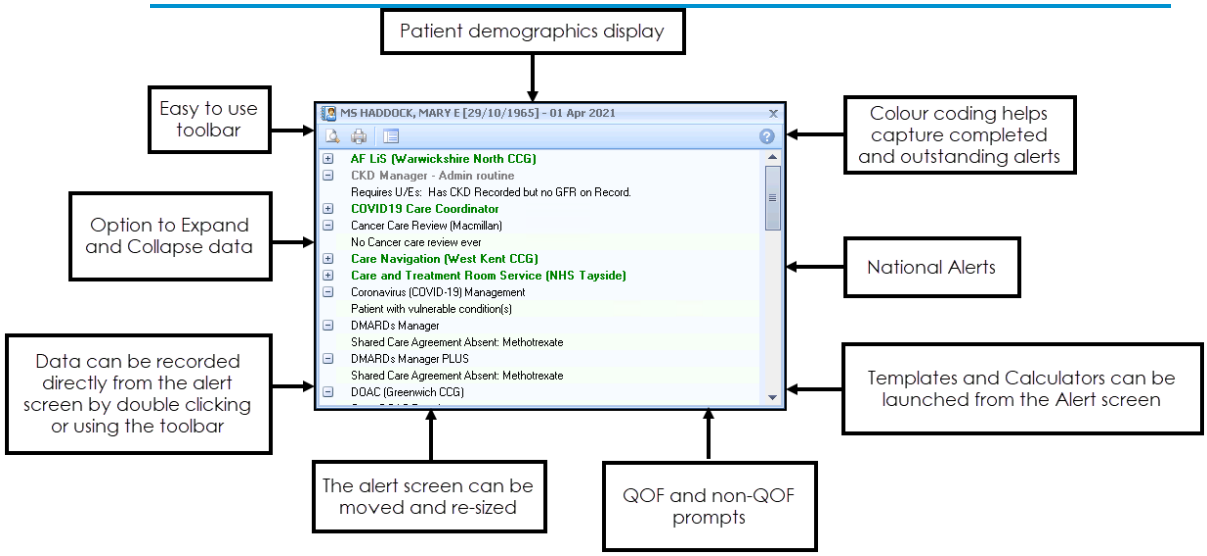
Quick Reference Guide - Vision+ Data Entry Tools

Vision+ Alert Screen

The **Vision+ Alert** screen displays when you select a patient in **Consultation Manager**. It enables you to view and capture "real time" data for a patient.

Important - The **Alert** screen does not display if you are in **Vision+ Practice Reports**. To view the alert screen in the patient record, close **Vision+ Practice Reports**.

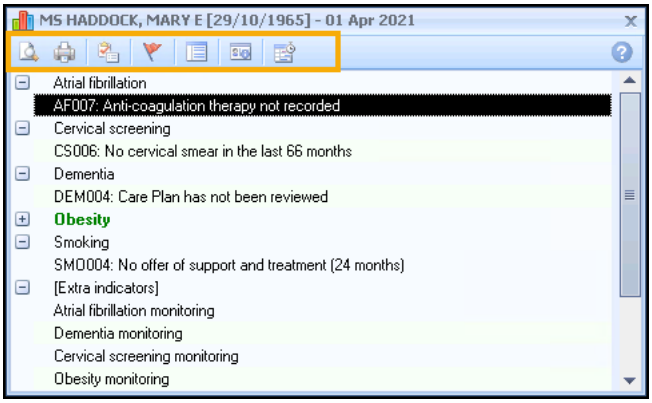


The screen displays the following for a patient:

- **QOF/QAIF areas** - Outstanding and completed QOF/QAIF areas.
- **Enhanced services** - Local and national enhanced services.
- **National alerts** - For example Sepsis, Diabetes UK, Macmillan Cancer Support.
- **Local alerts** - For example templates designed by your Integrated Care Board (ICB) or Health Board (HB).

