



Notifications and Clinical Summaries (NaCS)

User Guide

ICT Service Delivery and Operations | Applications
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WHAT IS NaCS?

NaCS is a web-based computer application that allows users to generate patient Discharge Summaries, Progress Summaries, PBS Scripts and Medication Lists.

Upon admission of an inpatient via the Patient Administration Systems (WebPAS or TOPAS) an incomplete Discharge Summary can be auto-generated in NaCS, pre-populated with patient demographics and visit details. Discharge Summaries can be generated for same day admissions and can be configured for use for Emergency admissions. Outpatient visits are not covered by NaCS.

Upon finalisation, Discharge Summaries are able to be sent electronically to the designated recipient(s) where those Health Providers are registered for secure electronic delivery via compatible software, secure messaging or facsimile on the Global Health Provider Registry (GHPR).

Finalised NaCS Discharge Summaries are uploaded to other applications within WA Health including iSoft Clinical Manager, PSOLIS, and BOSSnet. The NaCS Discharge Summary will also upload to the patient's My Health Record (if registered), which is a secure online storehouse of patient's health information available to Health Providers nationally.

NaCS is created by Health Support Services (HSS) and is consistent with the Australian Digital Health Agency (formally NEHTA) standards and maintained under the guidance of the Business User Group comprising of statewide clinical and admin representatives.

This user guide is designed to assist Health Care Professionals within WA Health Hospital Sites with the knowledge and skills to create, modify and complete electronic discharge health summaries.

Benefits for users:

- Offer one consistent handover system for the whole of the state, assisting in better communication and clinical handover between healthcare providers
- Support better transferred and co-ordinated care between hospitals, nursing homes and other healthcare facilities
- To be incorporated as part of a patient's My Health Record (MHR) , providing that patient has enrolled and has given consent to upload their information
- Secure electronic exchanges of timely, accurate and structured Discharge Summary information to health care providers upon finalisation, enabling better patient outcomes
- Generates PBS scripts from the application
- Integrates with other clinical systems used in WA Health; webPAS, iPharmacy, ADA, EDIS, cVIEW, GHPR, WAND, iCM, BOSSnet, Journey Board and PSOLIS

LOGGING ON


To open NaCS, select from the following options:

1. If NaCS is installed on your PC:

Open the Start Menu  / All Programs / Health Apps

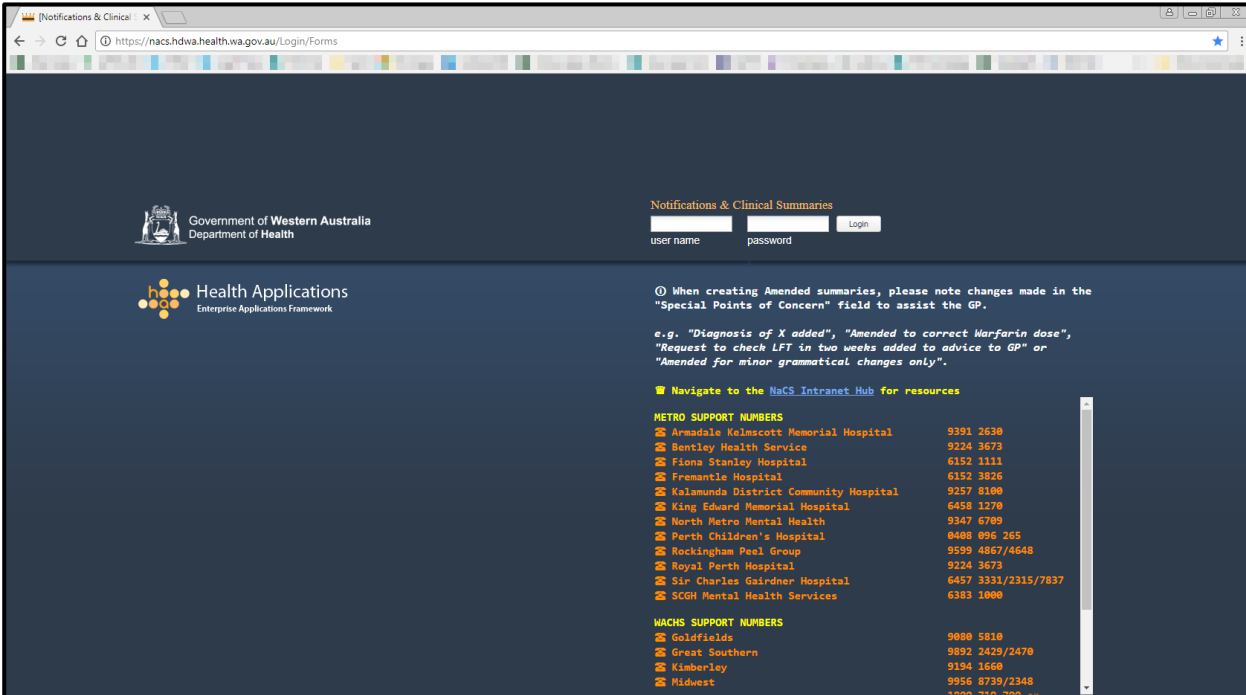
Select  WA Health Notifications and Clinical Summaries

2. If NaCS is not installed on your PC:

Open Chrome Browser 

Enter <http://nacs.hdwa.health.wa.gov.au>

At the log on screen enter your **User Name** which is your HE number followed by your normal network **Password**.



Notifications & Clinical Summaries

Government of Western Australia
Department of Health

Health Applications
Enterprise Applications Framework

When creating Amended summaries, please note changes made in the "Special Points of Concern" field to assist the GP.
e.g. "Diagnosis of X added", "Amended to correct Warfarin dose", "Request to check LFT in two weeks added to advice to GP" or "Amended for minor grammatical changes only".

Navigate to the NaCS Intranet Hub for resources

METRO SUPPORT NUMBERS	
Armadale Kalamunda Memorial Hospital	9391 2630
Bentley Health Service	9224 3673
Fiona Stanley Hospital	6152 1111
Fremantle Hospital	6152 3826
Kalamunda District Community Hospital	9257 8100
King Edward Memorial Hospital	6458 1270
North Metro Mental Health	9347 6709
Perth Children's Hospital	0488 096 265
Rockingham Peel Group	9599 4867/4648
Royal Perth Hospital	9234 3673
Sir Charles Gairdner Hospital	6457 2331/2315/7837
SCGH Mental Health Services	6383 1000

WACHS SUPPORT NUMBERS	
Goldfields	9080 5810
Great Southern	9892 2429/2470
Kimberley	9194 1660
Midwest	9956 0739/2348

i The system will log you out after 10 minutes of inactivity but will prompt you prior with this message:

Your session has been idle for too long. Click this bar to keep working... (32)

If you are having trouble logging on then you will need to either contact your local Health Systems Support Office (HSSO) or the IT helpdesk via phone or by lodging a service call:

Online: <https://myservice.hdwa.health.wa.gov.au/src/secure/main.jsp>

Phone: Metro 13 44 77 or Country 1800 794 748

RECOMMENDED COMPUTER SPECIFICATIONS

It is recommended that workstations have the following specifications in order to run NaCS most efficiently:

Processor:	Intel Core i7 (optimal) or Intel Core i5 2.8 GHz or higher
Operating System:	Windows 7 or above
Browser:	Google Chrome Version 65
Monitor resolution:	Minimum 1280x1024

NaCS HOME PAGE

When you have logged on you will be presented with the NaCS home page. From the Home page you can locate and open a Discharge Summary, include and exclude records and access the Patient Search, Tools and Help menus. The patients displayed will depend on the search criteria you have set. For first time users you will need to modify these criteria if required.

The patient list and information displayed feeds through from the PAS (TOPAS / WebPAS).

UR Number	Patient Name	Gender	Date of Birth	Admit Date	Discharge Date	Specialty	Consultant	Location	Days Late	Status
K9322344	01QA, 01TEST	M	02-Feb-2002	07-Aug-2013		General Surgery	WALLACE, MARINA	AAAA -		Amended
C9322700	02MERGE, 02TEST	M	08-Aug-1988	21-Aug-2013		General Surgery	WALLACE, MARINA	CTUP - RP		Amended
D9322712	02ST2, UMRN	M	01-Jan-1980	22-Aug-2013		General Surgery	WALLACE, MARINA	AAU -		Amended
B9322710	111ST2, 111UMRN	M	01-Jan-1950	22-Aug-2013		General Surgery	WALLACE, MARINA	CTLB -		Amended
C9322733	112MERGE, 112 TEST	M	01-Jan-1977	22-Aug-2013		General Surgery	WALLACE, MARINA	AAU -		Amended Plus
E0751854	12ST2, UMRN12	M	01-Jan-1975	22-Aug-2013			AKERS, JOHN ANDREW	CIS TESTING WARD E - B		Amended Plus
K0751859	2MERGE, TEST2	M	01-Jan-1955	22-Aug-2013		Anaesthetics	ADAMSON, ROSLYN M...	3G STATE MAJOR TRA...		Amended Plus
K0751848	2MRGUMRN, TEST2	M	10-Oct-1970	21-Aug-2013			WALLACE, MARINA	6B IMMUNOLOGY DAY ...		Amended Plus
B7103988	ABALONE, TERRY	M	10-Sep-1956	14-Jan-2014		General Medicine	WALLACE, MARINA	DAY WARD - CONV		Amended Plus
F0745904	ABBOT, RAYLENE	F	01-Jan-1970	17-Feb-2014		Gastroenterology	TARQUINIO, LORENZO	Ward 7A - F		Finalised Plus
G0751790	ACTIVE PATIENT SC2, ...	F	09-Sep-1982	26-Jul-2013			ADAMSON, JOHN EDM...	RITH - A		Amended Plus
E0741195	ADAMS, ANTHONY	M	07-Jun-1967	21-Nov-2013	17-Dec-2013	General Medicine	AARON, SHAWN (BILL)	Ward 6A - A	90	Draft
A0751938	ADKINS, MERLIN	M	26-Jun-1995	16-Sep-2013			ADAMSON, STUART JA...	Ward 6H - A		Amended Plus
K0660361	ADOLPHE, CLOTHILDE	M	13-Mar-1960	24-Sep-2013		Neurosurgery	BANNAN, PAUL ELLIOT	Ward 5H - E		Finalised Plus
J0752023	AGENT, JUAN	F	02-Jun-1982	28-Nov-2013		General Medicine	AARON, SHAWN (BILL)	CCU - E		Amended Plus
E9317598	ALBANY, NAC33	I	01-Mar-2000	08-Nov-2013			AARON, SHAWN (BILL)	TREATMENT - A		Amended
F9317610	ALBANY, NAC39	F	01-Sep-2000	07-Nov-2013			AARON, SHAWN (BILL)	GEN MED / NEURO / ST...		Amended
L0700457	ALIAN, MARTIAN	M	12-Dec-1945	28-Nov-2013		General Medicine	AARON, SHAWN (BILL)	DAY OF SURGER UNIT ...		Amended Plus
D9315661	ALLEN, MICHAEL	M	25-Aug-1968	15-Aug-2013		Anaesthetics	ADAMSON, ROSLYN M...	3G STATE MAJOR TRA...		Amended Plus
J0752881	AMIT, MISHRA	M	04-Jan-1985	31-Jan-2014		General Medicine	ADAMSON, STUART JA...	AAAA - A		Finalised
K0741486	ARGYLE, WILLIAM	M	23-Sep-1940	18-Dec-2013		Neurology	EDIS, ROBERT HOWARD	Ward 7A - H		Finalised Plus
K0751936	ARNOLD, KIRRIILY	F	20-Aug-1997	16-Sep-2013			ADAMSON, STUART JA...	Ward 6H - B		Finalised Plus
K0751936	ARNOLD, KIRRIILY	F	20-Aug-1997	23-Jan-2014		General Surgery	WALLACE, MARINA	AAU - RA		Finalised Plus
K9322894	ATKINS, LOU	M	23-Dec-1996	21-Nov-2013	21-Nov-2013	General Medicine	AARON, SHAWN (BILL)	Ward 7A - ADMRM	116	Finalised Plus
K9322894	ATKINS, LOU	M	23-Dec-1996	27-Nov-2013		General Medicine	AARON, SHAWN (BILL)	Ward 6A - F		Finalised Plus

- ⓘ If horizontal scroll bars appear in the NaCS application, then your screen resolution is too small. Either change the screen resolution or contact the helpdesk via phone or by lodging a service call.

You can reduce the number of Discharge Summaries displayed through use of the six different **filters**. These filters control, Patient Type, Location, Specialty, Consultant and Ward.

Home Page Functionality:

- ① From the home page you can find a Discharge Summary, save your filtered settings, include and exclude records, refresh, access the Help menu and see which user is currently logged in.
- ① The “Open Notifications and Clinical Summaries” filter displays:
 - Discharge Summaries that are not complete regardless of if the patient is in hospital or has been discharged. So this includes Discharge Summaries in Enrolled, Draft, Finalised Plus or Amended Plus statuses.
 - Completed Discharge Summaries for patients that have been discharged for less than 24hrs
- ① If you want to view a Discharge Summary that is complete and the patient has been discharged for greater than 24 hrs then the **Patient Search** page will need to be used.

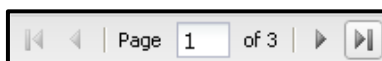
ORDER OF HOME PAGE DATA

By default, the Home Page data is sorted alphabetically by Patient Name. NaCS allows the user to sort by several other fields, namely: Patient Name, Admit Date, Discharge Date and Days Late.


To sort the data by these fields, simply hover over the Column heading and click on the black arrow that appears. Then select either Sort Ascending or Sort Descending.

Patient Name	Gender	Date of Birth
644 TEST, S.TEST		6
ABBOT, RAYLENE		0
ABBOTS-FORD, SANDRA		6

- ① It is a known issue that the Patient name cannot be sorted into reverse alphabetical order and the Days Late field cannot be sorted into ascending order. If you wish to view this information then sort the data in the available way, i.e. alphabetically for Patient name or descending for Days Late, then use the record navigator buttons at the bottom left of the page to go to the last page.



