

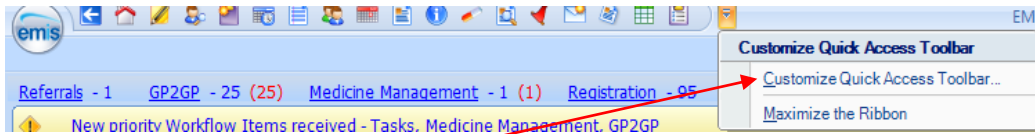


Emis Web

Clinician Quick Reference Guide

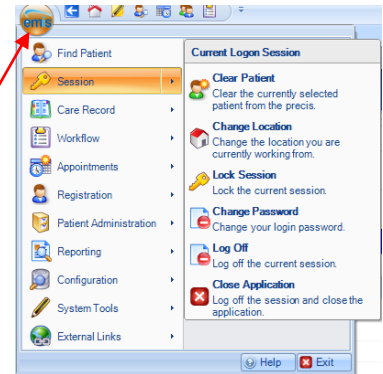
February 2018

Toolbar



This can be configured so you can quickly access many parts of the system. The first 4 icons are set - In 'Customise Quick Access Toolbar' select each item to be added from the list on the left and click Add.

These options can also be accessed from the EMIS bubble



Finding the Patient Record

The patient record can be accessed in 2 ways.

Access a patient via the EMIS bubble or click the 'Find Patient' icon on the quick access toolbar or F5. Enter the patient name and click Search. Select the patient from the search results and the patient **Patient Precis Bar** is opened.

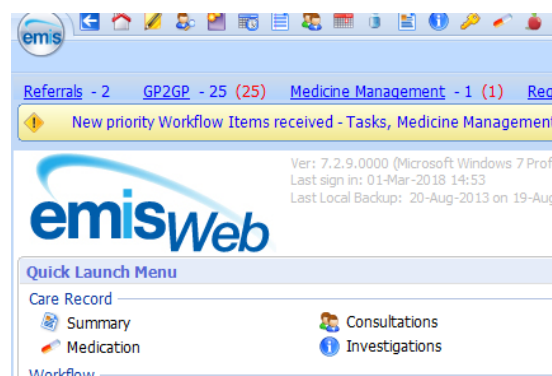


You can view additional demographic and patient warning information by clicking the chevron icon

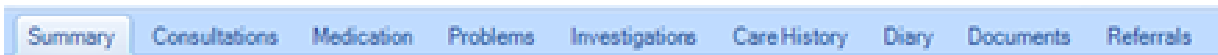
To access the patient record, click on the required icon from the **Quick Access Toolbar** eg consultations. The icons are in alphabetical order (screen tips will appear when you hover over each icon). Or click **Consultations** from the Quick Launch menu on the home page. Or click the **Emis bubble** and **Care Record** and click **Consultations**.



Alternatively, from the home screen select **Consultations** from the Quick Launch Menu and the system will then prompt you to find the patient.



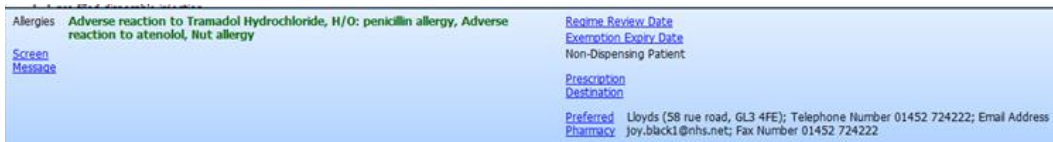
There are several navigation tabs within the Patient Record. These include:



Summary – Overview of the patient record

Consultations – Add a new consultation and view previous ones - Most recent consultation at the top of the list. The view can be filtered if required using 'My Consultations' or setting up Filters using the filter icon.

Medication - All acute, repeats and repeat dispensing medication issued to the patient. Can be filtered by current, past or all. This screen also shows any allergies the patient may have.



