Electronic Medical Report

Electronic Medical Report

GP Guide

V1.1

Copyright

For permission requests, contact MediData at:

MediData Exchange Limited
https://medi2data.net
GPstudy@medi2data.org

Note: All Patient information in this document is fictitious test data - Names, addresses, conditions and other patient data has been developed specifically for use in the test version of the eMR application. Any resemblance to actual persons, living or dead, or actual events is purely coincidental.

Contents

Product Overview

Over 2.5 million consented requests for Patient Medical Reports are received by GP Practices every year from 3rd parties outside the NHS. This additional work on already busy GP Practice, brings unnecessary pressures and the use of costly processes, long completion times and more often non-compliant data-structured reports being released to 3rd parties. eMR is an accredited FREE to use secure Web App, compatible with your existing operating system.

Delivering **VALUE** to your Practice:

- Seconds to generate an auto-redacted clinical coded medical report.
- At a 'click' produce GDPR compliant copies of a Patient records.
- Complete reports on your tablet or phone within our secure data encryption environment.
- Generate more fee income c. £300 per hour.
- Provide a better service to your Patients.
- Instructions include viewable Patient consent.

Delivering **ADDITIONAL** services:

- An automated electronic payment service providing Automated electronic payment service to improve cashflow and reduce administration costs.
- Intuitive dashboard process for ALL 3rd party requests.
- 'Create, Save and Submit' feature allows Practice staff to prepare reports prior to GP sign-off.
- Re-direct ALL requests through your eMR App.

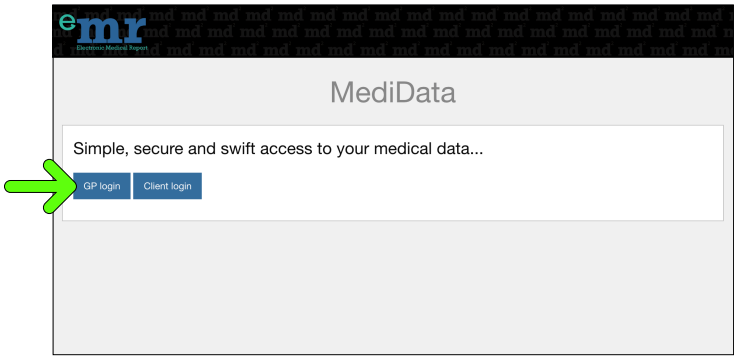
GP/Practice User Guide

2.1 Logging into eMR

2.1.1 Once registered with MediData you will be provided with a login and password to access the application.

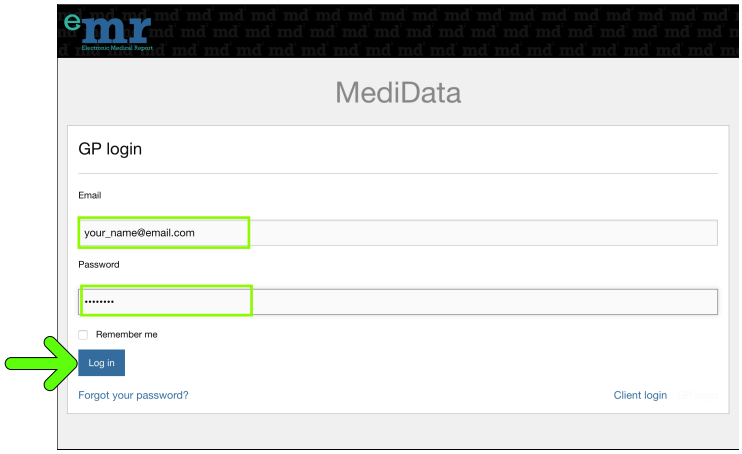
Access the MediData application by visiting https://medi2data.net

Click the 'GP login' button as indicated [Fig 1]



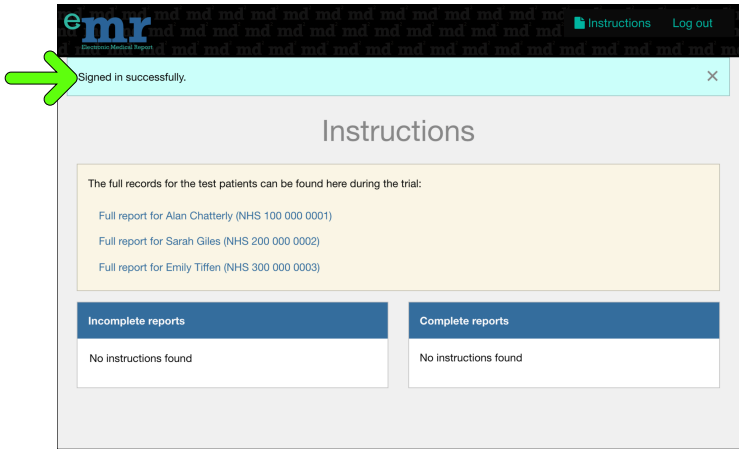
[Fig 1]