SAVING HOME PAGE PROFILE

The value in the filters can be saved via selecting the  icon located at the top right hand side of the screen (see below)

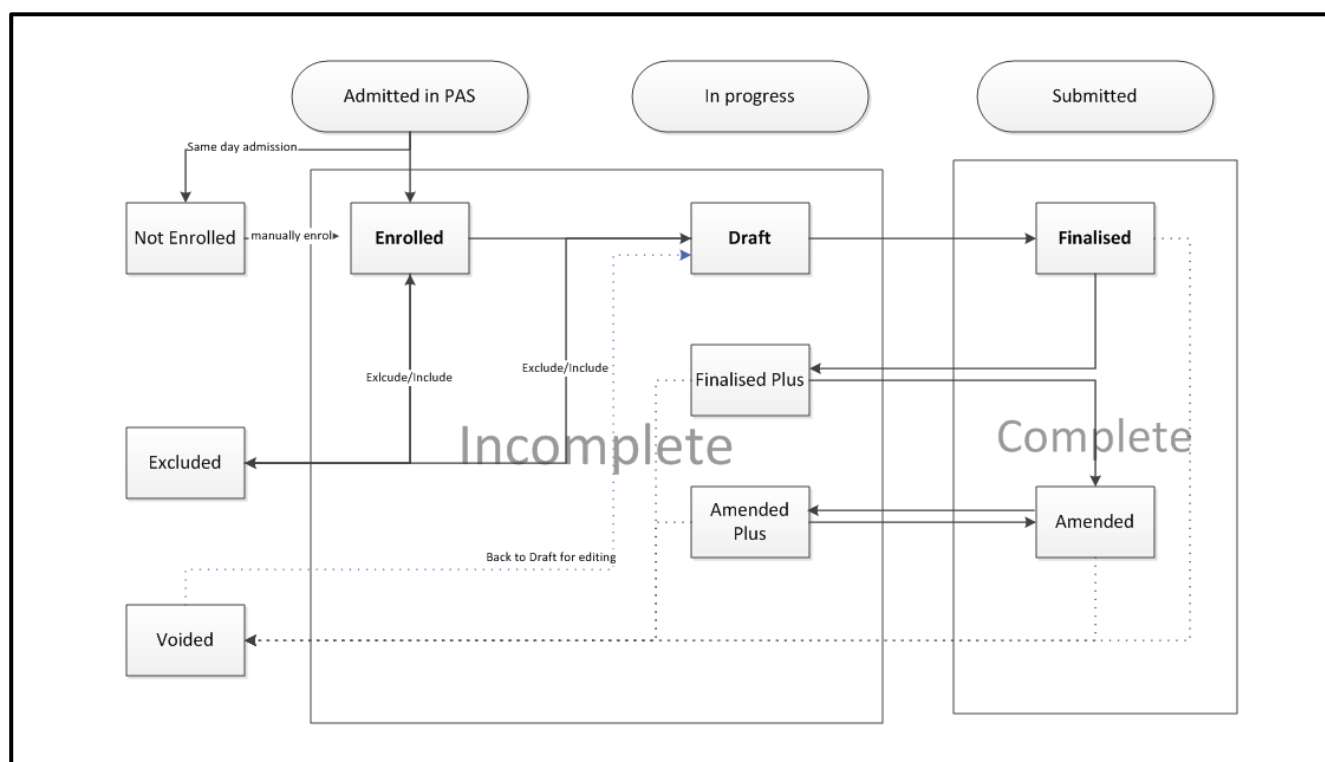
The screenshot shows the NaCS Home page interface. At the top right, there is a 'Save' button. Below the header, there are several filter dropdown menus: 'Open Notifications and Clinical Summaries', 'Albany', 'All Specialties', 'All Consultants', and 'All Wards'. A callout box points to the 'Save' button with the text: 'Set your search criteria from the Home page by using the drop down options.'

DISCHARGE SUMMARY STATUSES

When a patient is admitted into the PAS their status in NaCS will be “Enrolled” meaning summary information can be entered at the time of admission. All statuses thereafter indicate that data has been entered into the patient’s summary. In the Appendices of this document is a detailed meaning of each summaries status.

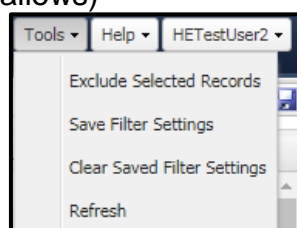
- ❶ Inpatient Day Cases may display in the Patient Search results as ‘Not Enrolled’ status.
 - ❷ Outpatient cases are by default not recognised by NaCS.
 - ❸ **Completed statuses:** Finalised; Amended
 - ❹ **Incomplete / In Progress statuses:** Enrolled; Draft; Finalised Plus and Amended Plus
- See Appendix A for a list of all the Discharge Summary Statuses and their meanings.

Below is a diagram of the lifecycle of a NaCS clinical summary.

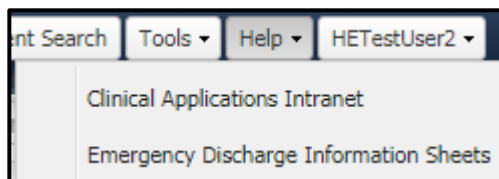


TOOLS and HELP Menus

From the **Tools** menu you can, Exclude or Include selected records, Save or Clear your filter settings on the Home Page, Refresh the webpage and access Site Administration functions (where your access role allows)

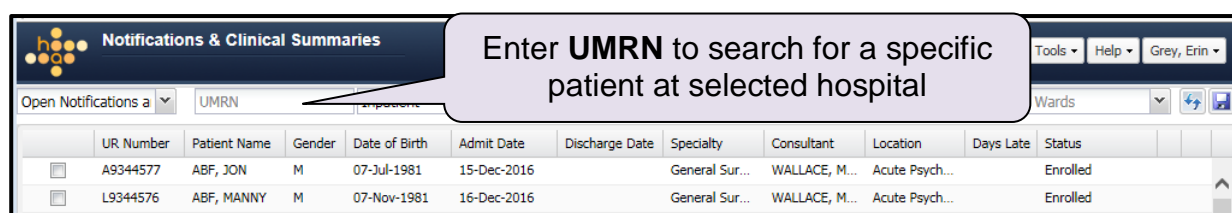


From the **Help** menu you can access a link to the NaCS Intranet Support Page (contains NaCS & MHR User Guides) and the Healthpoint Emergency Discharge Information Sheets.



PATIENT SEARCH

On the Home page, you can use the UMRN field to search for a patient – this search will only display summaries matching the filters you have selected (Patient Type and Site).




If the patient summary you are after does not appear in the results, a search via the Patient Search function is recommended to widen your search.



- Click on the **Patient Search** icon, fill out the search criteria fields and click on **Search**
 - **Searching by UR number** (recommended), all other search criteria fields will be disregarded and search will display all discharge summaries (regardless of patient type and location).
 - **Searching by Surname and Given Name** will only display search results for the selected Site and Patient Type (Emergency or Inpatient)
 - Search is not case sensitive
 - At least two characters are required for both surname and given name
- All patients that match the search criteria entered will be displayed. The individual Discharge Summaries can be viewed by pressing the Expand **+** icon next to the patient name.

PROGRESS SUMMARIES

Within NaCS, it is possible to save a draft version of the Discharge Summary before it has been finalised. These draft versions of the Discharge Summary are called Progress Summaries. The NaCS home page and Patient Search page both have functionality to display if Discharge Summary has a Progress Summary or not.



Consultant	Location	Days Late	Status	
MCCOMISH, MICHAEL...	Ward 9A - A		Draft	P5
TARQUINIO, LORENZO	Ward 7A - F		Finalised	

“PS” indicates a Progress Summary has been created.

To view the progress summary, the user must open the Discharge Summary (Clinical roles only) and navigate to the Version History section. For further details about the Version History, please see the Administrative – Version History section of this user guide.

VIEWING FINALISED DISCHARGE SUMMARIES

Once a Discharge Summary has been finalised by a clinician, the document can be viewed and printed in PDF format via NaCS, iCM, BOSSnet and PSOLIS (mental health patients only). In both the Home page and the Patient Search page, if the Discharge Summary has been completed, a magnifying glass will be displayed next to the status column.

Location	Days Late	Status	
Ward G51 - R16		Finalised	
Ward G71 - R19		Amended	

Click to view the completed Discharge Summary

Selecting this magnifying glass will open a new window in which the user can select to open and print the most recent finalised version of the Discharge Summary, Patient Medication List (Dr's and Pharmacists only) and / or any cover sheets associated with the Discharge Summary.

Re-Print Options

<p>Cover Sheet</p> <p><input type="checkbox"/> Nominated Primary Healthcare Provider</p> <p><input type="checkbox"/> Patient</p>	<p>Discharge Summary</p> <p><input type="checkbox"/> Discharge Summary (last finalised version)</p> <p><input type="checkbox"/> Patient Medication List</p>
---	--

Print Cancel

HINT: Only the most recent finalised version of the summary for this case will be opened.

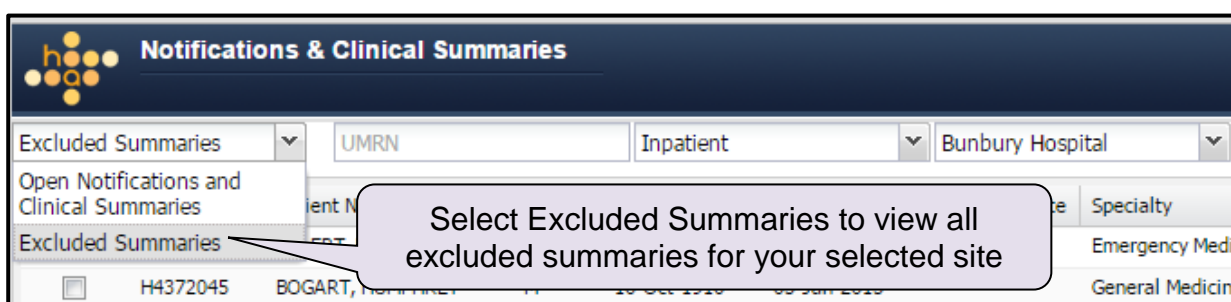
- ① Selecting the Print button will **not** automatically send the Discharge Summary and or Cover Sheet to the printer. The Print button opens the Discharge Summary and or Cover sheet in PDF for viewing, then will need to be printed using the printing functionality.
- ① If both Cover Sheets and a Discharge Summary reprint are requested, then all Cover Sheets will be open in one PDF and the Discharge Summary will open in a second separate PDF. You will need to click the print icon on both PDF documents to print both documents.
- ① NaCS has functionality that automatically saves any data that has been entered into a Discharge Summary. This automatic save can have the effect of updating the status,

for example from Finalised to Finalised Plus or from Amended to Amended Plus. To ensure that Amendments to summaries are not accidentally created, a warning message is displayed every time a user attempts to open a Finalised or Amended Discharge Summary. This warning message allows the user to either open the existing hard copy or to create the Amendment

EXCLUDING / INCLUDING DISCHARGE SUMMARIES

An Excluded Summary is an Enrolled or Draft summary which is deemed to not require finalisation and has subsequently been Excluded by a NaCS user. This may be required where, within a particular speciality there are patients who meet set criteria for not requiring a Discharge Summary. NaCS will still generate a Discharge Summary entry for all patients within the speciality, and the clinician will need to 'exclude' the summary to ensure it does not appear as an outstanding discharge summary.

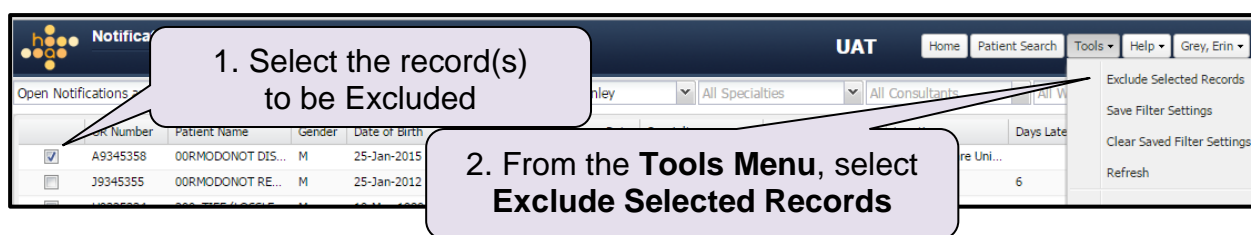
Summaries which have been excluded will appear when the Home page Filter is changed to display 'Excluded Summaries' based on the site filter preferences chosen.



To **Exclude** an Enrolled or Draft Discharge Summary which is recognised as not requiring finalisation:

Step 1 From the **Home** page patient list (ensure the view is **Open Notifications and Clinical Summaries**) or the Patient Search results, find the patient record(s) to be excluded and check the box next to each record;

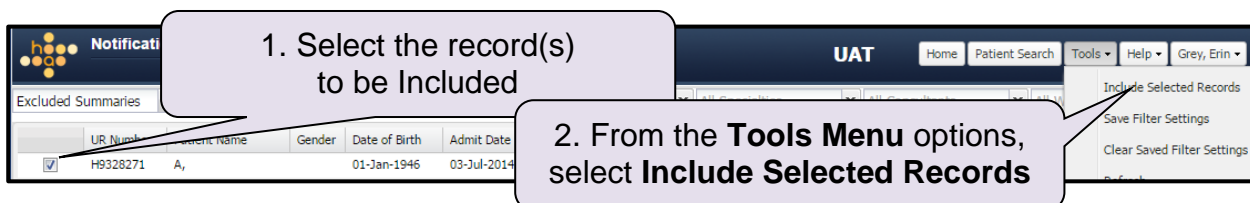
Step 2 Go to **Tools** Menu drop down, select **Exclude Selected Records**



To **Include** an Excluded Discharge Summary which is recognised as needing inclusion:

Step 1 From the Home Page patient list (ensure the view is **Excluded Summaries**) or the Patient Search results, check the box next to each record to be included;

Step 2 Go to **Tools** Menu drop down, select **Include Selected Records**



CREATING A CLINICAL SUMMARY

Once your patient is located via the homepage or the patient, select that patient by double clicking and you will be presented with a blank **Template**. Here you will notice that NaCS is broken down into 5 sections:

1. **Event**
2. **Health Profile**
3. **Medications**
4. **Plan and**
5. **Administrative**

The steps below describe the sections, from top to bottom and in sequence when completing your clinical summary.

BANNERS


There are two banners at the top of the clinical summary. To view the information within these headers hover over the information and pop ups will appear.

- **Patient Demographics Banner:** this information is populated from the PAS and includes demographic information on the selected patient including any Micro/Med Alerts. There is a drop down arrow located at the top right hand side which will display more detailed information
- **Case Details Banner:** this information is also populated from the PAS and includes information such as admission details, location, current consultant, admission/discharge date and specialty. There is no drop down in this section

① On the printed summary the case details will display on the first page

① On the printed summary the patient information will display on every page

The screenshot shows a patient banner for JOYCE, Casandra (MRS). The banner includes the following information:

JOYCE, Casandra (MRS)		Born: 25-Jun-2004 (9y 8m)	Gender: Female	Address: 594 HUNG CCT, TELFER WA 6762		E 075 19 42
AL1 Site	A, - Location	DIVER, Neil Current Consultant		Admission Date: 23-Sep-2013 at 03:32pm	GPR/Med... Specialty / Teams	
				Expected Discharge Date: 23-Sep-2013		
				Financial Classification: -		

Callouts in the image identify:

- Patient Demographics banner**: points to the top header area.
- My Health Record icon**: points to the colorful icon on the right.
- Case Details banner**: points to the bottom header area.
- Micro, Med & Risk alerts from the PAS**: points to the bottom right area.

MY HEALTH RECORD VIEWER (MHR)

Also Located in the **Patient Demographics** banner is a **My Health Record** icon (**MHR** formally **PCEHR**)



The icon provides the entry point to the NaCS MHR Viewer where you can access and view a patient's My Health Record.

Please Note: only Clinical, Pharmacy, Allied Information and Editor roles in NaCS have access to the NaCS MHR Viewer

- ① For more information about what a My Health record is, how to access a patient's MHR and information regarding your obligations concerning a patient's MHR please refer to the HSS My Health Record Support Page – <https://wahealthdept.sharepoint.com/sites/hss-customer-ict-core-clinical/SitePages/my-health-record.aspx>

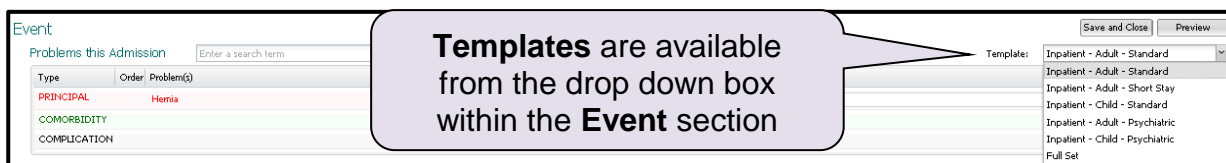
TEMPLATES

As the plan for NaCS is to be used at multiple-sites the use of templates has been introduced.

Located under the banner information on the top right hand side is the **Template** drop down. Here you are able to select a template based on the site/location you are working at and the type of patients you are working with.

When clicking on a particular template you will notice changes in certain **Clinical Synopsis** fields. For example: an **Inpatient – Child – Standard** template includes an **Advice to Parents** field.

Click on the drop down to see what is available and select the suitable template and continue to the **Problems** section of the summary.



EVENT

The **Event** section of your summary consists of the following and holds the bulk of your summary information:

- Problems
- Procedures
- Significant MHx
- Clinical Synopsis and;
- Diagnostic Interventions

PROBLEMS THIS ADMISSION

The Problems section allows input of a patient's relevant problems and diagnoses relating to that admission. All selected problems and diagnoses are selected from a standardised clinical terminology database known as SNOMED CT-AU.

