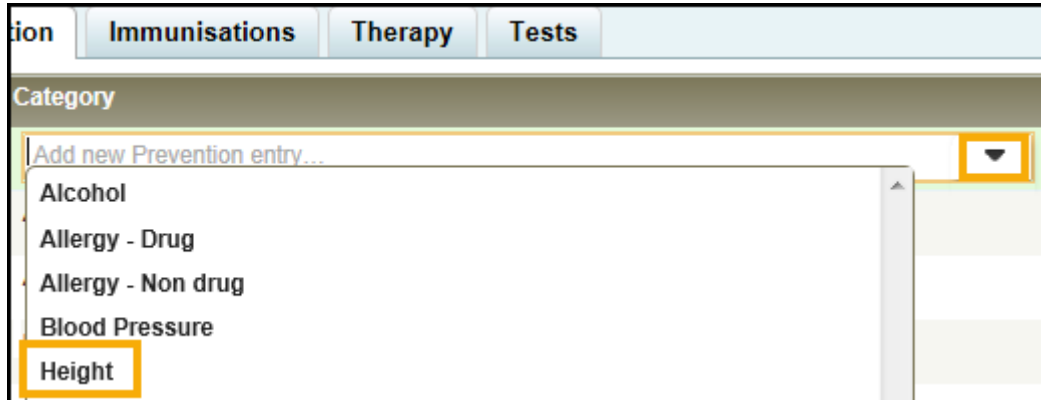
3. Complete as required:

    - **Date** - Defaults to today's date, update as required.

    - **Systolic/Diastolic** - Enter the reading.

    - **Comment** - Enter any comments to support this record.

4. Select **Save** to save and close the entry.

Height

To add a height record:

1. From the **Prevention** screen, select the **Add new Prevention** entry list and select **Height**:

2. The **Height** form displays:

    Complete as required:

    -   **Date** - Defaults to today's date, update as required.

    -   **Height** - Enter the patient's height in metres, a maximum of 2 decimal places.

        > **Note** - The last recorded weight in kilograms, if available, displays below the **Height** along with the calculated BMI.
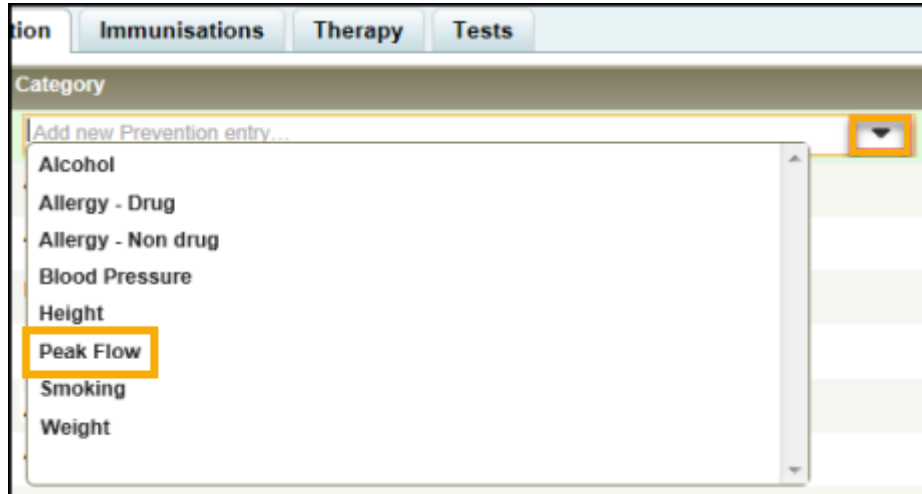
    -   **Comment** - Enter any comments to support this record.

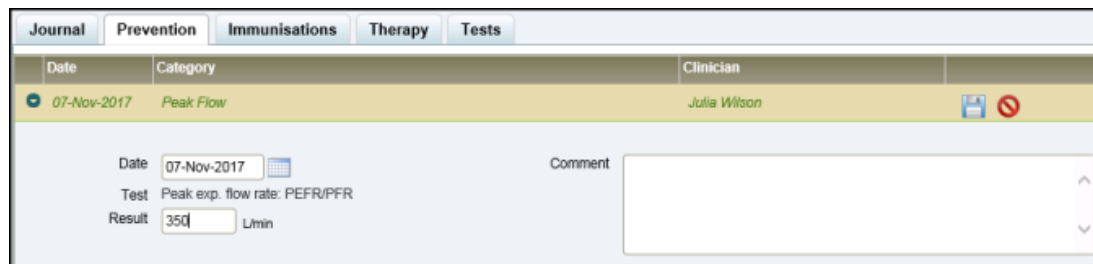3. Select **Save** to save and close the entry.