2.1.1 Enter login information and click log in [Fig 2]



[Fig 2]

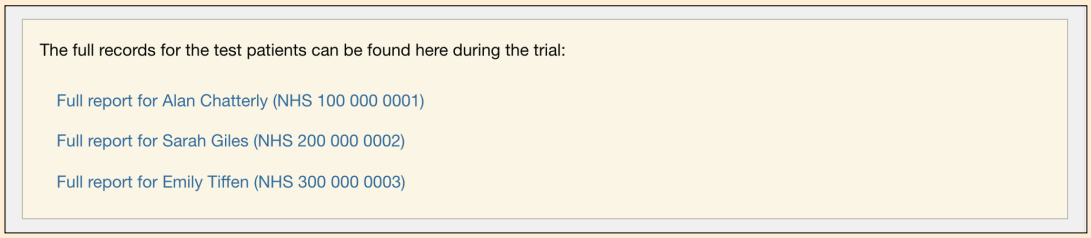
2.1.3 A successful login confirmation will be displayed if login details have been entered correctly - You will now be looking at the 'Instructions' homepage for your Practice [Fig 3]



[Fig 3]

Trial Instructions Only

NOTE: During the trial, GPs will have have access to 3 complete Patient record exports from the EMIS Test database. These Patient records can be viewed by clicking the Patient links shown below:



These Patient records contain static information to enable GPs to compare the eMR report builder against the original Patient data.

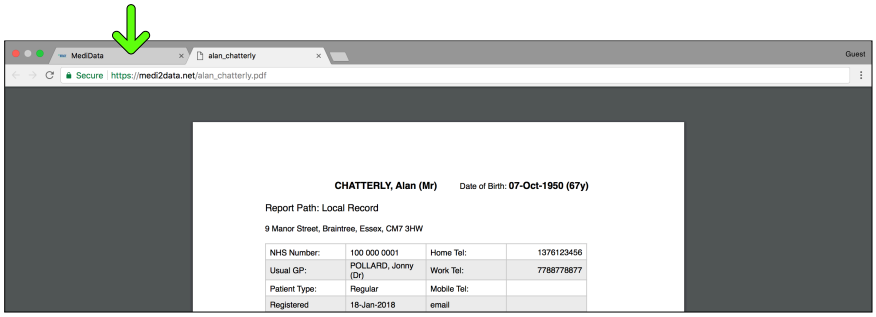
Secure automatic account log out

NOTE: If your account is left inactive for **20 minutes** you will be logged out of the application and will have to log back in if you need to access the application.

2.2 Viewing trial Patient full records

The test Patient records are stored as PDFs and contain the complete, unrelated medical records for the test Patients - these reports provide a means to compare against the redacted reports you will be creating with the eMR application.

To view a Patient record click the link of Patient you want to view, a new browser window will open containing the Patient record [Fig 4] - To return to the eMR application, click on the 'MediData' tab.



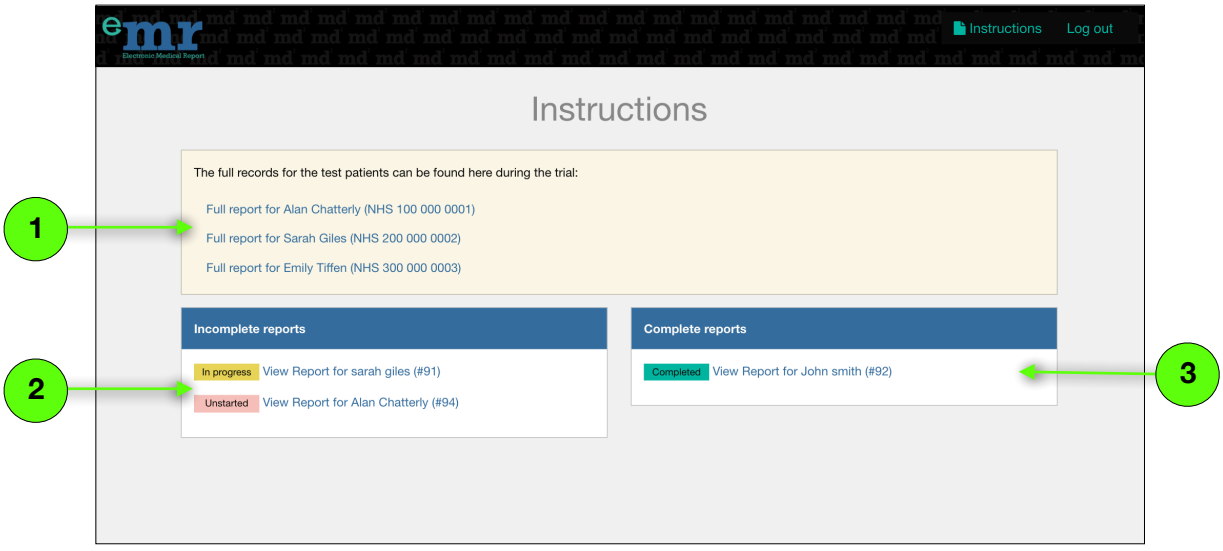
[Fig 4]

2.3 Instructions homepage

When logged into eMR you will be on the 'Instructions' homepage [Fig 5] - This page is your dashboard displaying key information for all outstanding Instruction request for your surgery. and the starting point for navigating through the eMR application.