- ① There is a limit of 20 words in the search criteria. Entering more than this will produce an error message. When OK is pressed on the error message the user is returned to the discharge summary
- ① SNOMED CT-AU stands for Systematized Nomenclature of Medicine Clinical Terms Australian Release, and is a comprehensive internationally recognised collection of medical terms, synonyms and definitions. SNOMED complies with The Australian Digital Health Agency's requirements for standardised medical terminology used in Discharge Summaries and aims at improving patient care and provides core general terminology for eHealth Records including clinical findings, procedures, diseases and therapeutic products.

① *More information on SNOMED CT-AU can be found at:*

<https://www.healthterminologies.gov.au/learn/clinical-terminology/snomed-ct-au/index.html>


There are 3 sections within the Problems section:

Principal Diagnosis, Co-Morbidity and Complication

① A Principal Diagnosis must be entered before a Discharge Summary can be finalised.

HINT: the more detail you type into the search the better the SNOMED search results will be

Entering a Principal Diagnosis, Comorbidity and/or Complication

- Type in a problem in the **Enter a search term** box
- Press the **Search** button or hit enter
- Locate and select the relevant problem from the SNOMED search results at the bottom of the page. (Selecting the SNOMED term is covered below)
- Once the term has been added to the correct section you can free text any **Qualifying/Additional Information** and add **Laterality** or **Date Identified** values
- **Only one diagnosis** can be entered into the Principal Diagnosis field for a Discharge Summary. Multiple values are permitted for the Comorbidity and Complication sections. If multiple entries are entered for one of these sections, then you can change the **order the entries appear** on the Discharge Summary through selecting the order keys
- If you have accidentally entered an incorrect Principal, Comorbidity or Complication, then you can **remove** this by simply selecting the red button  on the far right hand side of the Problem

- ① A **Principal Diagnosis** is defined as the diagnosis, established after study, to be chiefly responsible for occasioning the patient's episode of care in hospital. Procedures must not be recorded as a diagnosis. Events must not be recorded as the principal diagnosis e.g. "fall", "MVA".
- ① There can only be one Principal Problem.
- ① A **Comorbidity** is a condition that exists at the time of admission which affects the patients care in terms of requiring;
 - therapeutic treatment; OR
 - diagnostic procedures; OR
 - increased clinical care and/or monitoring.
- ① A **Complication** is a condition not present on admission which arises during the patient stay, or is the result of a procedure or treatment during the stay.

To select the term you want from the SNOMED search results you have **3 options** (diagram below):

1. **Double click** on the relevant finding and this will populate into the heading
2. **Right click** on the relevant finding allowing you to select the relevant field destination
3. Select the term then **press the coloured arrows** at the bottom of the search to add to the relevant sections (hot keys)

If an appropriate SNOMED term is not available, you have the option to **enter a new term** located at the bottom of the search results. To ensure that the SNOMED search has been performed, the “Enter new term” value must be very similar to the original SNOMED search value. The “Levenshtein Distance” is a calculation of how similar the two strings are. Levenshtein Distances of over 3 are not permitted.

Notes on Adding Problems:

- ① **Principal** diagnosis can NOT be a **Finding** it must be a **Disorder**
- ① If the search term selected requires further information, you have the option to free text in the **Qualifying/Additional Information** field
- ① You can **drag Problems** to another field and add multiple problems to one field

The screenshot displays the 'Event' form with a search for 'asthma'. The search results are shown in a table with columns for Type, Order, Problem(s), Laterality, Qualifying/Additional Information, Date Identified, and Actions. The results are categorized into PRINCIPAL, COMORBIDITY, and COMPLICATION. A callout box points to the search input field with the text 'Enter search term and press Search'. Another callout box points to the search results table with the text 'SNOMed Problems Search Results - to select, use one of the 3 options described above'. A third callout box points to the 'Specify: Disorder/Finding' field with the text 'Specifies: Disorder/Finding'. A fourth callout box points to the 'Copy entry to...' buttons with the text 'Coloured arrows relate to Problem fields'. A fifth callout box points to the 'Enter new term' field with the text 'Enter new term (free text)'. A large orange callout box at the bottom contains a hint: 'HINT: when entering a term in Event you can use hot keys. I.e.: select your term and press 1, this will place the entry in Principal'.



CLINICAL INTERVENTIONS

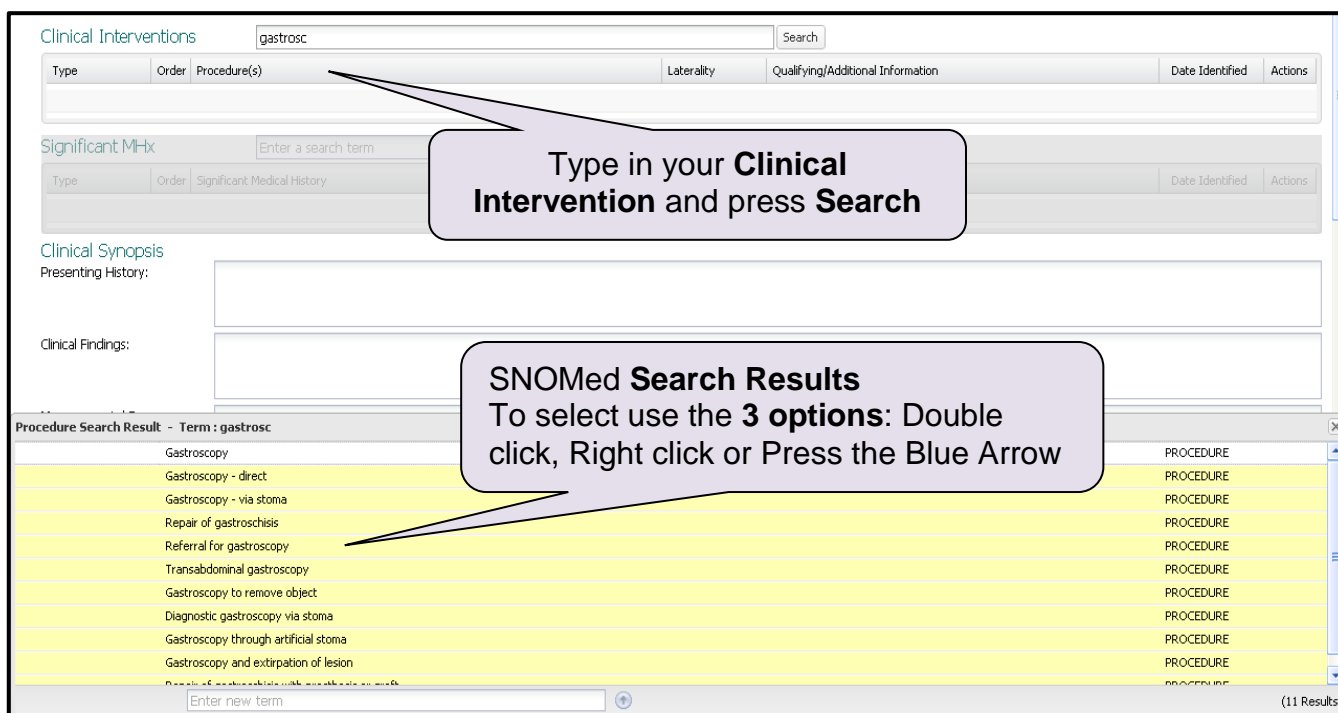
Entering **Clinical Interventions** follows the same instructions mentioned above and asks you to select a search term from SNOMED whilst still giving the ability to add **Laterality** from the drop down options and input free text into the **Qualifying/Additional Information** field.

- Type in a procedure in the **Enter a search term** box and press **Search** or hit enter
- From the SNOMED **Procedure Search Result** select the relevant procedure OR if the procedure isn't listed **Enter a new term**

Remember: to select a SNOMED term you have **3 options:**

1. Double click on the procedure OR
2. Right click to copy entry to Procedures OR
3. Press the Blue Arrow

Clinical Interventions entered will appear in the **Clinical Interventions Performed This Visit** section in the printed summary.



SIGNIFICANT MHX



To enter a new Significant Medical History (MHx), follow the same steps above in using a SNOMED search.

- ① **Significant MHx** from previous admissions entered in NaCS will populate into the current clinical summary, even if the patient was previously admitted to a different hospital.
- ① This section will appear in the **Medical History** section of the printed summary and subsequent summaries for that patient
- ① The **Significant MHx** on subsequent Discharge Summaries is **not** updated on previous discharge summaries irrespective of the status of the previous Discharge Summaries

Previous Principal Diagnosis

The Principal Diagnosis from the previous admission will automatically be brought forward into the subsequent Discharge Summary. When this occurs, the entry will be displayed with a Pink Highlight as below.

Type	Order	Significant Medical History	Laterality	Qualifying/Additional Information	Date Identified	Actions
DISORDER		Hernia				 

An extra green tick button  will be displayed next to this entry that allows the user to confirm this Significant MHx item. If you confirm that this is significant, then select the green icon, which will result in the pink background disappearing. If you do not believe that this is a Significant MHx item, then simply select the Red  button, which will remove the entry.

CLINICAL SYNOPSIS

The **Clinical Synopsis** section is entirely made up of **free text** fields

Listed below are all the fields available from the **Full Set** template (these will vary depending on which template you are using):

• Presenting History	• Additional Comments
• Past Psychiatric History	• Allied/Health Nursing
• Family Psychiatric History	• HITH Nursing
• Drug & Alcohol	• Injury Cause
• Forensic History	• Examination
• Mental State on Admission	• Investigations
• Clinical Findings	• Consultations
• Management/Progress	• ED Management
• Special Points of Concern	• Discharge Plan
• Social Issues	

- ① Only add information to a section where it is relevant to do so. If no information is entered into a section i.e. Social Issues, then that field will not appear on the Discharge Summary.
- ① **Presenting History is the only mandatory field** in the Clinical Synopsis and must be completed (at least three words) before the summary can be finalised. The information contained here makes up the bulk of the clinical summary. This information will appear in the **Clinical Synopsis** section of the printed summary
- ① To copy and paste: **Ctrl + C** to copy, then **Ctrl + V** to paste

DIAGNOSTIC INVESTIGATIONS

This section allows an interpreted summary of investigations for pathology results to be typed into and / or pasted from current clinical systems used such as Pathwest online and iCM.

- ① Remember: a clinical summary is supposed to be just that – please include relevant results but **do not exhaustively copy and paste long reports that are not useful** to ongoing care.

The image shows a screenshot of a form field labeled "Diagnostic Investigations Interpreted Summary". A callout box points to the text input area, stating: "Free text field for an **Interpreted Summary** of patient test results".

- ① This information will appear in the **Diagnostic Investigations Interpreted Summary** section of the printed summary

HEALTH PROFILE

ADVERSE REACTIONS

To record any **Adverse Reactions** click on the  icon.

Here you have the option to enter any **New** Adverse Reactions, and **Change** or **Void** any existing Adverse Reactions.

- ① **Remember:** ADRs and Allergies will remain on the patient record and be included on subsequent Discharge Summaries as the patient is readmitted
- ① When a patient is readmitted to the same hospital or is admitted at a different hospital, their previously entered ADR and Allergies will populate from the most recent, previous NaCS Discharge Summary but only if the new Discharge Summary has a status of "Enrolled".
- ① Changing the ADR or Allergies in a previous discharge summary when the current discharge has a status other than "Enrolled" will NOT update the ADR or Allergies in the current discharge summary. These must be updated manually by the user.

To enter a **New ADR/Allergy**

- Click **Manage**
 - Click **New**
 - Select the **Type of allergy or reaction** from the radio buttons
 - Select a **Substance/Agent** from the list provided and work your way from most common (left) to more specific (right) across the columns to select the actual **Agent**
 - If the required Agent is not provided in the Most Common or More Specific values, select the “**Add Unlisted**” option and enter an Agent in the **Agent** field.
 - Complete all the **Optional** fields if you would like more information on your summary
 - If the required clinical manifestation is not in the clinical manifestation list, then comments can be added in the Additional Comments field
 - The **Reaction Details** section allows you to enter the different episodes in which the ADR / Allergy has occurred for this patient. It is completely optional. To add a new Reaction Detail, simply select a clinical manifestation, enter other optional information and press the **Add** button.
- ⓘ Although not a mandatory field when saving an ADR/Allergy, if a **date first identified** is known, please enter it
- ⓘ Adverse Drug Reactions are printed on the Discharge Summary

The screenshot shows the 'Adverse Drug Reactions and Allergies' form. The 'Type' section has radio buttons for 'Allergy (Immune Mediated Response)' and 'Intolerance/Sensitivity'. Below this is a list of 'Substance / Agent' categories: Medication (Adverse Drug Reaction), Trade Product (Excipient), Food, Plant/Pollen, Animal, Mite (Dust/Mite), Insect (including Stings), Mould (including Spores), Latex/Metal, and Chemical/Other. The 'Medication' category is expanded, showing two columns: 'Most Common' and 'More Specific'. The 'Most Common' column lists various drug classes like ACE Inhibitors, Antidepressants, Beta Blockers, etc. The 'More Specific' column lists specific agents like 3,4-Diaminopyridine, Abacavir, Abatacept, etc. Below the lists are 'OPTIONAL' fields: Certainty (None Selected), Additional Comment, Date First Identified, and Clinical Status (Active). The 'Reaction Details' section includes 'Clinical Manifestations' (None Selected), Severity (None Selected), Date of Onset, and Date Resolved. Callout boxes provide instructions: 'Select a Type: Allergy/Intolerance' points to the radio buttons; 'Select a Substance/Agent and work your way across' points to the medication lists; 'Adding additional information is optional' points to the 'Additional Comment' field; and 'The Reaction Details section is optional, but if added, must contain a clinical manifestation' points to the 'Clinical Manifestations' dropdown.

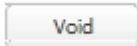
Trade Products

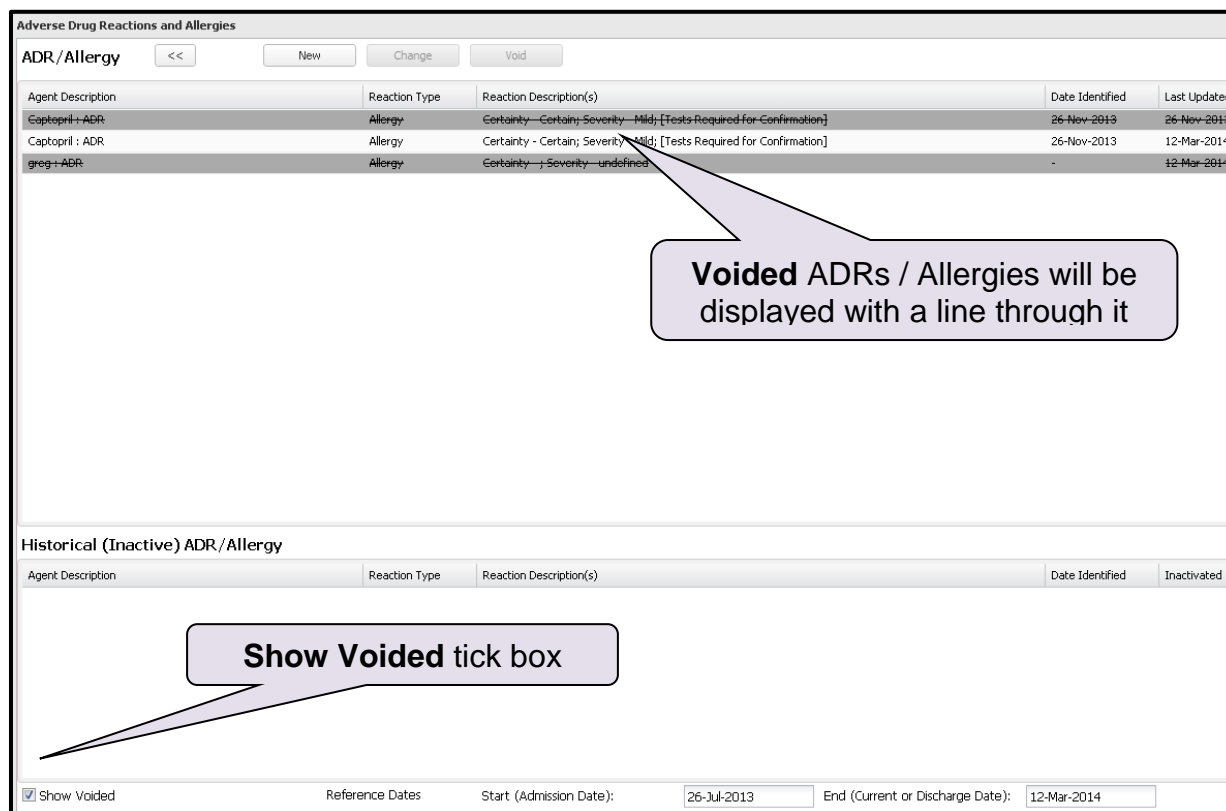
If you select the “Trade Product” option under the Medication Substance, when you select a value from the Most Common list, the actual trade products for that medication group are listed in the More Specific column.