Problems - All active and past problems

Investigations - Results of all investigations for the patient. These can be viewed in 'values view' or 'reports view'. When an item is selected i.e. blood pressure, previous results are shown in the right hand pane. Note: The default is to only show the latest results - If you want to view all previous results in the list you need to untick **latest only** in the ribbon.

Care History - All read coded entries on the patient record. When you select an item from the list, details and any additional values are shown in the right hand pane.

Diary - All outstanding appointments, planned items, tasks and test requests. Past appointment information along with completed tasks can also be viewed from here.

Documents - All incoming and outgoing documents. The creating of a letter can also be done from here.

Referrals - All standard outbound, inbound and e-referrals for the patient.

Consultation Screen

Add – Start a new Consultation (Click the top half of the add button)

Save – Consultation **must** be saved within the record when complete. A



new consultation yellow **Sticky Tab** opens in the ribbon to remind you that you have commenced a new consultation.

Next problem – Opens up a new consultation tab for recording of another problem.

Cancel – Cancels the current consultation and reminds you that any data entered will not be saved.

Online Visibility – Option to not show consultation in patients online record.

Date, Consulter, Place – Amend consultation date, location, consultation type if necessary.

Run Template – Add data using a clinical template – Opens **Template Picker**. Search for the required template using text search. Recently used templates appear in the Template Picker automatically. Double click to select the template. **TIP:** QOF templates are prefixed “GP Contract....”

Book Appointment – Book an appointment for the patient

Create Task – Send a patient task to a user or team.

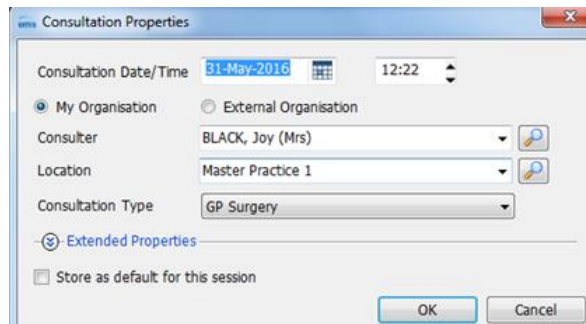
Medication review – Records that medication review has been performed and sets follow up Diary Entry in patient record for date of next medication review.

Fit Note – Issues Fit Note for printing. By default the Fit Note picks up the current problem within the consultation. This can be overwritten if necessary. The Fit Note can be previewed before printing.

Spell Check – Checks spelling within current consultation.

Adding a New Consultation

In the Consultations tab click the **Add**. Select the type of consultation you are doing from within **Consultation Properties**.



Note: If the type of consultations for the rest of your session will not change, click on **store as default for this session** box which will stop the consultation properties dialogue box from appearing each time.

The column on the right-hand side of the screen contains two tabs: Summary (Summary of patient record) and Resource (Patient information leaflets etc).

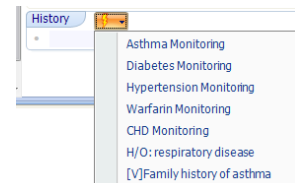
A list of headings is displayed on the left-hand side of the screen - Use these to add different information to the consultation:

Problem - Click the Problem section on the left to begin adding a problem.

Existing - The Summary pane on the right side of the consultation screen displays Active and Significant past Problems. Double click an existing problem to add it to the consultation.

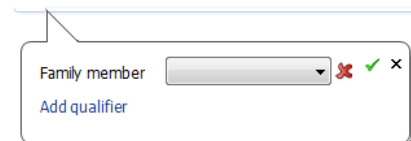
New - To add a new problem start typing the details e.g. Ear and suggestions of appropriate Read Codes will appear - Double click to select a code. Click on the F4/more link to open the read code browser to select other codes..

History - Used to record the history of a problem. The lightning bolt icon can be used to add commonly used codes if set up.



Examination - Used to record an examination of the patient i.e. blood pressure, weight, height, peak flow etc.

Family History - Used for entering family history of a problem or condition. You will be prompted to select which family member.