Peak Flow

To record a peak flow:

1. From the **Prevention** screen, select the **Add new Prevention** entry list and select **Peak Flow**:

2. The **Peak Flow** form displays:
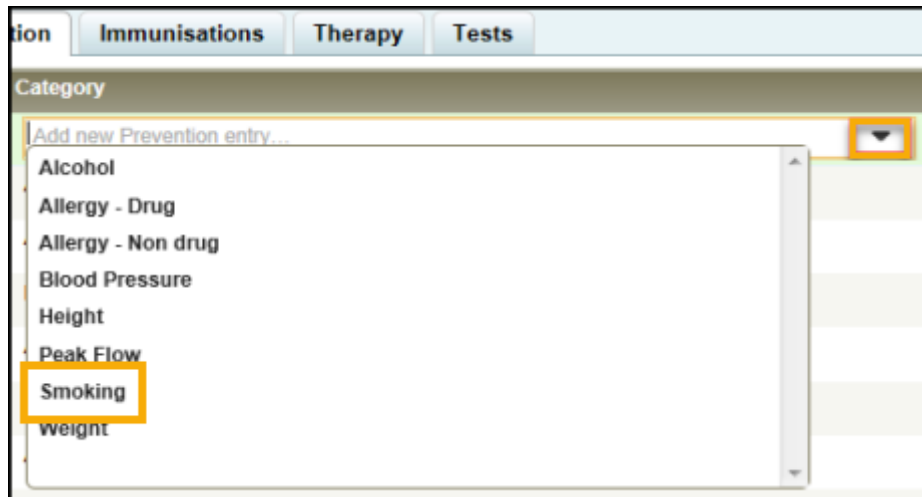

Complete as required:

- **Date** - Defaults to today's date, update as required.
- **Result** - Enter the peak flow in L/min.
- **Comment** - Enter any comments to support this record.

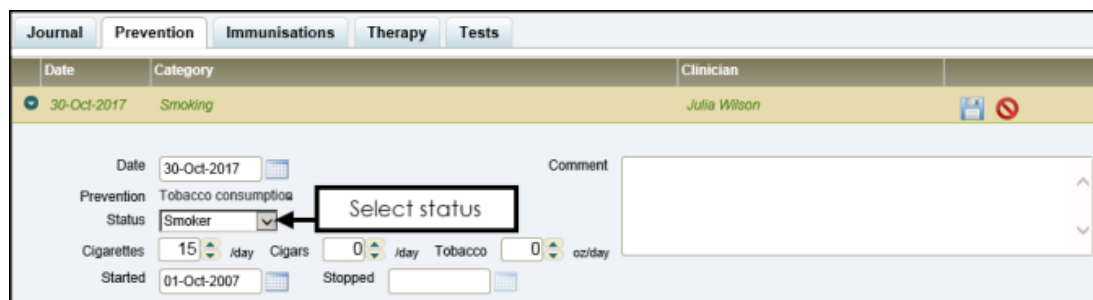3. Select **Save** to save and close the entry.

Smoking

To record smoking status:

1. From the **Prevention** screen, select the **Add new Prevention** entry list and select **Smoking**:

2. The **Smoking** form displays:

    Complete as required:

    *   **Date** - Defaults to today's date, update as required.
    *   **Status** – Select the appropriate status.
    *   **Cigarettes/Cigars/Tobacco** - Enter the daily values.
    *   **Started/Stopped** - Enter started and stopped dates if appropriate.
    *   **Comment** - Enter any comments to support this record.
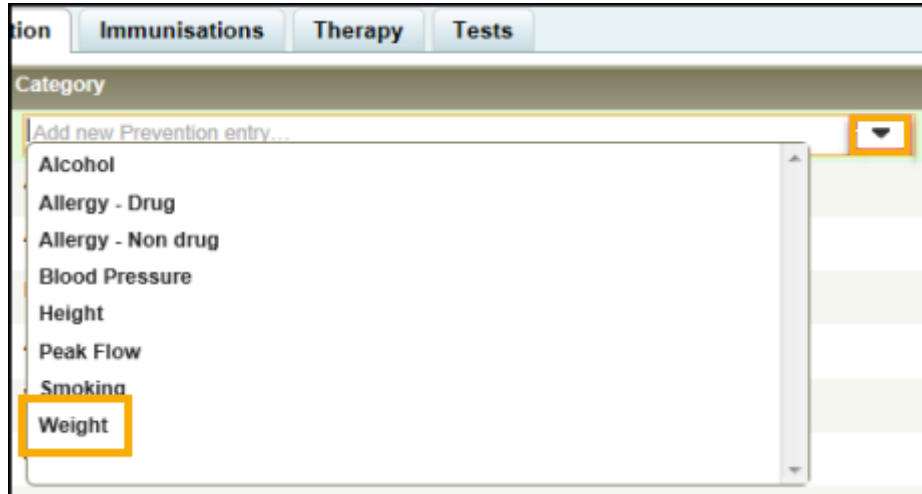
    > **Note** - Some options may be disabled depending on status chosen.

3. Select **Save** to save and close the entry.

Weight

To add a weight record:

1. From the **Prevention** screen, select the **Add new Prevention** entry list and select **Weight**:

2. The **Weight** form displays:

Complete as required:

- **Date** - Defaults to today's date, update as required.

- **Weight** - Enter the patient's height in kilograms, a maximum of 2 decimal places.

    > ✎ **Note** - The last recorded height in metres, if available, displays below **Weight** along with the calculated BMI.

- **Comment** - Enter any comments to support this record.