To Change any existing Adverse Reactions/Allergies:

- Highlight the medication/allergy from the list displayed
- Click on **Change** from the tabs above and complete the optional fields
- ① All fields on the ADR can be changed except for the Substance

To Void an ADR/Allergy:

- Select an ADR/Allergy already listed and click 
- Enter your HE number and Network Password and click **Void**
- The voided entry will disappear from the screen, to view the Voided ADR/Allergy click on the tick box – **Show Voided** at the bottom left of the screen
- ① *Voiding an ADR / Allergy should only be used when an ADR / Allergy has been entered incorrectly against a patient. For example, the wrong patient was selected for the ADR, or the wrong Agent was entered for the Allergy. If you want to indicate that the patient no longer has an ADR / Allergy, then please mark the ADR / Allergy as Inactive instead.*



Adverse Drug Reactions and Allergies

ADR/Allergy << New Change Void

Agent Description	Reaction Type	Reaction Description(s)	Date Identified	Last Updated
Captopril - ADR	Allergy	Certainty - Certain; Severity - Mild; [Tests Required for Confirmation]	26-Nov-2013	26-Nov-2013
Captopril - ADR	Allergy	Certainty - Certain; Severity - Mild; [Tests Required for Confirmation]	26-Nov-2013	12-Mar-2014
greg - ADR	Allergy	Certainty - Severity - undefined	-	12-Mar-2014

Voided ADRs / Allergies will be displayed with a line through it

Historical (Inactive) ADR/Allergy

Agent Description	Reaction Type	Reaction Description(s)	Date Identified	Inactivated
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Show Voided tick box

Show Voided Reference Dates Start (Admission Date): 26-Jul-2013 End (Current or Discharge Date): 12-Mar-2014

Inactive ADR's and Allergies

NaCS has the ability to record if a patient is no longer affected by a particular ADR or Allergy. If an Allergy is Inactive, then it will be displayed on the lower half of the Manage

ADR / Allergy window. The Inactive / Active status can be set in either of the New or Change functionality defined above.

i Inactive ADR's and Allergies will **not** appear on NaCS Discharge Summaries

Adverse Reaction List Status

If an Adverse Drug Reaction or Allergy has been entered into NaCS, then it will appear on the Discharge Summary. This raises the question of what to display if there are no Adverse Drug Reactions or Allergies entered. This could mean that, the user has not completed this section as they are too busy or the user has not asked the patient about their ADR's or Allergies, or that the patients does not have any ADR's or Allergies. To overcome this issue, the NaCS Discharge Summary has implemented the Adverse Reaction List Status field.

Identified	Agent Description	Reaction Type	Reaction Description(s)
26-Nov-2013	Captopril : ADR	Allergy	Certainty - Certain; Severity - Mild; [Tests Required for Confirmation]
	Plavix : ADR	Allergy	Certainty - ; Severity - undefined

Adverse Reaction List Status: Unknown / Incomplete Not Asked NKDA Above List Correct

Adverse Reaction List Status

If you are completing a Discharge Summary then fill out the Adverse Reaction List Status in the following way;

- Unknown / Incomplete – Use if you have not filled out all of the ADR / Allergy information and plan to come back to it later
- Not Asked – Use if you have not asked the patient about their ADR / Allergy information and do not intend to include any on the Discharge Summary
- NKDA – Use if you have confirmed that the patient has No ADR's or Allergies (Stands for No Known Drug Allergy)
- Above List Correct – Use if you have entered all the ADR's and Allergies for the patient

i **The Adverse Reaction List Status requires a value to be selected before the Discharge Summary can be finalised.**

Retrospective Updates to ADRs / Allergies

If summaries are completed as each case is discharged, then the ADR / Allergy information will flow from one summary to the next. However, if you want to make an update to an old discharge summary after the patient has been readmitted for another case, these changes to the older case will not automatically flow onto subsequent summaries. Instead, each summary will need to be updated individually.

For example, if you find that a patient record states an ADR to Penicillin and has been included on the past four summaries. If the patient has never had an ADR to penicillin, then to fix this issue, you will need to Void the ADR and re-finalise each of these four individual summaries. Voiding the ADR on the current summary will not flow to previous summaries.

MEDICATIONS



Medications populate from any previous admissions into your current summary, allowing you to **Change**, **Cease** or **Void** any existing medications also allowing you to add any **new** medications.

Within NaCS there is a function that enables **Pharmacists** to complete medication entries into the summary regardless of whether the Clinician has finalised it or not, this is explained later.

CURRENT MEDICATIONS

When a patient is readmitted to the same hospital or is admitted at a different hospital, their previously entered medications as listed in the Medications section (Significant MHx) will populate from the most recent, previous NaCS Discharge Summary but only if the current Discharge Summary has a status of "Enrolled".

To add a **new** medication:

- Click on  at the **Current Medications** section to display the **Best Possible Medication List** page
 - Select 
 - Type your medication in the **Search** field and hit enter / select **Medication Search**. This will return all Medications from iPharmacy and any matching Medication Templates.
 - Do not use apostrophes when performing medication searches. Doing this will result in the search not returning any records.
 - Click on the medication from the list of results. The selected medication will now appear in the **Medication** field (above Search)
 - All mandatory fields have a **Blue** label and a yellow background
- ⓘ **IMPORTANT:** If status selected is **New** (meaning this is a new medication the patient is commencing since being admitted) it **MUST** be linked to a **Clinical Indication**. This is discussed in more detail below in the **Linking Clinical Indications to Problems entered** section
- Once all **Blue** Mandatory information has been entered, either select **Save** or **Save and Add New**
- ⓘ Clicking the **Show Brands** box displays the generic brand names
- ⓘ **IMPORTANT:** NaCS displays the Allergies and Adverse Reactions in the Medications list but it does not offer any form of decision support for Medication Instructions or Adverse Drug Reactions. It is the **responsibility of the user** to ensure that the patient concerned does not have a significant adverse reaction or allergy to any medication prescribed. It is also the responsibility of the user to ensure that the medications prescribed can be safely prescribed together for the patient without any harmful effects.

Linking Clinical Indications to Problems entered

For all **new** medication entries it is mandatory to select a **Clinical Indication** from the list of previously added **Problems** or **Significant MHx**.

- ① **Clinical Indications** are useful but NOT mandatory for any **Unchanged, Increased, Decreased** or **Ceased** medications or when making changes to existing medications however, because they are useful, where the **Clinical Indication** is not mandatory the user will still be able to link if desired and/or add their own using the **Add Indication** button

- ① Hover over  icon to display tooltip.

Medication Selection **Amoxicillin (Amoxycillin) 875mg Clavulanic Acid 125mg Tablet [C**

Directions

Dosage Directions: PRN

Dosage / Times: Morning: Midday: Evening: Bedtime:

Duration: Route:

Additional Instructions:

Status:

Clinical Indication(s): Prophylaxis / Prevention Community acquired pneumonia

Cannot be reliably determined / Yet to be determined

Change Reason: Change Description:

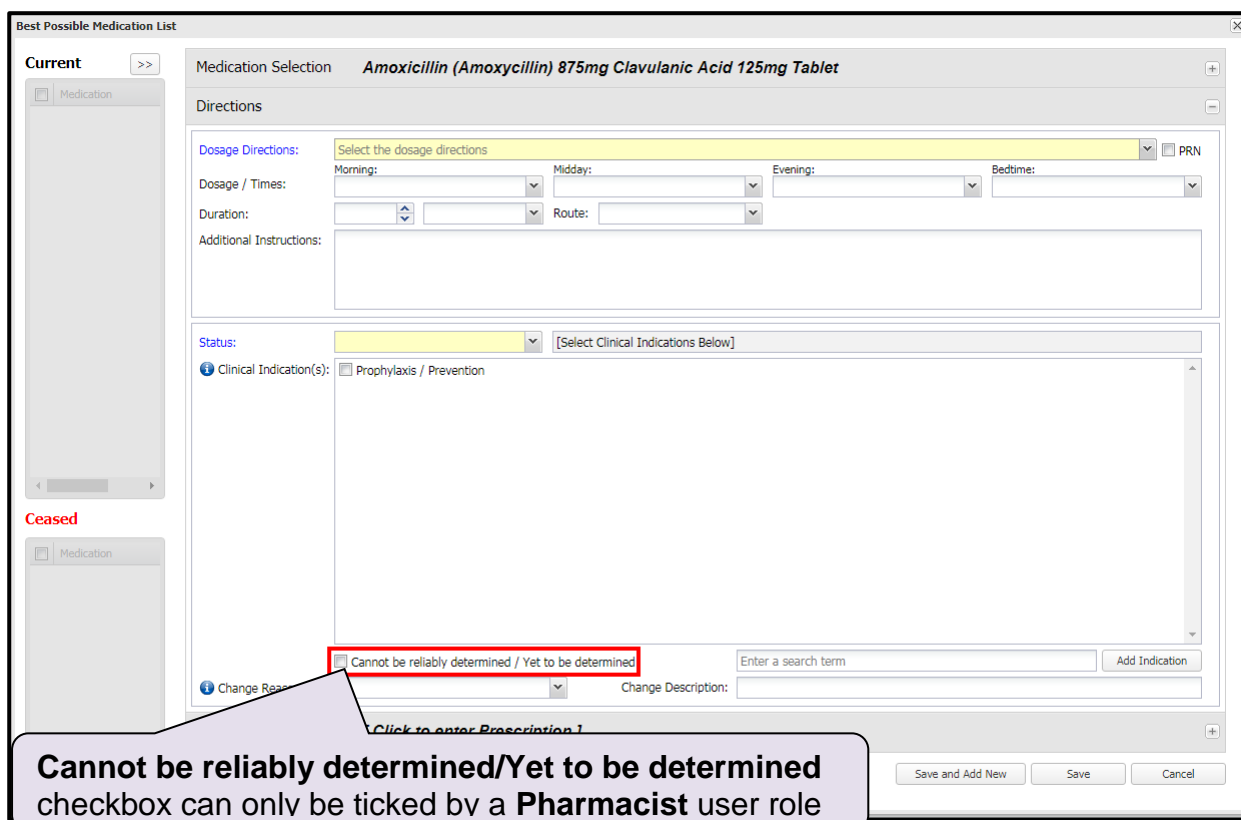
Dispensing **[Click to enter Prescription]**

Once a medication is selected you will notice a letter next to it indicating the **Status** of that medication. Appendix C has a list of the Medication Status values.

Cannot be Reliably Determined / Yet to be Determined

Q) What if a Pharmacist wants to add Medications prior to the Clinician finalising the summary?

A) A Pharmacist user will be able to add new medications prior to finalisation with the introduction of the **Cannot be reliably determined / Yet to be determined** check box. By ticking this box it will add the value **Undetermined** to the **Clinical Indication** list.



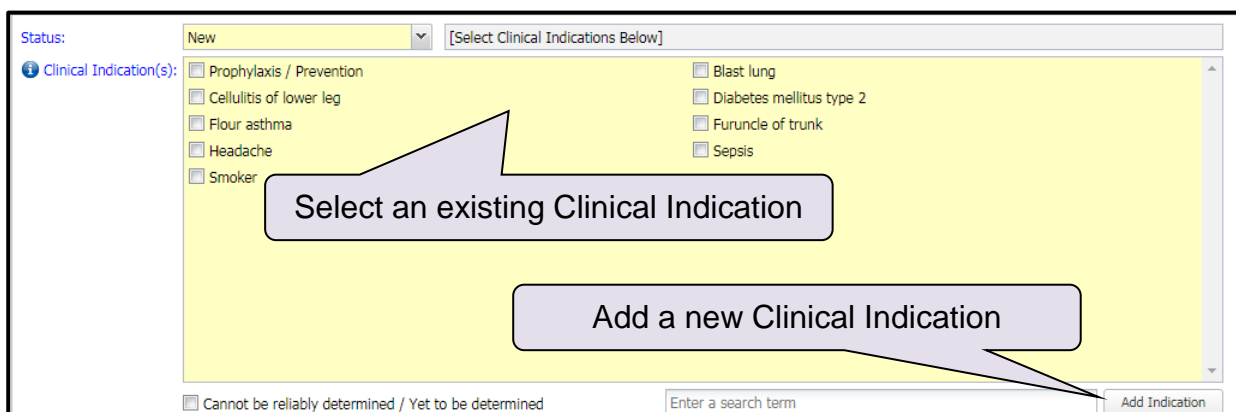
Finalisation and Clinical Indications

A Discharge Summary cannot be completed while there are medication instructions with the “Cannot be reliably determined / Yet to be determined” value. The reason for this is to ensure a clinician has checked the final medication entries prior to finalisation.

A Clinician can update the Clinical Indication in two ways:

1) Through the Change functionality

Once the desired medication has been selected, you can choose the Change button. From within the Change window, a different Clinical Indication can be selected from the drop down list, or a new Clinical Indication can be entered through the “Add Clinical Indication” functionality. **Note:** The Add Clinical Indication functionality is very similar to the Problems and Significant MHx functionality defined before, where the user searches, then adds a SNOMED term through either a double click, pressing a hot keys or click and drag functionality



2) Through the main Best Possible Medication Window

The Best Possible Medication Window has a drop down list of all the available Clinical Indications (Problems, Significant MHx). Any medication instructions that have been set to “Cannot be reliably determined / Yet to be determined” will be displayed with a value of “Undetermined”. You can select a different Clinical Indication for the medication instruction by selecting a different value from the drop down list

The screenshot shows a software interface titled "Current" with buttons for navigation: "<<", "New", "Change", "Cease", and "Void". Below these is a table with columns for checkboxes, Medication, Duration, and Reason(s) for. The table contains two rows: Aspirin 100mg Tablet (Undetermined) and Warfarin 2mg LAVENDER Tablet (Undetermined). A dropdown menu is open for the Warfarin row, showing options: Undetermined, LR Hernya, LR hernia, and Prophylaxis / Prevention. A callout box points to the dropdown with the text "Select an existing Clinical Indication".