Toolbar

The **Toolbar** is located at the top of the **Alert** screen and is used to access different functions, for example, calculators, templates, merge options. If you highlight an **Alert** line, the options on the toolbar are enabled or disabled depending on your selection:



The following table shows the toolbar options:

Option	Function
	Displays the codeset data entry screen, see **Data Entry in Vision+** on page **3**.
	Displays the template for the selected indicator.
	Displays the **Indicator Logic Tool**.
	Displays the smoking data entry screen, see **Recording Smoking Status** on page **5**.
	Displays the **Rule Logic Tool**.
	Displays the **BMI Calculator.**
	Displays exception terms for the current contract year, see **Adding Current Exception Codes** on page **8**.
	Displays expiring terms for the previous contract year.
	Displays data entry terms for entering additional clinical terms.
	Displays the Blood pressure data entry screen, see **Recording Blood Pressure Values** on page **6**.
	Displays the **Rule Logic Exception Tool**.
	Displays the Depression questionnaire.

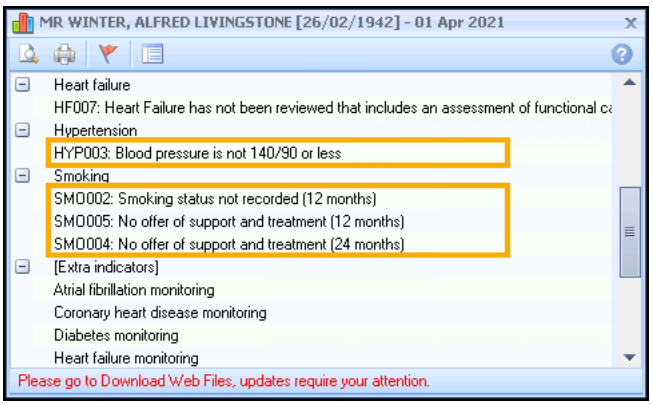
Option	Function
	Displays the **General Practice Physical Activity Questionnaire (GPPAQ)** questionnaire.
	Displays the **Scottish Physical Activity Screening Questionnaire (Scot-PASQ)** questionnaire.
	Displays the **ASSIGN CVD Risk Calculator**.
	Displays the QRISK calculators.
	Displays the **CHADS2-VASc - AF Stroke Risk Calculator**.
	Displays the **Diabetes Risk Calculator**.
	Print preview or print the alert screen.
	Perform a Mail and/or SMS merge.

 **Training Tip** - Hover the cursor over the **Toolbar** for a description of its function in a tooltip.

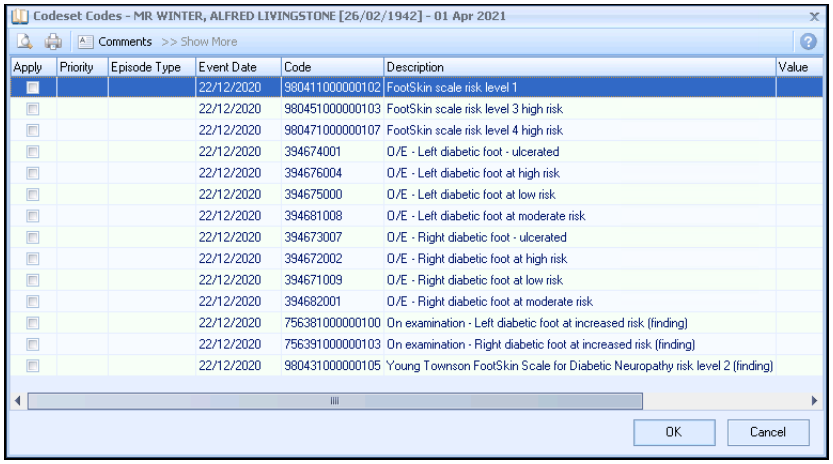
Data Entry in Vision+

The **Codeset Codes** data entry screen is the most used tool in **Vision+**. From this screen you can list and select individual or multiple clinical terms. To access the **Codeset Codes** data entry screen:

1. From **Consultation Manager**, select a patient and open a Consultation.
2. If your practice uses Problems, open or create the relevant Problem.
3. The alerts screen displays showing data that is missing from the patient record:



4. From the alerts screen you can either:
   - Double click on the indicator line,
   - Highlight the Indicator line and select **Contract** on the toolbar,
   - Right click and select **Contract** Contract.
5. The **Codeset Codes** screen displays:



6. In the **Apply** column, select the code you wish to use. You can also make selections from the other columns:
   - **Priority** - Select from the drop-down list. If left blank the **Priority** is the same as your default setting.