3. Select **Save** 🖫 to save and close the entry.

Immunisations Tab

The **Immunisation** screen displays the patient's vaccination history and allows you to record new immunisations:

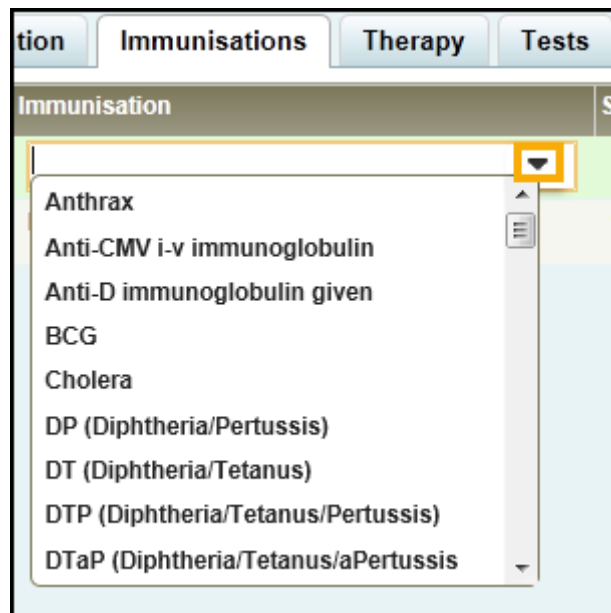The **Immunisation** screen displays the following:

- **Date** - The date of the immunisation.
- **Immunisation** - Displays a summary of the entry, to expand the entry, select the arrow.
- **Stage** - The stage of the immunisation.
- **Batch #** - The batch number of the immunisation where recorded.
- **Comment** - Any text recorded.
- **Clinician** - Displays the clinician that recorded the entry. Entries made in a **Shared Care Setting** display the **Shared Care** clinician.

> **Note** - If you are recording the first saved entry of this consultation with the patient, the **Consultation** screen displays. Complete as appropriate, see **Consultations** on page **12** for details.
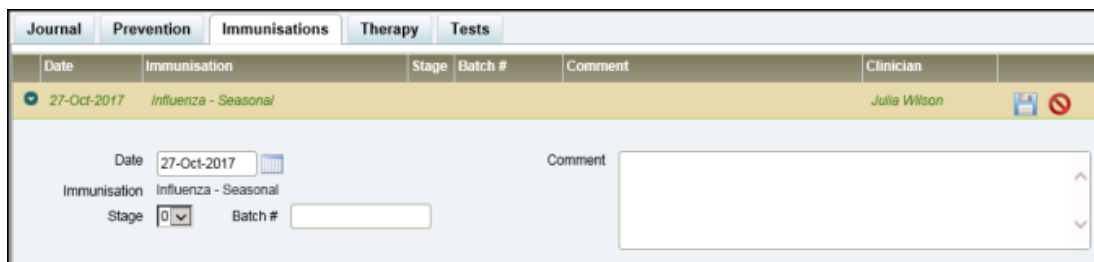
To record new immunisations:

1. From the **Immunisations** screen, select **Add new Immunisations** and select from the available list:

2. The **Immunisation** form displays:

Complete as required:

- **Date** - Defaults to today's date, update as required.
- **Stage** - Select the appropriate stage for this immunisation.
- **Batch** - Enter the batch number of the vaccine.
- **Comment** - Enter any comments to support this record.

3. Select **Save** to save and close the entry.

Referral History

Patient referral information displays in the **Journal** tab and is identified by **Refer for** in the description column.

Select the arrow to expand the entry:

- **Date** – Displays the date of the referral.
- **Clinician** – Displays the referring clinician.
- **Refer for** – Displays the clinical term for referral.
- **Referral to** – Displays the clinician and location.

Editing Entries

ℹ️ **Important** - You can only edit or delete data that has not yet been synchronised. Prescriptions that have been printed cannot be edited.

To edit recorded data:

1. With the patient selected, select the relevant screen.
2. Locate and highlight the entry you wish to update:

Journal	Prevention	Immunisations	Therapy	Tests		
Date	**Description**				**P** 🔽	**Clinician**
ⓞ 27-Oct-2017				🔍		*Julia Wilson*
ⓞ 27-Oct-2017	Low back pain Fell down stairs				3	Julia Wilson ✏️ ❌
ⓞ 12-Oct-2017	Cough				3	Dr Julia Wilson

3. Select **Edit** ✏️ to the right of the entry.
4. The data entry form displays, update as required.
5. Select **Save** 💾 to save and close the entry.

✏️ **Note** - All changes made, including deletions, can be viewed in the audit trail.

➡️ See **Data Synchronisation** on page **6** for details.

Deleting Entries

> **ℹ Important** - You can only edit or delete data that has not yet been synchronised. Prescriptions that have been printed cannot be deleted.

To delete recorded data:

1. With the patient selected, select the relevant screen.
2. Locate and highlight the entry you wish to delete:

3. Select **Delete** ✖ to the right of the entry.
4. The '*Are you sure*' message displays, select **Yes** to proceed:

The entry is removed from the record.

> **✎ Note** - All changes made, including deletions, can be viewed in the audit trail.