<input type="checkbox"/>	Medication	Duration	Reason(s) for
<input type="checkbox"/>	N Aspirin 100mg Tablet		Undetermined
<input checked="" type="checkbox"/>	N Warfarin 2mg LAVENDER Tablet		Undetermined

Dropdown menu options for Warfarin:
 Undetermined
 LR Hernya
 LR hernia
 Prophylaxis / Prevention

Callout: Select an existing Clinical Indication

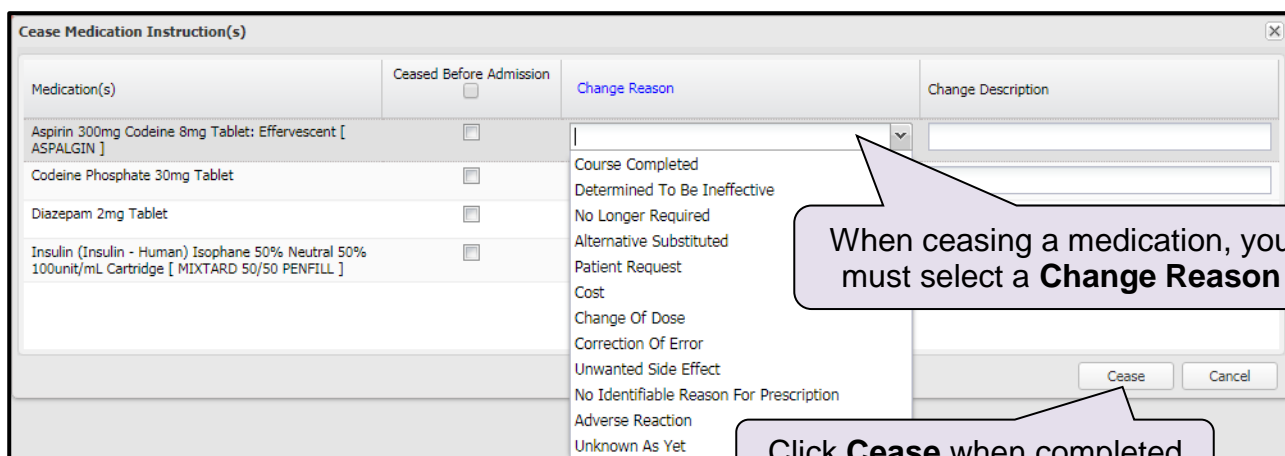
PRINTING A PATIENT MEDICATIONS LIST

- ① Click on in **Medications** and select **Medication List**
- ① Click on the Medication List button
- ① Read the “Confirm Medications Cross Checked Against Allergies / Adverse Reactions” box
- ① Tick the checkbox and press the “Confirm” button to confirm your responsibility for checking any allergies or adverse reactions
- ① Click the button
- ① Select the **Printer** on which you want to print
- ① Click **Print**
- ① Print the list and give to the patient

CEASED MEDICATIONS

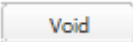
To cease any existing medications:

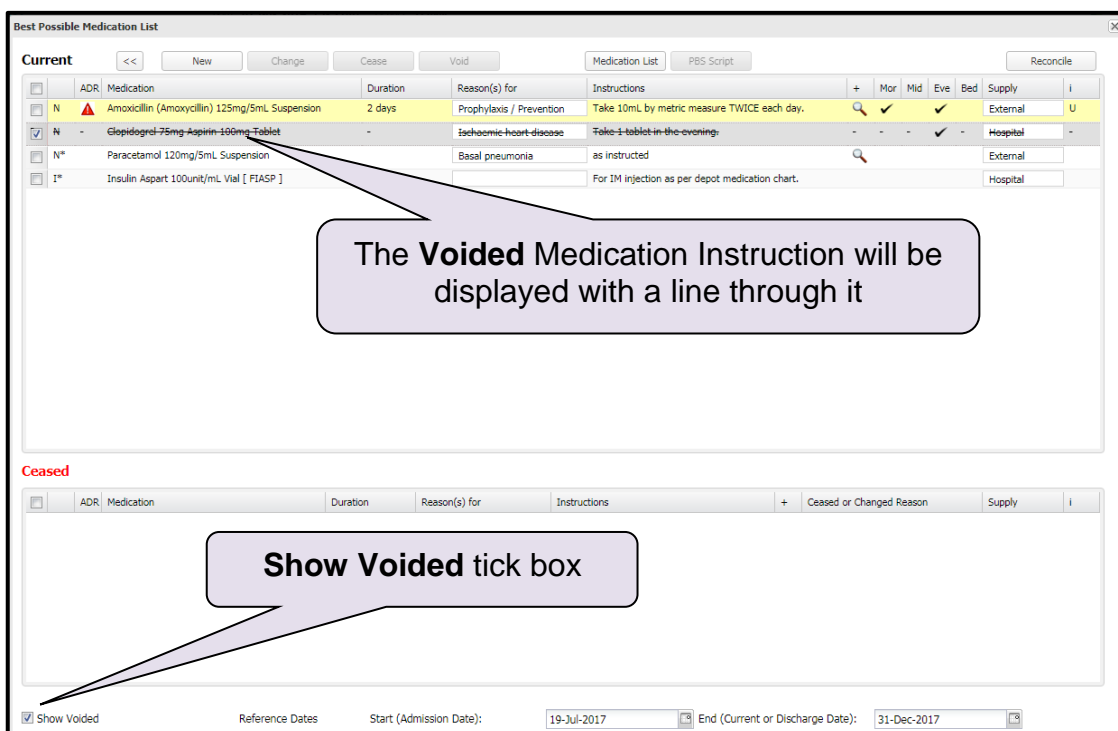
- Click on in **Medications**
 - Select the medication you wish to cease and select
 - Select the **Change Reason** and enter a **Change Description** and click **Cease**
 - The ceased medication will now appear in the **Ceased** section
- ① Medications can also be ceased by setting the status to Ceased in both the **New** functionality and the **Change** functionality
 - ① All medications will appear in the **Medications** section of the printed summary



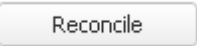
VOIDING A MEDICATION

To **Void** a Medication

- Select an Medication from the Best Possible Medication List and click 
 - Review the “Void Medication(s) Confirmation” window and click **Void**
 - The voided entry(s) will disappear from the screen, to view the Voided Medication(s) click on the tick box – **Show Voided** at the bottom left of the screen
- ⓘ Voiding a Medication should only be used when the Medication Instruction has been entered incorrectly against a patient. For example, the wrong patient was selected for the Medication Instruction, or the wrong Medication was entered for the Medication Instruction. If you want to indicate that the patient no longer needs to take a medication, please use the “Cease” function instead.
- ⓘ If you need to indicate that a medication instruction was ceased prior to the current case, then you will need to use the CEASE function and select the tick box “Ceased Before Admission”. This will result on the medication instruction NOT appearing in the Ceased medication instruction list.

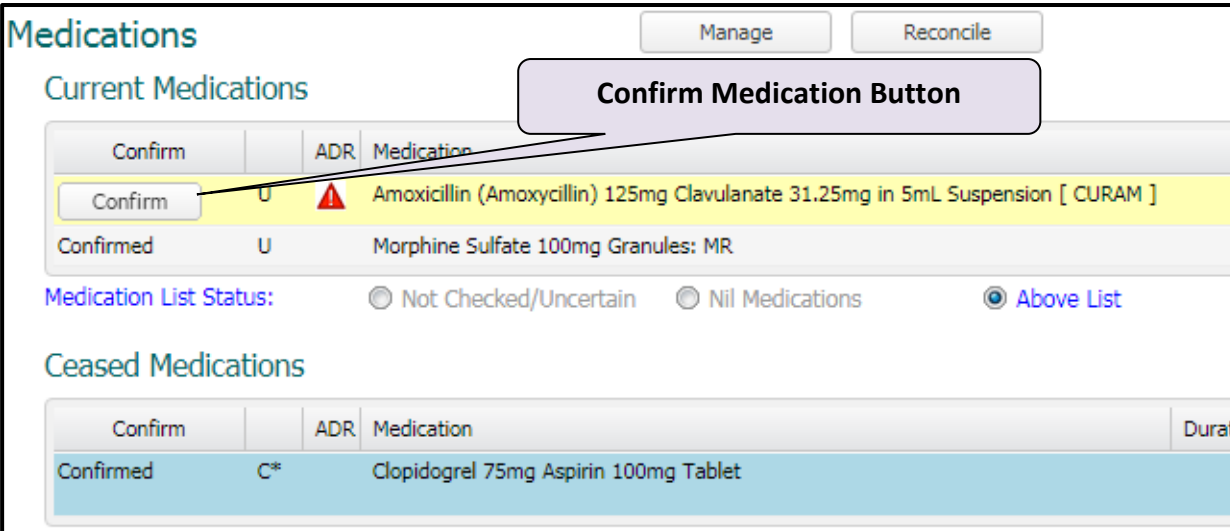


RECONCILING A MEDICATIONS LIST

- ① Click on  in from either the Discharge Summary Edit page or the Best Possible Medication List page
- ① Once a Discharge Summary is reconciled, both the name of the reconciler and the date and time of reconciliation will be displayed above the Medications Instructions
- ① The Reconciliation can only be performed by a Pharmacist
- ① The Reconciliation is lost as soon as a user adds, changes, ceases or voids any medication instructions or adds, changes or voids any ADR or Allergy
- ① The Discharge Summary Reconciliation does not appear on the Discharge Summary PDF, currently, it is only recorded in the database

CONFIRMING A MEDICATION INSTRUCTION

Medication Instructions are stored on the patient's record. As subsequent readmissions occur, the medication instructions from the previous admission are carried onto the next admission. To assist with the identification of medication instructions from previous cases a "confirm medication" button has been introduced into NaCS.



The screenshot displays the 'Medications' section of the NaCS interface. At the top, there are 'Manage' and 'Reconcile' buttons. Below this, the 'Current Medications' section is visible, featuring a table with columns for 'Confirm', 'ADR', and 'Medication'. A callout box labeled 'Confirm Medication Button' points to the 'Confirm' button in the first row of the table, which contains the medication 'Amoxicillin (Amoxycillin) 125mg Clavulanate 31.25mg in 5mL Suspension [CURAM]'. The status for this medication is 'U' (Unconfirmed). Below the 'Current Medications' section, there is a 'Medication List Status' section with three radio buttons: 'Not Checked/Uncertain', 'Nil Medications', and 'Above List' (which is selected). The 'Ceased Medications' section is also visible, with a table containing one row for 'Clopidogrel 75mg Aspirin 100mg Tablet' with a status of 'C*' (Confirmed).

- ① To confirm a Medication Instruction, click on the Confirm icon next to the Medication Instruction on the main Discharge Summary edit page.
- ① Both Current and Ceased Medication Instructions will need to be confirmed.
- ① Any new medication instructions, if added by a Clinician will be marked as Confirmed. If the new medication instruction is added by a Pharmacist, then it will be marked as Unconfirmed
- ① Any changes to existing medication instructions, if made by a Clinician, will be mark the medication instruction as Confirmed. Changes made by Pharmacists will mark the medication instruction as Unconfirmed
- ① All medication instructions will need to be marked as "Confirmed" before the Discharge Summary can be completed
- ① All medication instructions that are copied from previous Discharge Summaries will have the status automatically updated to "U" meaning "Unchanged" by NaCS

MEDICATION LIST STATUS

If a Medication Instruction has been entered into NaCS, then it will appear on the Discharge Summary. This raises the question of what to display if there are no Medication Instructions entered. This could mean that, the user has not entered the patient's medication instructions or that the patient does not have Medication Instructions. To overcome this issue, the NaCS Discharge Summary has implemented the Medication List Status field.

The screenshot shows a table of 'Current Medications'. The table has columns for 'Confirm', 'ADR', and 'Medication'. A callout box labeled 'Medication List Status' points to a dropdown menu at the bottom of the table. The dropdown menu has three options: 'Not Checked/Uncertain', 'Nil Medications', and 'Above List'. The 'Above List' option is selected.

If you are completing a Discharge Summary then fill out the Medication List Status in the following way;

- Not Checked / Uncertain – Use if you have not confirmed the patient's Medication Instructions and do not intend to include any on the Discharge Summary
 - Nil Meds – Use if you have confirmed that the patient does not have any current discharge medication instructions
 - Above List Correct – Use if you have entered all the Medication Instructions for the patient
- ⓘ The Medication List Status requires a value to be selected before the Discharge Summary can be finalised
- ⓘ The Not Checked / Uncertain and Nil Medication fields can only be selected if there are no current medication instructions for the patient
- ⓘ When a medication's status is set to Withheld the following information will appear in the Dosage Directions "This medication has been withheld. Talk to your doctor before restarting this medication." This message is deleted if a withheld medication's status is set to a different value.

Retrospective Updates to Medication Instructions

If summaries are completed as each case is discharged, then the medication instructions will flow from one summary to the next. However, if you want to make an update to an old discharge summary after the patient has been readmitted for another case, these changes to the older case will not automatically flow onto subsequent summaries. Instead, each summary will need to be updated individually.

For example, if you find that a patient record states the patient should take warfarin and this information has been included on the past four summaries. If this information was never correct, to fix this issue, you will need to Void the Warfarin medication instruction and re-finalise each of these four individual summaries. By voiding the medication instruction on the current summary, it will not flow onto the next case.

- ① Removing the medications (Significant MHx) in a previous Discharge Summary will only flow through to the current Discharge Summary if the current Discharge Summary is has a status of “Enrolled”.
- ① Removing the medications in the current Discharge Summary does not flow back to previous Discharge Summaries.

Own Supply Medications

Patients may bring their own supply of medications. When this occurs the Supply field on the Best Possible Medications List in NaCS should be set to “Own Supply”. This is done by performing the following:

- Open the medication section of the discharge summary
- Select the medication to be changed
- Change the supply status from “Hospital” to “Own Supply”. This will clear the Quantity to Supply information
- ① This change is only reflected when you click on the “Medications List” button and the “Supply” field on the PBS Script is set to “N”.

External Medications

Changing the Supply Status to “External” enables medications to be printed on a prescription separate to the medications for hospital supply. This creates two sets of scripts, one for the hospital, and one for the community pharmacy.

GENERATING/PREPARING AN ELECTRONIC PBS SCRIPT

There are 2 steps that need to be followed when preparing and generating a PBS compliant script;

- 1) Link a medication instruction to a PBS item And;
- 2) Include the linked medication instructions on a Prescription

It is important to remember that Pharmacist (like Clinicians) users have the ability to prepare a PBS compliant medication instruction for a patient being discharged; however they do not have the ability to create the prepared script. The Clinician can only create a PBS generated script and print it after they have completed their Prescriber number.