     Note - Where the entry does not require a **Priority**, for example tests, any selection is ignored and is not written back to the patient's record.

   - **Episode Type** - Select the **Episode Type** from the drop-down list. If not selected the **Episode** defaults to blank.

     Note - Where the entry does not require an **Episode Type**, for example tests, any selection is ignored and not written back to the journal.

   - **Date Recorded** - Enter a date or select the drop-down list to display a calendar.
   - **Code** - This is the clinical term and is for information only.
   - **Description** - This is for information only and cannot be changed.
   - **Value** - Use for recording data requiring numeric values.
   - **Comments** - Optional free text comments can be accessed from a pre-defined list. Alternatively, you can enter free text comments.

- **Comments** 

- Select to setup a pre-defined list of items. To enter a new comment start typing. If you press return you move to a new line as if you are creating a new comment. Select **OK** to save the changes.
- **Show More** 

- Some clinical term lists are quite exhaustive which is why the list displays the most commonly used codes. Select **Show More** to expand the selection.

Note - The **Apply** column is automatically ticked if you change any of the other columns.

7. Select **OK** to record the data to the patient record.

The alert for the missing data is now removed from the alert screen.

Recording Measurements and Values

To help with recording of data, **Vision+** has some additional screens that make it easy to record everyday information such as Blood Pressure and BMI as well as various calculators. These user-friendly screens simply require the values to be entered and the **Vision+** automatically adds the appropriate clinical terms for you.

Recording Smoking Status

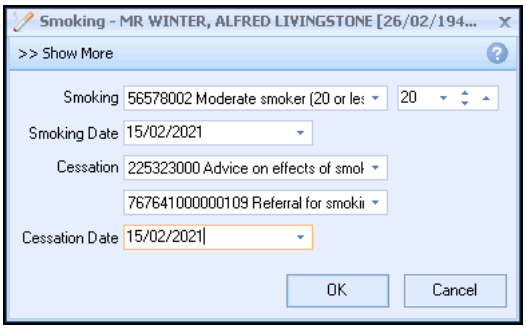
The **Smoking Status** screen enables you to quickly input a patient's smoking status.

To record a smoking status:

1. Highlight the required indicator and either:
   - Double click the indicator line,
   - Right click and select **Smoking** 

from the menu, or,
   - Select **Smoking**  from the toolbar.
2. Select a smoking code and optionally enter a quantity.
3. Record the **Event Date** or use the drop-down list to select from the calendar.
4. If the patient is a smoker or ex-smoker record the Smoking Cessation advice code and optionally enter a second cessation code.
5. Record the **Cessation Date** or use the drop-down list to select from the calendar.

6. Select **OK** to save the changes to the patient record:

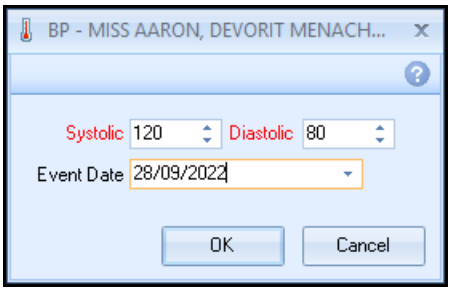


Note - When the smoking entry is added to the patient record, the **Date Started** and **Date Stopped** data entry boxes do not populate.