Social - Used to record the patients social activities i.e. alcohol consumption, smoking status etc.

Comment - This can be used for any additional comments that need adding to the consultation.

Medication - Clicking Medication, via the consultation, will bring up the 'Add a Drug' browser. This is where prescribing of Acute and Repeat medication is actioned.

Alergy	Date	Clinician
Adverse reaction to atenolol	13-Apr-2016 12:54:00	MAYALL, Bernie (Ms)
Adverse reaction to Tramadol Hydrochloride	10-Oct-2014	MAYALL, Bernie (Ms)
H/O: penicilin alergy	20-Nov-2015 14:57:00	BLACK, Joy (Mrs)
Nut alergy	02-May-2016	BLACK, Joy (Mrs)

Dictionary of Medicines + Devices (dm+d)
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Start to type in the name of a drug and a list of options will appear

Name	Quantity	Rx Types
A Amoxicillin 500mg capsules		P
B Amoxicillin 125mg/5ml oral suspension sugar free		P
C Amoxicillin 250mg capsules		P
D Amoxicillin 125mg/5ml oral suspension		P
E Amoxicillin 250mg/5ml oral suspension		P
F Amoxicillin 3g oral powder sachets sugar free		P
G Amoxicillin 500mg/125mg tablets		P

When you select the drug, if there are any contraindications or warnings relating to the drug, a dialog box will appear informing you of this.

You will then be prompted to select a dosage

Dosage	Quantity	Rx Types
A One To Be Taken Three Times A Day (15 capsule)		
B One To Be Taken Three Times A Day (21 capsule)		
C Two To Be Taken Twice A Day (28 capsule)		
D Two To Be Taken Three Times A Day (30 capsule)		
E Two To Be Taken Three Times A Day (42 capsule)		

Depending on the dosage you select, the quantity and duration will automatically insert. If you need to change the default, Insert the quantity required and click the 'tab' button and the duration will automatically calculate.

The type of prescription can be changed here.

- Acute
- Repeat
- Repeat Dispensing
- Automatic

If you select Repeat, Repeat Dispensing or Automatic, insert the number of issues authorised.

Authorised Issues

Review Date

Select if required. This review date is for the individual item, not a general medication review date for the patient. You can set the general medication review date on the Issue screen later.

Review Date 29-Sep-2016

Days before next issue

If required, type the minimum/maximum number of days before the item can be issued again; if you try to issue outside this timeframe, a warning message is displayed (This can be overridden).

Days Before Next Issue	Min	<input type="text"/>	Max	<input type="text"/>
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Issuing medication

If issuing a **single** medication, click **Issue**. The issue authorisation screen will appear.

To add **multiple** items to a prescription, Click **Add Another**, select the drug, complete quantity and duration details. Click Issue.

The Issue Authorisation screen will appear and Items can be **Removed** if necessary.

Authorising Prescriptions

If the patient has a nominated EPS Pharmacy and items are ETP compliant click **Approve and Complete** to proceed to the EPS digital signing process. Enter Smartcard PIN number to authorise the prescription issue.

If the patient requests the prescription to be printed on this occasion, click **Change All** and select **NHS Printed Script (Change All** is not a permanent setting and only applies to this prescription)

Follow Up - Used to add a diary entry to the patient record. Select Read Code for diary event eg Diabetic Annual Review. Set the diary date and click OK.

Procedure - Used to record procedures eg Minor surgery performed

Test Request - Used to create an Offline or Online Test request - Connects to ICE.

Referral - Used to process a referral. This could be a standard outbound referral or an e-referral.

Document - Used to create a new letter, proforma or document. You can also attach a document not currently filed in EMIS or attach a document from the patient record to the consultation.

Allergy - Used to record an allergy for the patient.

QOF alerts - When accessing a patient record, any QOF alerts or Information alerts for the patient will show in a pink alert pane at the bottom right hand corner of the patient record. A more detailed explanation can be viewed by hovering over the alert. Double click on an alert to open the appropriate Data entry template.