LINKING TO PBS

1. To link a medication instruction to a PBS item:

- Click on **Manage**
- Click **New** (you should now be in the **Best Possible Medication List** screen)
- Complete all required fields and click on the **Dispensing** panel
- You should now have the ability to enter in your PBS details, the type and Quantity to supply.
- If this item is not PBS then you can still select the check box to “**prescribe as Non PBS**”

Best Possible Medication List

Current >>

Medication Selection [none selected]

Medication Selection [none selected]

Metformin Search Show Brands: Global Search: Add/Edit Unlisted Medication

Medication	PBS
Alogliptin 12.5mg Metformin 1g Tablet	Y
Dapagliflozin 10mg Metformin 1g Tablet: MR	Y
Dapagliflozin 10mg Metformin 500mg Tablet: MR	Y
Dapagliflozin 5mg Metformin 1g Tablet: MR	Y
Empagliflozin 12.5mg Metformin 1g Tablet	Y
Empagliflozin 12.5mg Metformin 500mg Tablet	Y
Empagliflozin 5mg Metformin 1g Tablet	Y
Empagliflozin 5mg Metformin 500mg Tablet	Y
Glibenclamide 2.5mg Metformin 500mg Tablet	Y
Glibenclamide 5mg Metformin 500mg Tablet	Y
Linagliptin 2.5mg Metformin 1g Tablet	Y
Linagliptin 2.5mg Metformin 500mg Tablet	Y
Linagliptin 2.5mg Metformin 850mg Tablet	Y
Metformin 1g Tablet	Y
Metformin 1g Tablet: MR	Y
Metformin 500mg Tablet	Y
Metformin 500mg Tablet: MR	Y
Metformin XR 500mg Tablet: MR	Y
Rosiglitazone 2mg Metformin 1g Tab	Y
Rosiglitazone 2mg Metformin 500mg	Y
Saxagliptin 2.5mg Metformin 1g Tabl	Y
Saxagliptin 5mg Metformin 1g Tablet	Y
Saxagliptin 5mg Metformin 500mg T	Y
Sitagliptin 100mg Metformin 1g Tabl	Y

Medications that are linked to PBS through iPharmacy will display with a "Y" in the PBS field

Complete all mandatory Medication Selection and Dosage Directions fields and then select the Dispensing panel

Directions Dispensing

Save and Add New Save Cancel

Best Possible Medication List

Current >>

Medication Selection **Dapagliflozin 10mg Metformin 1g Tablet: MR**

Directions Dosage Directions: *Take 2 tablets in the morning, 2 tablets at lunchtime and 2 tablets at bedtime. Space each dose at least 6 hours apart.* Status: New Clinical Indications: *Diab*

Dispensing

Prescribe as: PBS Non-PBS Selected PBS Item Code: 10515K

PBS Type	Code	PBS Form and Strength	Max Qty	Repeats	Pack Size	RPBS	Max Qty Reg 24
Authority Required	10515K	dapagliflozin 10 mg & metformin hydrochloride 1 g modified release tablet, 28	28 Tab	5	28 Tab		168 Tab

Non-PBS prescribing is possible by selecting this checkbox

Selecting the hyperlink will open the PBS online website and display information pertaining to the selected PBS item

Quantity to Supply: 28 Tablet Reg 24: Telephone Authority (AT): Authority Streamlined (AS):

Indication / PBS Notes: 5631 - Diabetes mellitus type 2 Clinical criteria: * Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR * Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with metformin. The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 receptor agonist (GLP-1 RA), a glucagon-like peptide-1 receptor agonist (GLP-1 RA) or an SGLT2 inhibitor is initiated. The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a thiazolidinedione (glitazone), a glucagon-like peptide-1 receptor agonist (GLP-1 RA) or an SGLT2 inhibitor was reduced or discontinued. 5657 - Diabetes mellitus type 2 Clinical criteria: * Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR * Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with insulin and oral antidiabetic agents, or insulin alone where metformin is contraindicated. The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment

Items requiring a streamlined authority must have an indication selected from the indication dropdown.

Save and Add New Save Cancel

- ⓘ When selected, Medication instructions that require Authority will default to either Streamlined Authority or Telephone Authority. If no Authority is defaulted, then the medication is an HSD Complex Authority medication

- ❶ Unless the medication instruction is set to Telephone Authority, the quantity to supply must be less than or equal to the Maximum Quantity
- ❷ When Regulation 24 is selected for a medication instruction, the quantity supplied must be less than or equal to the maximum quantity under Regulation 24. (Note this can only be used when the Regulation 24 rules apply)
- ❸ Both PBS and RPBS (Repatriation PBS) entries are listed in the PBS Items section. Please ensure that RPBS entries are selected for applicable patients only.
- ❹ Once saved, a “PBS Template Status” will be calculated for the Medication Instruction. Please see Appendix D for a list of the PBS Template Status values
- ❺ The user cannot link a medication instruction to a PBS entry through the Pre-Prescription Authorisation page. This can only be through the PBS Dispensing tab on the New / Change medication instruction page (above).
- ❻ To be included on a Prescription, a Medication Instruction needs to have either a PBS entry selected from the PBS Dispensing Tab OR have NON PBS selected from the PBS Dispensing Tab. NaCS will prevent medication instructions from being prescribed if they do not have one of these pieces of information.

PBS PRESCRIPTION

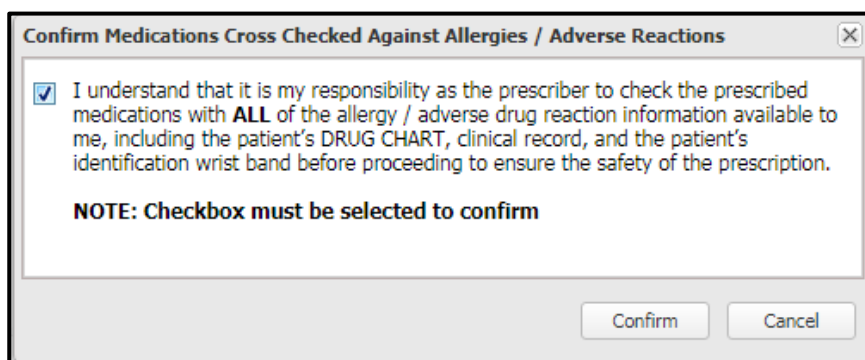
- At the **Best Possible Medication List** screen **select** the medication(s) you want to generate a script for
- Change the **Supply** field if the medication is for external supply or own supply
- Click on **PBS Script**

The screenshot shows the 'Best Possible Medication List' interface. It features a table of medications with columns for ADR, Medication, Duration, Reason(s) for, Instructions, and Supply. The 'Supply' column includes fields for Hospital, Own Supply, and External. A 'PBS Script' button is visible at the top right. Callouts provide the following information:

- Select medications for prescribing here:** Points to the medication list table.
- Print a patient Medication List upon discharge:** Points to the 'Medication List' button.
- PBS Script button:** Points to the 'PBS Script' button.
- Supply field:** Points to the 'Supply' column in the table.
- Medications in Blue are to notify you that this was the last entered Medication:** Points to the blue-highlighted row for Clopidogrel 75mg Aspirin 100mg Tablet.
- PBS Template Status field:** Points to the 'AS' status in the 'Supply' column for the blue-highlighted row.

Below the main table is a 'Ceased' section with a similar table structure for discontinued medications. At the bottom, there are date selection fields for 'Start (Admission Date): 13-Oct-2020' and 'End (Current or Discharge Date): 15-Oct-2020'.

- ❶ The default position is that all medication instructions will not be added to the Prescription. Through use of the left hand tick box, each separate medication instruction can be individually added to the Prescription, or all medications can be added in bulk using the select all option (tick box in title row)
- ❷ The supply field value results in the following data on the Prescription
 - Hospital – Will be displayed with other Hospital prescribed medications. Supply field on resulting Prescription will display “Y”
 - External – Will be displayed with other External and Own Supply prescribed medications. Supply field on resulting Prescription will display “Y”
 - Own Supply – Will be displayed with other Own Supply and External prescribed medications. Supply field on resulting Prescription will display “N”
- Read the **Confirm Medications Cross Checked Against Allergies / Adverse Reactions** box that is then displayed
- Tick the checkbox and then click on the **Confirm** button to confirm you have cross checked the patient’s medications against any allergies or adverse reactions before generating the script.



PBS Pre-Authorisation Page

- Complete all mandatory fields accordingly (see diagram below)
 - Click **Validate** to confirm that all authorisations have been correctly provided
 - Enter you HE password when prompted and click **OK** to confirm
- ❶ Prescriptions need to print on **Approved Pre-printed** prescription stationery

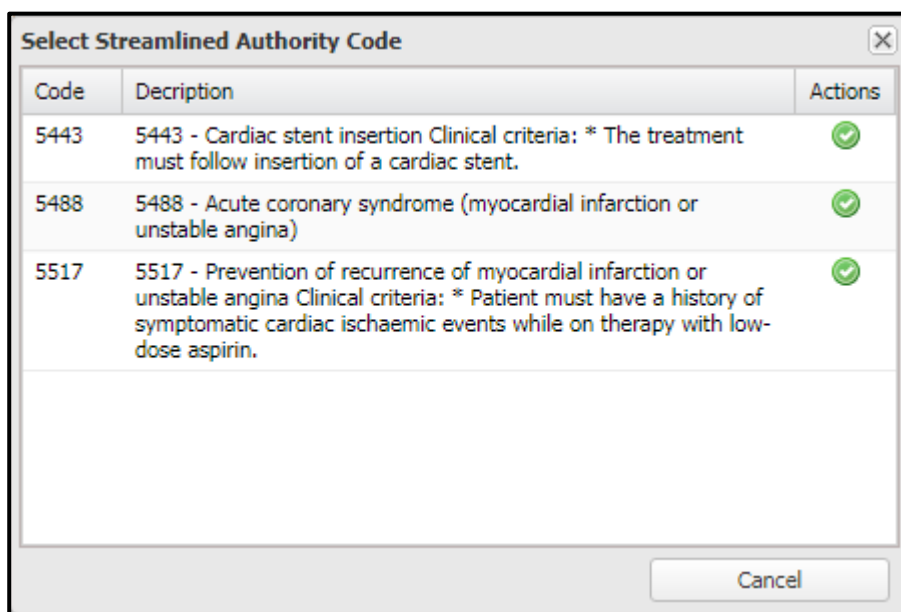
Prescriber Number is mandatory before printing

Status	Item Name, Strength and Form	Dose, Route and Frequency	Qty	UOM	Rpts	Total	Reg 24	Streamlined	Supply	Approval No.	Instruction	Non PBS
Prescription: General PBS (External) (Authority Prescription No: 00044763)												
R	Amoxicillin (Amoxycillin) 125mg Clavulanate 31.25 5mL Suspension [CURAM], 75 mL	Take 2.5mL by metric measure in the evening, free trect	1	Bottle	0	1 Bottle						
Prescription: General PBS (Hospital) (Authority Prescription No: 00044774)												
AT	Clopidogrel 75mg Aspirin 100mg Tablet	Take 1 tablet in the morning, 1 tablet at midday, 1 tablet in the evening and 1 tablet at bedtime.	30	Tab	3	30 Tab			✓			
AS	Dapagliflozin 10mg Metformin 1g Tab	Take 2 tablets in the morning, 2 tablets at lunchtime and 2 tablets at bedtime. Space each dose at least 6 hours apart. Swallow tablets whole. Do not take	28	Tab	1	28 Tab		✓	✓	5631		
Prescription: Sched...												
R	Morphine Sulfate		5	Sachet								

Prescription Number is located in the group heading.

Orange background means an approval number is required

- ① Each medication instruction that is set to Authority Telephone requires an approval number to be entered before the Prescription can be created. The PBS Authority Prescription Number to quote to PBS is located in the group heading for the medication instruction. **Details of Approval numbers and other information will be lost if you cancel out of the PBS Pre-Authorisation page.**
- ① NaCS will automatically divide the medication instructions selected into the correct groupings. So, Schedule 8 medications will all be on a separate Prescription to non-schedule 8 medications. Likewise, RPBS medications will appear on separate Prescriptions to PBS medications. There are many rules in place for this
- ① Patient Weight can contain up to 2 decimal places, e.g. for a 72.75kg patient enter "72.75"
- ① A lot of validation is performed prior to the final Prescription being created. If you would like to determine if the entered information is valid for Prescribing without actually creating the Prescription, press the **Validate** button
- ① A different Streamlined Authority Indication can be selected for a medication by unselecting, **then** selecting the "Streamlined" tick box. This will trigger the Streamlined Authority Indication dialogue box to appear. Selecting a green tick against any of the indications will link the indication to the medication for Prescribing



PBS Prescription Printing

When the **Print Scripts** button is pressed you will be asked to enter your password. Once this is validated a new browser tab/window will display the PDF prescription.

To print the PBS Prescription, you will need to use the built in PDF (Adobe) printing functionality:

Please note: the PDF is for printing purposes only. It is not a valid prescription itself, and should not be electronically sent via e-mail or any other form and is not to be saved.

The Prescription will then be displayed in the Adobe window as shown below:

- Select the **Printer** you want to print to.
 - **Please note:** some sites have dedicated print queues to print PBS Prescriptions that will automatically select the correct tray (e.g. *PRQEPBSS03 - SCGH*).
 - If required Click on the **Properties** button and select the **tray** that contains PBS Script paper (usually on the Paper/Finishing tab)
 - Ensure that the PBS Prescription paper is correctly loaded in tray of the printer
 - Click **OK**
 - Before printing the prescription ensure the “**Shrink oversized pages**” option is selected. This option will ensure the PDF prints as expected.
 - Click on the **Print** button
 - After printing, **collect the scripts from the printer** and review to ensure all copies have printed successfully **prior to closing the PDF**. You will not be able to reopen the PDF once it is closed, so please ensure correct printing has occurred.
- ⓘ All copies of all prescriptions must be signed by the prescriber. Electronically generated prescriptions for schedule 8 medications no longer require Drs to handwrite; drug, strength, form and quantity.

PLAN

The plan section relates to **Recipients** who you are sending the summary to and who you want to be notified of a patient’s discharge.

RECIPIENTS (BASE)

For NaCS to automatically send a Discharge Summary to a GP, the GP details from the Patient Administration System (PAS) must be matched to a record in the Global Health Provider Register (GHPR). The GP information displayed from the PAS will be displayed initially in an “Unconfirmed” state.

To assist with the Confirmation process, potential matching GHP entries are displayed below the PAS information. If you want to select one of these entries, simply select the “Confirm” button next to the GHP suggestion and the NaCS status will then change to “Confirmed”.

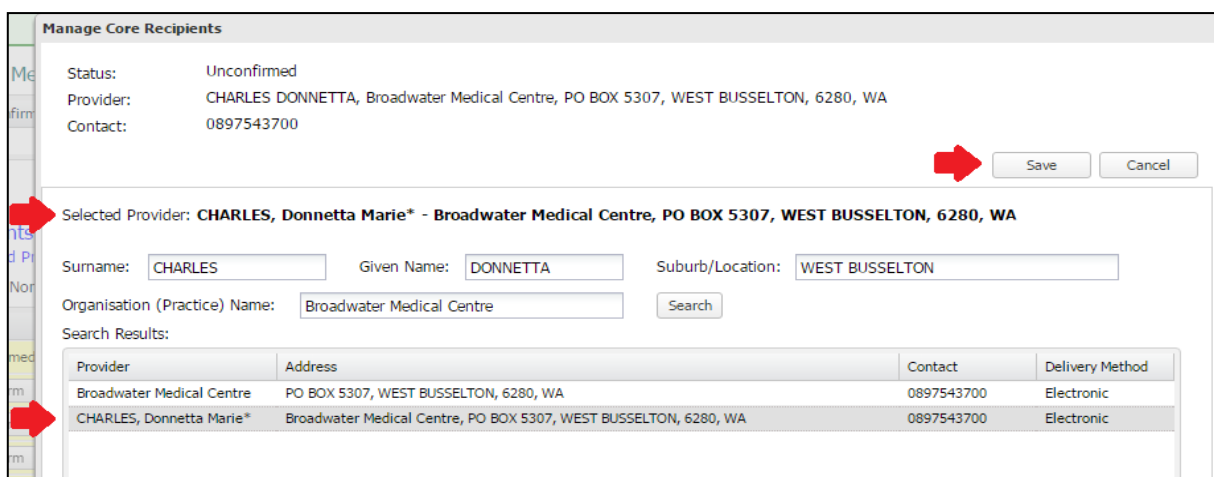
GP records with the Delivery Method of Electronic or Fax will automatically get a copy of the Discharge Summary when it is finalised

NOTE: The GP details must be confirmed before the Discharge Summary can be finalised.