Recording Blood Pressure Values

The **Blood Pressure** data entry screen enables you to quickly record blood pressure values. To record blood pressure values:

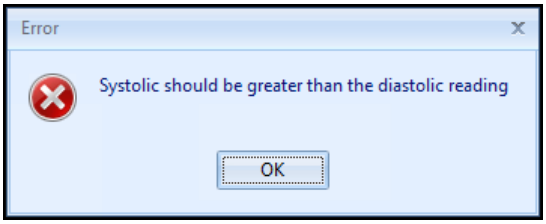
1. From the **Alert Screen**, highlight the relevant indicator line and either double click or select **Blood Pressure** .
2. The **BP** screen displays for the selected patient, enter the **Systolic** and **Diastolic** readings.
3. Record the **Event Date** of the blood pressure or use the drop-down list to select from the calendar:



4. Select **OK** to save the changes to the patient record:

Data Validation

If you enter a reading outside of the expected range a warning displays:



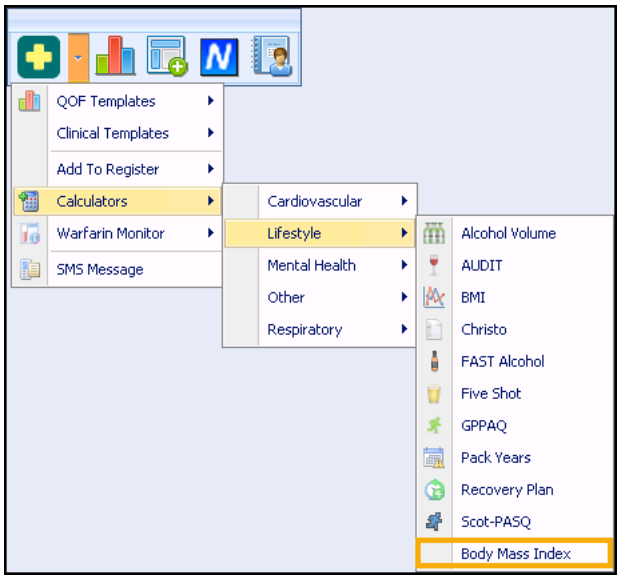
Select **OK** to return to the **BP** screen and check the readings are correct.

BMI Calculator

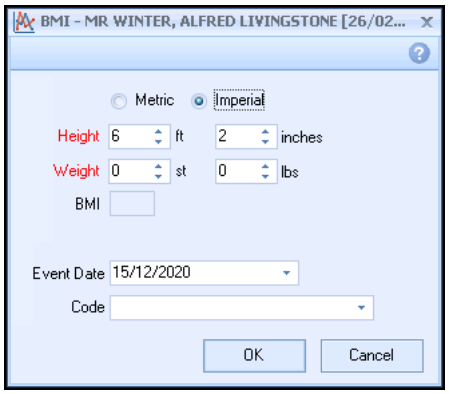
The **BMI Calculator** enables you to quickly input a patient's height and weight values. **Vision+** calculates the BMI and records the appropriate term in the patient's record.

To access the BMI calculator:

1. From **Consultation Manager**, select the **Vision+** alert screen, highlight the indicator and select **BMI** or select **Vision+** from the floating toolbar and select **Calculators - Lifestyle - BMI**:



2. The **BMI Calculator** displays:



   Select either **Metric** or **Imperial**.

3. Enter the **Height** and **Weight** values or select from the drop-down list.
4. Record the **Event Date** or use the drop-down list to select from the calendar.
5. A default **Code** displays but can be changed using the drop-down list.
6. Select **OK** 

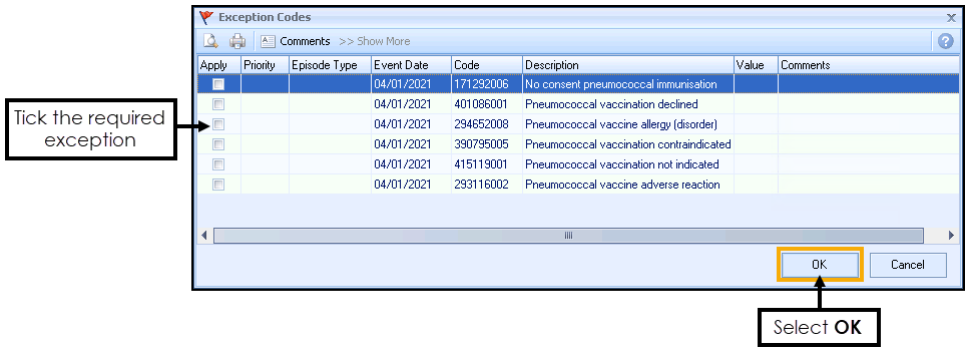
to save the changes to the patient record.

