Facilitating the management of long term conditions

A Navigation guide to NHS Greater Glasgow and Clyde Clinical Support templates
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Introduction

This navigation booklet is intended to provide comprehensive support to practitioners using the Clinical Support templates. Clinical Support (CS) is an electronic clinical support system that provides an evidence based decision making tool. Its dynamic features facilitate patients with co-morbidities to have person centred consultations.

This document provides guidance and links to the updated user guides. It also presents the information which has been regularly requested, as well as providing solutions to common areas of difficulty.

Clinical Support (CS)

Designed by the software company MSDi, the templates have been produced in partnership with practice staff, patient representatives and the Managed Clinical Networks (MCNs).

- CS is a software system that sits separately to both EMIS and VISION.
- To access this system, you must first select a patient in your clinical system (EMIS or Vision).

The “dynamic” functionality of the templates enables practitioners to combine more than one disease to produce a tool which will support a multi-morbidity review. The Health Determinants template has “dynamic” functionality but does not combine with the clinical templates.

Software Navigation Guides

The links below will
- Show you how to access CS via EMIS or Vision.
- Demonstrate how the templates combine
- Improve your understanding of the recording requirements of these templates
- Give you confidence that you are using the templates effectively

Quick start guide for EMIS

Quick start guide for VISION
Navigating CS

Default screen when access CS

Click this link to gain information re any new updates. These pages are managed by NHSGG&C. All the background information for all sections throughout the templates are linked to this website.

Pre-Consultation Template

This has been designed to help the practitioner identify and plan for any additional support needs their patient may have in advance of their review.
The Clinical Template

The Purpose of this section of the handbook is:

- Outline features of the template
- Frequently Asked Questions.

The templates should be used as a framework or a tool to provide evidence based person centred care. It will facilitate you to ask appropriate questions and to quickly find resources your patient might identify they need.

Document map

The Document map is a useful tool that sits on the left hand side of the templates. It enables you to quickly access template sections, so allowing the consultation to flow naturally and enhance patient centeredness. This facility reduces the need to scroll through the template.
**Clinical Template Frequently Asked Questions**

**Can I add a diagnosis code or medication in CS?**

No.
All diagnosis and medications should be recorded in the clinical system prior to using CS.

**Is there a place at the end of the template for review or recall?**

No.
Every practice has its own systems for review and recall. This can be done in the same way as you do at the moment in EMIS or Vision.

**Do I need to use SCI Diabetes to record a foot screen?**

Yes.
To enable better communication between Acute services and Primary care. Adding your patients’ foot screening results into SCI diabetes, then stratifies the foot risk. There are also many leaflets within SCI diabetes which are useful to download and print off for your patient.
How can I access My Diabetes My Way?

Link to SCI Diabetes log in page.

Link to My Diabetes My Way
Is there the ability to free text some clinical information within CS?

Free text boxes can be found as shown. These can be used to write some text pertinent to the read code you are recording.
The Health Determinants (HD) template

The Purpose of this section of the handbook is to outline the main components of the Health Determinants template including:

- How to navigate the Health and Wellbeing Directory
- To describe some common scenarios that you may face.
- Frequently Asked Questions.

1) Assess status

This part of the template enables the clinician to ascertain their patients’ current health status.

- Does your patient smoke? If so what do they smoke and how many? E cigarette usage can also be recorded.
- Alcohol status, including weekly units
- Weight and BMI (if recorded in the clinical section this will populate through)
- Does your patient exercise?
- Does your patient eat a healthy or unhealthy diet?
- Does your patient have any literacy problems? (only able to record a positive answer due to read code restrictions)
- Employment status. Is your patient a carer? Does your patient have any work related problems?
- Are money worries an issue? (only able to record if your patient does have money worries due to read code restrictions)
- Is your patient, in general, coping with their life? (only able to record if your patient does have problems coping due to read code restrictions)

2) Agenda setting

Ask your patient which aspects of their health they would like to discuss. You may wish to use the tools and information contained within the i icon to support your conversation.

Visual Summary of Health Areas

New functionality has been developed to enable you to have a visual summary of the areas where your patient is engaging in health behaviours, or experiencing circumstances that could have an impact on their health and wellbeing or management of their condition.

When ‘show status’ is clicked, these lobes will turn purple

This offers you an opportunity to highlight these to your patient. It is meant as a summary, and illuminated areas DO NOT necessarily need to be discussed at this point should another issue be more relevant to your patient. Some patients may need some
support with this decision but to ensure your patient’s agenda is met, this decision should be made by your patient.

3) Goal Setting

Discuss with your patient their readiness and confidence to make any changes and agree a goal with your patient. This can be anything from thinking about a change, returning next year for review, signposting or referring to a service.
Health and Wellbeing Directory

The Health Improvement Directory has undergone a major upgrade and name change to improve the design and functionality. In addition, the range of services has been expanded to include programmes from other Public Health functions. It has been renamed the **Health and Wellbeing directory**.

This guide is designed to
- Help you understand the functionality of the Health and Wellbeing directory
- Use the search functions to find the most relevant services
- Access the supporting information including referral forms

The Health and Wellbeing directory is situated behind the R icon in the Set Goals section of the HD template.
Front Page

Search Page

If you click on the link from the HD template you will be brought directly to the search page.

Choose the topic you want further information about.

Choose which area you want the service to be in.

If required, choose a target group. If not required leave blank.

Alternatively use a key word search.
Health Determinants Frequently Asked Questions

I can only record if a patient is or is not meeting the recommendations for a healthy diet, how do I record if my patients’ diet is very varied?

The National READ code dictionary does not have codes to comprehensively describe a patient’s diet. Recording whether a patient is meeting the Healthy Eating recommendations is one way to achieve this within the restrictions of the READ code system. You do have the ability to record any further information you would like in the free text box.

If my patient chooses to discuss their alcohol consumption, should I do a FAST score and Brief Intervention?

Yes.

Should I update cigarette quantity every year if my patient continues to smoke the same?

Yes. It is good practice to revisit cigarette consumption regularly.
Where is the Goal Setting Tool?

How can I save the Goal Setting Tool?

- Print out 2 copies – 1 to patient, 1 for scanning.
  or
- Print out 1 copy – save another copy to Docman.

Guidance

Editing Electronic records

Within CS there is no way to delete an entry made in error. This has to be done in EMIS or VISION. Every practice will have their own policy relating to editing and amending records.
Further information and support

The Practice Nurse Support and Development Team can support you and answer any questions that you may have, please do not hesitate to get in touch.

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