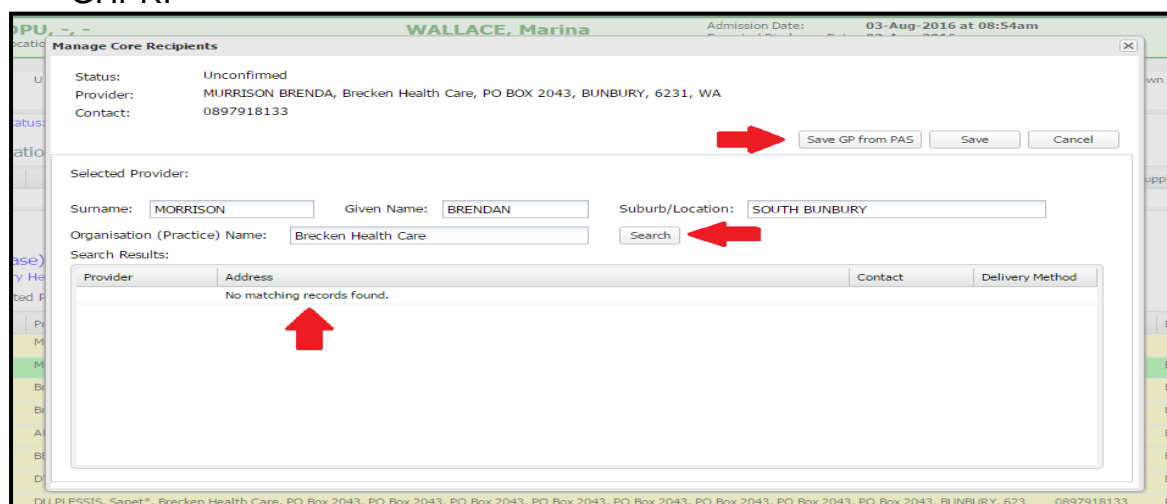
The screenshot shows the 'Plan' section with the following components:

- Recipients (Base):** A table with columns for Status, Provider, Contact, and Delivery Method. The status is 'Unconfirmed'. The table lists several GPs from 'Gwelup Medical Centre, 698 North Beach Rd, GWEELUP, 6018, WA'.
- PAS' GP and/or Practice:** A red bracket on the left side of the recipients table.
- GHPR Suggestions:** A list of suggestions on the right side, each with a 'Confirm' button.
 - Suggestion #1:** Exact GP Surname and Given Name(s), Practice Name and Suburb match between GHPR and PAS, if exists.
 - Suggestion #2:** Exact Practice Name and Suburb match between GHPR and PAS, if exists.
 - Suggestion #3:** All GPs listed in GHPR for matching PAS' Practice Name and Suburb, if exists. The list is ordered by Surname, Given Name(s) then Practice Name.
 - Suggestion #4:** GPs with matching Surname and Given Name(s) between GHPR and PAS, regardless of the Practice they are in, if exists.

- ① Ensure the *Notify Nominated Healthcare Provider* checkbox is ticked for the GP to be notified electronically or by fax.
- ① If there is an exact match between the GP details in the PAS and an entry in the GHPR, this suggestion will display with a **green** background. If no perfect match is found in GHPR, the user can scroll through the listed match results to look for the best match.
- ① The GP confirmed and displayed will appear under the **Primary Recipients** header of the printed summary
- ① If none of the suggestions correctly match the required GP, then a different entry will need to be found by selecting the **Change** button and then searching for the correct GP details.
- ① If no match is found when confirming the GP then remove all of the information from all of the search fields except for the practice name and then click search.
- ① Search for the GP; select the appropriate record (this is displayed in the “Selected Provider” field) and click “Save”.



- ① The “Save GP from PAS” function should be used only if no matching records are found.
- ① **N.B.** Using this option will **NOT** send the discharge summary to the GP and a copy of the discharge summary will need to be posted out as required.
- ① Notify your local Site Admin that the GP listed in the PAS is not registered in the GHPR.



- ① If the patient does not have a GP or the GP is unknown it will be recorded in the PAS and displayed in the Recipients Base as either 'Nil GP' or 'Unknown GP' and you must check the *Confirmed as not having a current GP* checkbox.

Plan

Recipients (Base)

Nominated Primary Healthcare Provider for this event Confirmed as not having a current GP

Notify Nominated Primary Healthcare Provider

Status	Provider	Contact	Delivery Method

Plan

Recipients (Base)

Nominated Primary Healthcare Provider for this event Confirmed as not having a current GP

Notify Nominated Primary Healthcare Provider

Status	Provider	Contact	Delivery Method
Unconfirmed	NIL GP/ Nil Practice, Nil GP / Nil Practice (Confirmed), Unknown, UNKNOWN, 6999, WA		

Plan

Recipients (Base)

Nominated Primary Healthcare Provider for this event Confirmed as not having a current GP

Notify Nominated Primary Healthcare Provider

Status	Provider	Contact	Delivery Method
Unconfirmed	UNKNOWN GP/ Practice Unknown, Unknown GP / Unknown Practice, Unknown, UNKNOWN, 6999, WA		

Determining preferred delivery methods from the discharge summary PDF

Primary Recipients			
Name	Contact	Address	Organisation
BRENDA MURRISON	Phone: 0897918133 (Workplace) Facsimile machine: 0897918199 (Workplace)	Work Place: PO BOX 2043, BUNBURY, WA, 6231, Australia	Breken Health Care
Secondary Recipients			
Name	Contact	Address	Organisation
DR VANESSA HYDE-SMITH	Phone: 0895571111 (Workplace) Facsimile machine: 0895571112 (Workplace)	Work Place: 18 Civic Boulevard, ROCKINGHAM, WA, Australia	Rockingham Medical Centre [Preferred Delivery Method - Secure Electronic]
DR JACQUIE GARTON-SMITH	Phone: 0893875000 (Workplace) Facsimile machine: 0893839337 (Workplace) Email: office@wfmp.com.au (Workplace)	Work Place: 272 Cambridge St, WEMBLEY, WA, Australia	Wembley Family Medical Practice [Preferred Delivery Method - Fax]
DR MARK DUNCAN - SMITH	Phone: 0894851333 (Workplace) Facsimile machine: 0894852333 (Workplace)	Work Place: Mount Hospital, Se 53 L 5 146 Mounts Bay Rd, PERTH, WA, Australia	Mount Medical Centre Se 53 - Plastic Surgery [Preferred Delivery Method - Mail]

END OF DOCUMENT

"Save GP from PAS" = No delivery method printed and needs to be posted out if required.

Delivery method = "Electronic"
Automatically sent electronically to GP

Delivery method = "Fax"
Automatically sent by fax to GP

Delivery method = "Mail"
Needs to be posted out to GP

OTHER RECIPIENTS

This section represents any other recipients who may play a role in the patient's care after discharge and will be listed on the summary as **secondary recipients**.

These secondary recipients are still able to receive electronic copies of the summary if they have been registered in the GHPR and have compatible software. Examples might include private surgeons practices, specialist rooms, aged care facilities, Silver Chain, the Royal Flying Doctor Service and other hospitals.

At this screen you can also document any **Arranged services/recommendations** that have been organised such as HITH appointments post discharge.

NOTE: Arranged Services / Recommendations are only designed to advise the recipients that services have been organised post discharge – this is not a referral

- ① Adding a Recipient and documenting the arranged service and / or recommendation for that recipient can all be performed at the same time. This saves time in finding and saving a recipient, then needing to re-find the same recipient to add an arranged service or recommendation.

Adding A New Recipient

- Click on in the **Other Recipients** section
 - Select from the **Recipients** section
 - Either type in the **Surname, Given Name, Organisation** or **Suburb/Location** and click **Search**, alternatively you can **Add an Unlisted Provider**. Use unlisted providers to add providers from outside Australia
 - The tick box for **Add to Recipient List** is set by default enabling your selection to receive a copy of the clinical summary you can uncheck this if you just want it documented on the summary but not to be sent out
 - Click **Save**
- ① The selected recipient will appear under the **Secondary Recipients** header in the printed summary

Adding an Arranged Service

- Click on **Manage** in the **Other Recipients** section
 - Select **New** from the **Arranged Services** section
 - Either type in the Surname, Given Name, Organisation or Suburb/Location and click **Search**, alternatively you can **Add an Unlisted Provider**
 - Tick the check box named **Add Arranged Service**, all **Blue** fields are mandatory
- ⓘ This section is not a referral but a flag so the recipient(s) can see what services have been arranged for that patient, if any
- ⓘ The selected **Arranged Service** will appear under the **Arranged Services** header in the printed summary

Adding a Recommendation

- Click on **Manage** in the **Other Recipients** section
 - Select **New** from the **Recommendations** section
 - Either type in the; **Surname, Given Name, Organisation** or **Suburb/Location** and click **Search**. Alternatively you can **Add an Unlisted Provider**
 - Tick the check box named Add Recommendation, the **Blue** field is mandatory, If the recommendation is to the patient, then check the **To Patient** tick box
- ⓘ The selected **Recommendation** will appear under the **Record of Recommendations and Information provided** section of the printed summary

Once one or more of the above have been entered, you have the option to **Void** if necessary.

Adding Advice to GP / Patient

- Click on the **Advice to GP** or **Advice to Patient** text box in the **Other Recipients** section.
 - Enter the Advice that you want to provide.
 - Click on the Add button to the right of the Advice to GP or Advice to Patient text box.
- ① Entries for Advice to GP and Advice to Patient are **saved as Recommendations**
 - ① To remove an incorrect piece of advice, use the **Void Recommendation** functionality in the recommendations section
 - ① The Discharge Summary cannot be **finalised** while unsaved text exists in the Advice to GP or Advice to Patient fields. In this situation either save the advice or use the **clear** button to remove it
 - ① An error message will appear if you attempt to **save and close** the Discharge Summary editor while unsaved Advice to GP or Advice to Patient text exists. If you press **Continue** then you will lose any unsaved Advice
 - ① When a patient is readmitted to the same hospital or is admitted at a different hospital, their previously entered Arranged Services and Recommendations will populate from the most recent, previous NaCS Discharge Summary but only if the new Discharge Summary has a status of “Enrolled”.
 - ① Voiding an arranged service or recommendation in the previous Discharge Summary only flows on to the current Discharge Summary if the current Discharge Summary is has a status of “Enrolled”.

Voiding an arranged service or recommendation in the current Discharge Summary does not flow through to previous Discharge Summaries.

ADMINISTRATIVE SECTION

ADMINISTRATION

This section enables finalisation of the clinical summary and allows upload to the patients **Personally Controlled Electronic Health Record (PCEHR)** providing that patient has enrolled.

There are several fields concerning the patient administrative side of the patient discharge.

- ① A Discharge Summary cannot be **finalised** until the Planned Destination is completed
- ① The Planned Discharge Date can be set if the patient has not yet been discharged from the PAS. By default, this can only be set to up to one day in the future. If the patient has been discharged from the PAS, this field will be set to the date and time of Discharge from the PAS and will not be editable.

Deceased Patients

If a patient is deceased, and this is recorded in the PAS, then the “Patient is Deceased” tick box will automatically be ticked and the Planned Discharge Date will not be able to be edited.

If the patient is deceased, and this is not recorded in the PAS as yet, then please select the “Patient is Deceased” tick box.

Mental Health

If a patient is a Mental Health Patient and is being admitted involuntarily, please indicate this through setting the “Mental Health Legal Status” field to “Yes” and selecting “Involuntary” in the “If Yes, then:” field.

Recording of this information is important for Clinical Coding purposes.

Cover Sheets

There are 3 tick boxes named **Cover Sheets**:

1. Nominated Primary Healthcare Provider
2. Patient
3. Other recipients

When selected these tick boxes will printout an address sheet that can be attached to the printout copies of the summaries. The significance of this is so it can be attached in a window faced envelope.

TIP: Scroll over the headings in this section for **TOOL TIPS** to be displayed

MY HEALTH RECORD EXCLUSION (MANAGING CONSENT)

It is presumed the patient has consented to uploading of their discharge summary to the My Health Record (MHR). If this is not the case and the patient does not wish for this information to be uploaded it is up to the patient themselves to advise medical staff. The patient’s removal of consent to upload should ideally be captured on admission if possible.

If the patient does not want their summary to be uploaded to the PCEHR then

- Click on the **My Health Record Exclusion** checkbox

My Health Record Exclusion

The patient or their attending doctor do not want this summary to be uploaded to the patient’s My Health Record (where available)

Do not send Discharge Summary to My Health Record

This will ensure the Discharge Summary is not uploaded to the patient’s My Health Record.

VERSION HISTORY

After a clinical summary is finalised there may be the need to make changes to the finalised version. In this instance NaCS will generate different versions of the clinical summary. Each version of the Discharge Summary for this patient’s case will be displayed in the Version History section. These older versions can be viewed by selecting the **View** button next to the desired entry in the Version History section.

NaCS will also send the amended versions to all recipients selected overriding previous versions however it is up to the staff at site to advise further on any sent copies to be destroyed at the recipients receiving end.

PREVIEW AND FINALISING

You have the ability to **Preview** your summary at any stage throughout the summaries life cycle, however you will only be able to finalise this summary enabling its upload to the My Health Record (MHR - if applicable) when all mandatory fields are complete.

Pressing **Finalise** will send electronic copies of the Discharge Summary to all the selected recipients. Finalising can only be performed by Clinician and Admin users and requires you to enter your system password.

- ❗ **Please ensure that you have reviewed the summary and double checked the clinical information prior to pressing Finalise.**
- ❗ Not all recipients will be able to receive a copy of the Electronic Discharge Summary. Hence, some sites, such as RPH, have adopted the policy of **printing** and **posting** a copy of the finalised Discharge Summaries to every nominated recipient of the Discharge Summary. This will be applied to all Discharge Summaries created.
- ❗ Pressing Finalise will also update the status of the Discharge Summary to **Final** or **Amended**. This will cause the Discharge Summary to disappear from the list of open Discharge Summaries if the patient has been discharged for more than 24 hours. Please see Appendix A for an explanation of all the Discharge Summary statuses and their meanings.

TIP: A copy of this summary once finalised will also appear in iCM within the Documents chart

PRINTING DISCHARGE SUMMARIES

Once the password entered has been validated the Discharge Summary will be finalised and the Discharge Summary and Coversheet PDF (if applicable) will open in a new browser tab/window.

The Discharge Summary will display as shown below:

Coversheet PDF (if applicable) will open in a new browser tab/window

Click on Print Icon to print the Discharge Summary

Discharge Summary
16 Mar 2017

MISS DEMO NACS
DoB: 1 Jan 1980 (37y) | SEX: Female | MRN: B9345161

START OF DOCUMENT

Health Department of Western Australia
Address: Department of Health, 189 Royal Street, EAST PERTH, WA, 6004, Australia
Phone: 089224222 (Workplace)

Consultant: MARINA WALLACE
Department: Cardiology

Admitted: 15 Mar 2017
Separated: 16 Mar 2017
LOS: 2 day(s)

Discharge To: Home/Other (usual residence)
Discharge From: SA

Event

Problems/Diagnoses This Visit

Date Identified	Type	Description (Title)	Comments
	Principal Diagnosis	vitamin d	
	Comorbidities	Amyotrophy due to type 2 diabetes mellitus	
		Leg fracture	

Clinical Synopsis
Clinical Synopsis
PRESENTING HISTORY:
one two three
ALLIED HEALTH / NURSING:
grace, physio 14/04/2017 - adfasda

Medical History

Date Identified	Problem / Diagnosis (Title)	Comments
	Closed fracture of femur	
	Vitamin A-rich diet	
01 Feb 2016	Urinary tract infection	
	Closed fracture of femur	

1. Click on the **Print icon** in the top right hand corner of the window
2. If required then **select** the **printer** that you want to print to
3. Before printing check that the “**Shrink oversized pages**” size option is selected. This option will ensure the Discharge Summary prints as expected.

NOTE: do not use the “Actual” size option when printing a Discharge Summary as this will result in the headers and footers to not print on the page.

4. Change the number of copies to 3. One copy for the patient, one for the GP and one for Medical Records
5. Click the **Print** button to print the Discharge Summary PDF
6. Sign all printed copies of the Discharge Summary

- ① The same steps as indicated above are required when previewing and/or printing a Discharge Summary or Progress Summary.
- ① The same steps as indicated above are required if printing the Discharge Summary Coversheets, however no particular size option is required to be selected before printing.

PROGRESS SUMMARIES

Before the Discharge Summary is finalised, you have the ability to create a **Progress Summary** containing the case information recorded so far. This Progress Summary looks exactly like a Discharge Summary, but has a “Progress Summary” watermark displayed across it to distinguish them from finalised Discharge Summaries.