The **Code** and the **BMI** value records in the patient's record.

Adding Current Exception Codes

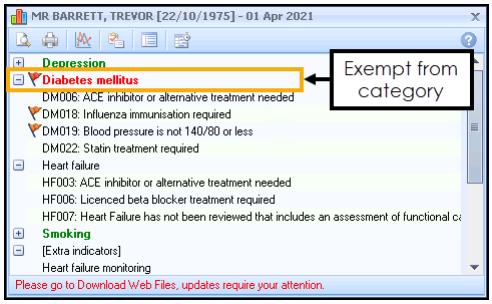
You can use **Exception codes** when you want to exclude a patient from QOF/QAIF. To enter an **Exception code**:

1. From the **Vision+ Alerts** screen in **Consultation Manager**, highlight the indicator line or the category heading you wish to exclude the patient from and either:
   - Select **Exception code** from the toolbar  , or
   - Right click on the relevant line and select **Exception**  .
2. The **Exception Codes** screen displays:



   Tick the item in the **Apply** column for the required exception and select **OK** to save the changes.

Where a patient is exempt from a full clinical domain, the whole category title displays in red:



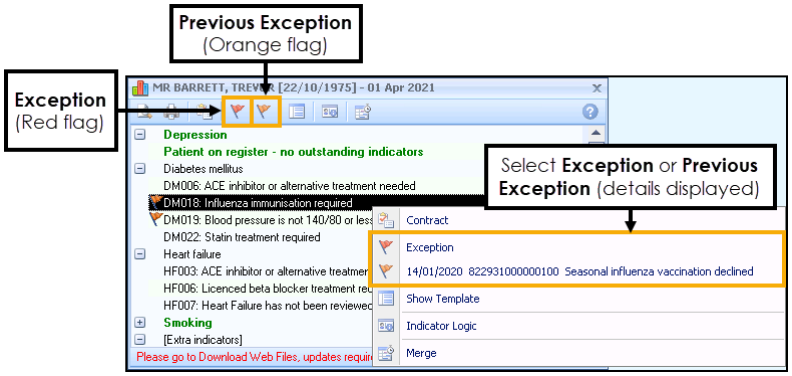
Note - Alerts for indicators with recorded exceptions are disabled, however when viewing the alerts via the QOF/QAIF Templates, the text displays in green.

Adding Expired Exception Clinical terms

Previously used **Exception codes** for the selected patient are represented with an **Orange** flag.

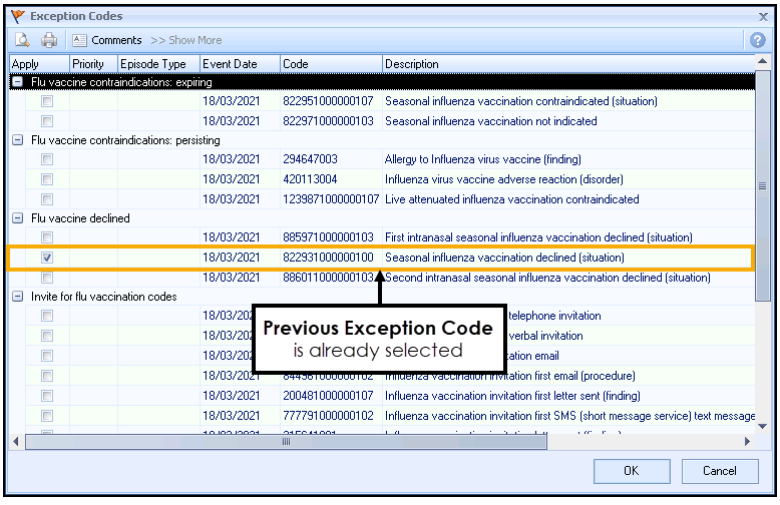
Training Tip - If you hover the mouse over **Previous Exception** on the toolbar the details of the previous exception entry display.