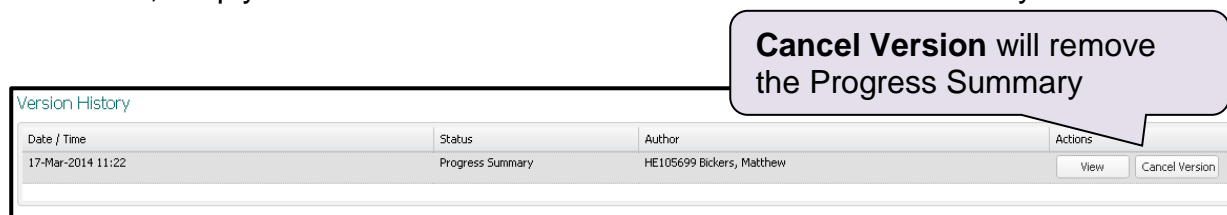
Amongst other needs, a Progress Summary can be used for clinical handover at the end of the term or if a patient is changing to the care of another team.

- ① Progress Summaries can only be created when the Discharge Summary is in **Enrolled** or **Draft** statuses
- ① Progress Summaries will be able to be **viewed through the Version History** functionality within the Discharge Summary Editor
- ① Each Summary that contains a progress summary will have the flag “**PS**” displayed on the Discharge Summary List page or Patient Search page
- ① All Progress Summaries will be able to be **viewed through iCM**
- ① Progress Summaries will be sent to the recipient GPs / other healthcare providers
- ① Progress Summaries will **not** be uploaded to the **PCEHR** (e-health record)
- ① Progress Summaries are **NOT** to be used **for transfers to other hospitals, HITH or RITH**, which all require a finalised discharge summary.
- ① Progress summaries will also need to be printed and copies sent to medical records and all recipients.

labelling="Section-Header">Cancelling a Progress Summary

It is possible for Progress Summaries to be cancelled if they have been created accidentally.

To do this, simply click the **Cancel Version** button in the Version History section.



- ❶ Only **Admin** users can cancel an Inpatient Discharge summary
- ❷ Both **Clinical** and **Admin** users can cancel an ED summary
- ❸ Cancelled progress summaries will have a watermark of **Void** and a document status of **Void**
- ❹ A copy of the cancelled progress summary with the Void watermark will be **sent to the recipient** GPs / other healthcare providers.

ADMIN USER

The earlier sections in this User Guide define the day to day functionality required for completing Discharge Summaries in NaCS. The following section defines tasks that relate more to the administration of NaCS and can therefore only be performed by Admin users.

NEW USERS

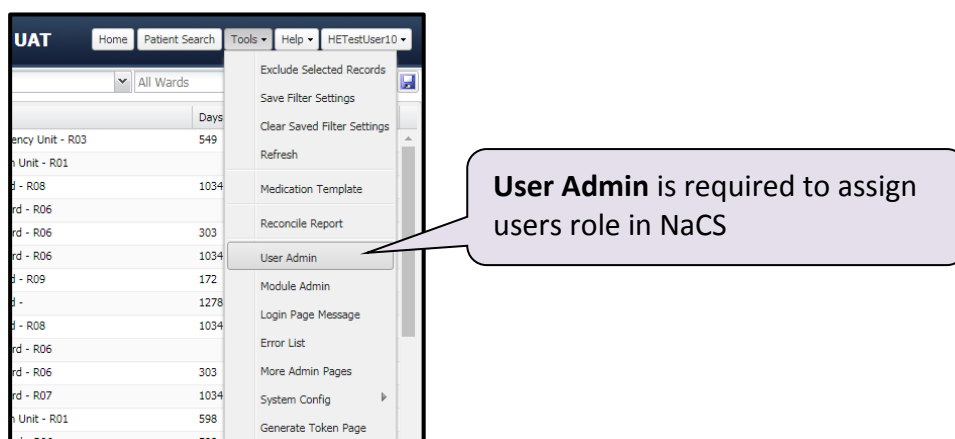
The process for creating a new user in NaCS involves two steps:

- 1) Add the user to the NaCS Active Directory User Group
- 2) Assign the user a role within NaCS

The relevant Service Desk User Provisioning team will carry out the first task upon receipt of a completed HFN030 form..

- ❶ There is a small delay between when the user has been entered into the correct User Group and can be assigned a role in NaCS. This is due to the propagation of information through the Active Directory to applications

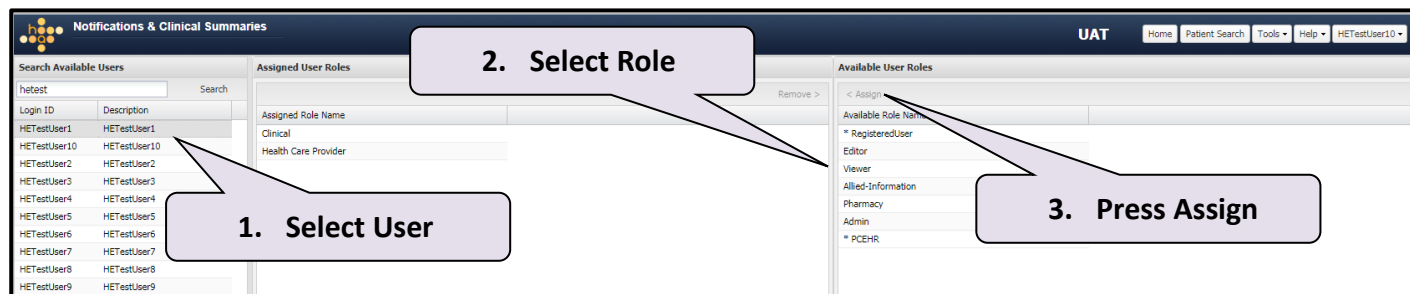
To assign a role in NaCS, simply go to the **User Admin** option on the Tools Menu.



Assign Role

The User Admin page allows the User to assign a required role to a particular user:

- Select the **User** from the **Available User List**
- Select the **Role** required from the **Available Role Name List**
- Press the **Assign** button



- ❗ The User must have an Admin role to assign a Role
- ❗ The **Health Care Provider** role is a standard role that is set by default for all users once an entry has been created in the Active Directory User Group. This role has no meaning in NaCS and cannot be assigned or removed
- ❗ Users will only be available in the Available User list once they have been created in the Active Directory and the Active Directory has propagated throughout the system.

Remove Role

The User Admin page allows the User to remove a role that is no longer required from a particular user:

- Select the **User** from the **Available User List**
- Select the **Role** required from the **Assigned Role Name List**
- Press the **Remove** button
- ❗ The User must have an Admin role to remove a Role
- ❗ Once a User has been removed from the Active Directory group their entry in NaCS should disappear. However, if you wish to remove all access to NaCS without going to HIN Support, this can be performed by removing all roles from a User, leaving only the **Health Care Provider** role

VOIDING A DISCHARGE SUMMARY

If a Discharge Summary is finalised in accident, then the only way to remove the document is to Void the Discharge Summary. An example of when this might happen is if a Clinician completes all the correct information for a patient, but on the wrong patient's Discharge Summary.

To Void a Summary:

- Find the correct Discharge Summary through Patient Search
- Open the Discharge Summary for Editing (Double Click)

- Scroll to the Administrative Section of the Discharge Summary Editor and Click the large Red **Void** button
- Enter your system password

Administrative
Administrative and Printing

Planned Destination: Home

Planned Discharge Date: 17-Mar-2014 2:46 PM Patient is Deceased

Discharge Reason: Not Known

Mental Health Legal Status: No

If Yes, then:

Patient Copy

Cover Sheets

Nominated Primary Healthcare Provider

Patient

Other Recipients

Save and Close

Preview

Finalise

Void

- ① The User must have an Admin role to Void a Summary
- ① Voiding a Discharge Summary will **mark all documents** created for the Discharge Summary as **Void**. That is, if there is a Progress Summary, a Final Version and an Amended Version and void is pressed, all three of these documents will be marked as Void
- ① When viewed through **iCM** all versions of the Void Discharge Summary will be marked as Void
- ① Any documents that have been sent to the PCEHR will be set to **Void on the PCEHR**.
- ① All electronic recipients of the Discharge Summary will receive another copy of **each** of the versions marked as Void
- ① All fax recipients of the Discharge Summary will receive another copy of the **fax** for each version with a **Void watermark**
- ① Pressing void will return the Discharge Summary **editor to Draft**, so that the Discharge Summary Editor can be completed correctly

APPENDIX A – Discharge Summary Editor States

Status of a patient's Clinical Summary from the home page:

State	Possible Pre States	Description	Possible Post States
Enrolled	Excluded	<p>The Enrolled state is the start point for all Discharge Summaries. When the patient is admitted in in the PAS a new Discharge Summary is automatically created.</p> <p>The state of an Enrolled Discharge Summary is changed to Draft when the first time that a save is performed.</p>	Draft
Draft	Enrolled Excluded Finalised Finalised Plus Amended Amended Plus	<p>The Draft state is the first update state that all Discharge Summaries go through. In this state the user may enter details into the Discharge Summary save them.</p> <p>When the user has finished their updates to the Discharge Summary, it can be finalised. The finalised process creates a snap shot of the Discharge Summary and changes the Discharge Summary status to Finalised.</p> <p>If the user does not want to complete a particular Discharge Summary, and have it disappear from their active list, they can elect to have it Excluded.</p>	Finalised Excluded
Excluded	Enrolled Draft	<p>The excluded state indicates that the Discharge Status is not complete and there is no intention to complete it.</p> <p>Excluded state Discharge Summaries are excluded from the Discharge Summary selection page. A specific search must be performed to return Excluded state Discharge Summaries to the Discharge Summary selection page</p> <p>If an excluded state Discharge Summaries needs to be re-included, it can be changed back to Draft state through the "include" functionality.</p>	Draft
Finalised	Draft Finalise Plus	<p>The Finalised state indicates that the Discharge Summary has been completed and a snap shot has been created. This status indicates that no further changes are currently being made to the particular Discharge Summary.</p> <p>A Finalised state Discharge Summary can have an amendment made to it. By</p>	Finalise Plus Draft

State	Possible Pre States	Description	Possible Post States
		<p>amending a Final state Discharge Summary, the state is changed to Finalise Plus.</p> <p>A Finalised state Discharge Summary can also be voided. This will create a snap shot of the Discharge Summary with a “Void” water mark. This will also set all previously created snap shots to void. The status of the Discharge Summary will also change to Draft.</p>	
Finalised Plus	Finalised	<p>The Finalise Plus state is the second possible update state that a Discharge Summary may go through. This state means that a snap shot has been created and the Discharge Summary is again in the process of being updated. In this state the user may enter details into the Discharge Summary and save them.</p> <p>When the user has finished their updates to the Discharge Summary, it can be finalised. The finalise process creates another snap shot of the Discharge Summary and changes the Discharge Summary status to Amend.</p> <p>A Finalised Plus state Discharge Summary can also be voided. This will create a snap shot of the Discharge Summary with a “Void” water mark. This will also set all previously created snap shots to void. The status of the Discharge Summary will also change to Draft.</p>	Amended Draft
Amended	Finalise Plus Amended Plus	<p>The Amended state indicates that the Discharge Summary has been completed and at least two snap shots have been created (a final and one or more amends). This status indicates that no further changes are currently being made to the particular Discharge Summary.</p> <p>An Amended state Discharge Summary can have changes made to it. By updating an Amended state Discharge Summary, the state is changed to Amended Plus.</p> <p>A Finalised state Discharge Summary can also be voided. This will create a snap shot of the Discharge Summary with a “Void” water mark. This will also set all previously created snap shots to void. The status of the Discharge Summary will also change to Draft.</p>	Amended Plus Draft

State	Possible Pre States	Description	Possible Post States
Amended Plus	Amended	<p>The Amended Plus state is the third possible update state that a Discharge Summary may go through. This state means that a multiple snap shots have been created and the Discharge Summary is again in the process of being updated. In this state the user may enter details into the Discharge Summary and have them saved.</p> <p>When the user has finished their updates to the Discharge Summary, it can be finalised. The finalise process creates another snap shot of the Discharge Summary and changes the Discharge Summary status to Amended.</p> <p>An Amended Plus state Discharge Summary can also be voided. This will create a snap shot of the Discharge Summary with a “Void” water mark. This will also set all previously created snap shots to void. The status of the Discharge Summary will also change to Draft.</p>	Amended Draft

APPENDIX B – Role Access

Different Roles and the functionality they can access in NaCS

Role	Access
Viewer	Home Page Patient Search Page Reprint Option
Allied Information	Home Page Patient Search Page Reprint Option Discharge Summary Editor <ul style="list-style-type: none"> - Clinical Synopsis - Medication List - Recipients Arranged Services / Recommendations - Notes to GP / Notes to Patient - Preview Discharge Summary
Pharmacy	Home Page Patient Search Page Reprint Option Discharge Summary Editor <ul style="list-style-type: none"> - Allergies / ADRs - Medication Reconciliation - Medication Add / Change / Cease / Void (Cannot add a Clinical Indication to a Medication) - Medication PBS (Cannot create a Prescription) - Medication List - Preview Discharge Summary

Role	Access
Editor	Home Page Patient Search Page Reprint Option Discharge Summary Editor <ul style="list-style-type: none"> - Problems / Procedures / Significant MHx - Confirm Significant MHx - Diagnostic Investigations - Allergies / ADRs - Medication Add / Change / Cease / Void - Medication PBS (Cannot create a Prescription) - Confirm Medications - Medication List - Recipients Arranged Services / Recommendations - Notes to GP / Notes to Patient - Preview Discharge Summary
Clinical	Home Page Patient Search Page Reprint Option Discharge Summary Editor <ul style="list-style-type: none"> - Problems / Procedures / Significant MHx - Confirm Significant MHx - Diagnostic Investigations - Allergies / ADRs - Medication Add / Change / Cease / Void - Medication PBS - Confirm Medications - Medication List - Recipients Arranged Services / Recommendations - Notes to GP / Notes to Patient - Preview Discharge Summary - Create Progress Summary - Finalise Discharge Summary

Role	Access
Admin	Home Page Patient Search Page Reprint Option Discharge Summary Editor - Problems / Procedures / Significant MHx - Confirm Significant MHx - Diagnostic Investigations - Allergies / ADRs - Medication Add / Change / Cease / Void - Medication PBS - Confirm Medications - Medication List - Recipients Arranged Services / Recommendations - Notes to GP / Notes to Patient - Preview Discharge Summary - Create Progress Summary - Finalise Discharge Summary - Void a Discharge Summary Assign User Roles (including PCEHR access) Create System Messages Create Medication Templates Set site configuration (PBS, ED, PCEHR per site)

APPENDIX C – Medication Statuses

Value	Meaning	
U	Unchanged	The medication instruction is the same as when the patient was admitted.
N	New	The medication instruction is new to the patient during this admission.
D	Decreased	The medication instruction is a dose than when the patient was admitted.
I	Increased	The medication instruction is a greater dose than when the patient was admitted.
E	Expired	The medication instruction has expired.
W	Withheld	The medication is being withheld
R	Recommenced	A medication that was previously withheld has recommenced
U*	Unchanged (Changed since discharge date)	The medication instruction is the same as when the patient was admitted and this has been recorded since the patient was discharged.
N*	New (Changed since discharge date)	The medication instruction is new to the patient during this admission and this has been recorded since the patient was discharged.
D*	Decreased (Changed since discharge date)	The medication instruction is a dose than when the patient was admitted and this has been recorded since the patient was discharged.
I*	Increased (Changed since discharge date)	The medication instruction is a greater dose than when the patient was admitted and this has been recorded since the patient was discharged.
E*	Expired (Changed since discharge date)	The medication instruction has expired and this has been recorded since the patient was discharged.

APPENDIX D – PBS Status Values

Value	Meaning
U	Unrestricted
U ²⁴	Unrestricted with Regulation 24 selected
R	Restricted
R ²⁴	Restricted with Regulation 24 selected
A ^S	Authority Streamlined
A ^{S24}	Authority Streamlined with Regulation 24 selected
A ^I	Authority Telephone
A ^{CAR}	Highly Specialised Drug with Complex Authority Required
--	Set to being a NON PBS medication
<i>Null</i>	No PBS information entered

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