1. To add another exception code, select either:



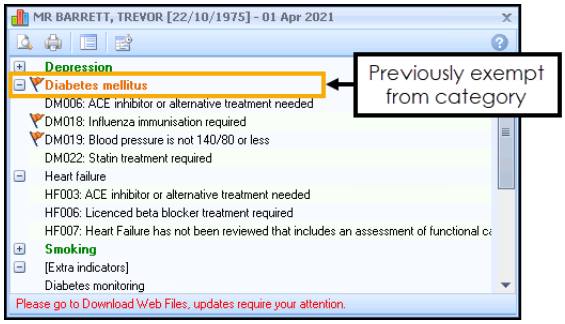
- From the toolbar:
  - **Exception** (Red flag) - Select a new exception code.
  - **Previous Exception** (Orange flag) - View previously selected **Exception code**.
- Right click an indicator line and select:
  - **Exception** Exception - Select a new exception code.
  - **Previous Exception** 14/01/2020 822931000000100 Seasonal influenza vaccination declined - Details of the previous exception entry display.

2. The **Exception Codes** screen displays:



The previous **Exception Code** is already selected, either select **OK** to save the changes or select another code.

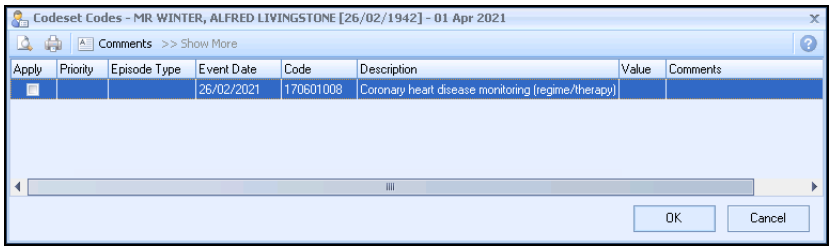
Where a patient was previously exempt from a full clinical domain, the whole category title displays in **Orange**:



Entering Additional Codes

Additional Codes help monitor patient annual reviews.

1. They display on the **Alert Indicator** screen under the heading **Extra Indicators** and can be accessed by:
   - Double clicking on the line(s) below **Extra Indicators**
   - Highlight the indicator line and select **Additional**  .
   - Right click and select **Additional** from the menu.
2. The **Codeset Codes** screen displays:



In the **Apply** column, select the code you wish to use. You can also make selections from the other columns:

- **Priority** - Select from the drop-down list. If left blank the **Priority** is the same as your default setting.

> **Note** - Where the entry does not require a **Priority**, for example tests, any selection is ignored and is not written back to the patient's record.

- **Episode Type** - Select the **Episode Type** from the drop-down list. If not selected the **Episode** defaults to blank.

> **Note** - Where the entry does not require an **Episode Type**, for example tests, any selection is ignored and not written back to the journal.

- **Date Recorded** - Enter a date or select the drop-down list to display a calendar.
- **Code** - This is the clinical term and is for information only.

- **Description** - This is for information only and cannot be changed.
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- Select to setup a pre-defined list of items. To enter a new comment start typing. If you press return you move to a new line as if you are creating a new comment. Select **OK** to save the changes.
- **Show More** 

- Some clinical term lists are quite exhaustive which is why the list displays the most commonly used codes. Select **Show More** to expand the selection.

Note - The **Apply** column is automatically ticked if you change any of the other columns.

3. Select **OK** to enter the data on the patient record.

Note - Additional codes can be used internally by the practice to improve patient care and manage patient reviews.

Note - **Extra Indicators** is a user specific setting. See Options Tab in the **Vision+** Help Centre for more details.