The Instruction homepage displays the following information, their location is shown below:

1. Test Patient data (trial version of eMR only)
2. Access to incomplete or new reports
3. Access to completed reports



[Fig 5]

2.4 Report status

Once a client has created an Instruction request, the Practice associated with the Patient will be made aware that there is an unstated Instruction waiting for them in eMR. As a GP works through the report the status will change - the three status levels are explained below:

The status levels are:

Completed	Completed reports have been created, reviewed and signed off by a Practice. Once completed these reports become viewable to the Client that requested them.
In progress	In progress reports are Instruction requests that have been opened by a Practice and work is underway in completing the report - they are not viewable by the Client.
Unstarted	Unstarted reports are Instruction requests that have been sent to a Practice (including an email notification) however the Practice is yet to open the request - they are not viewable by the Client

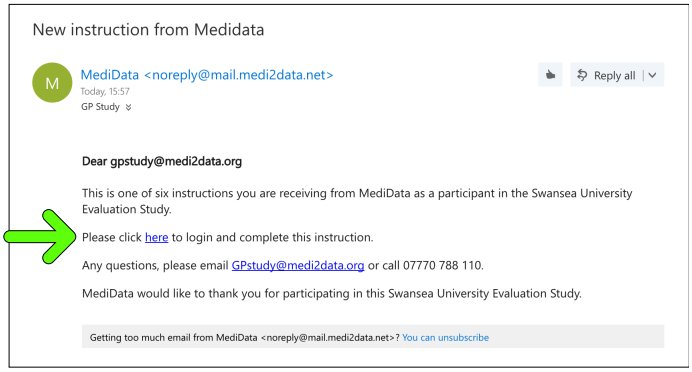
2.5 Starting new Instruction

A new Instruction can be started by either clicking the link in a notification email or by selecting an 'unstarted' Instruction from the 'Instruction homepage'

2.6 Starting a new Instruction via an email notification

Email notifications will be sent to your Practice whenever eMR creates a new Instruction for your Practice.

An example email notification is shown below [Fig 6] - the notification emails contain a link to which will direct you to the eMR application log-in screen.

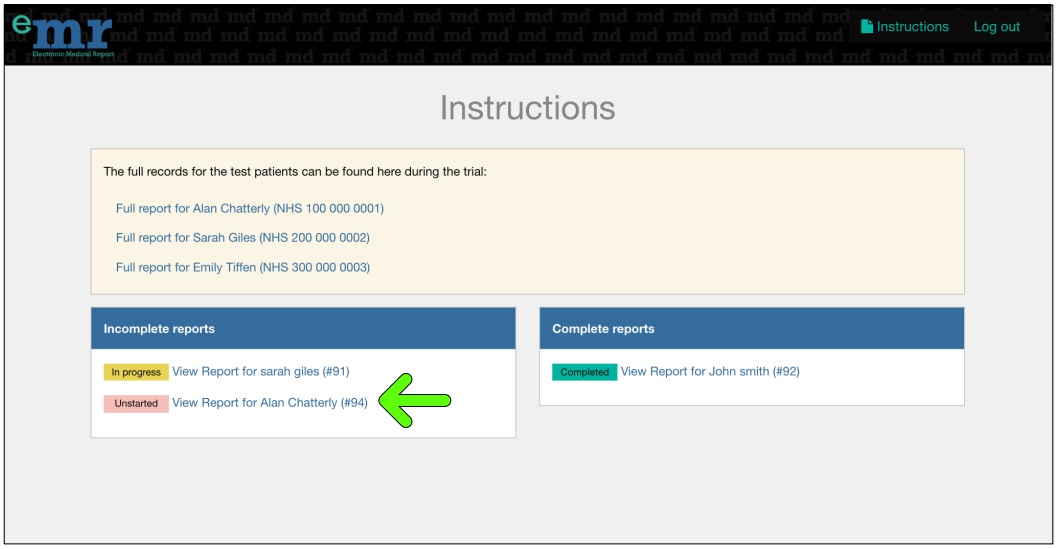


[Fig 6]

2.7 Starting a new Instruction from the 'Instruction' homepage

2.7.1 An unstarted Instruction can be started from the 'Instruction' homepage without the need to click the link in the notification email - This is useful if you delete the email or if you are already logged into eMR when the new Instruction comes in.

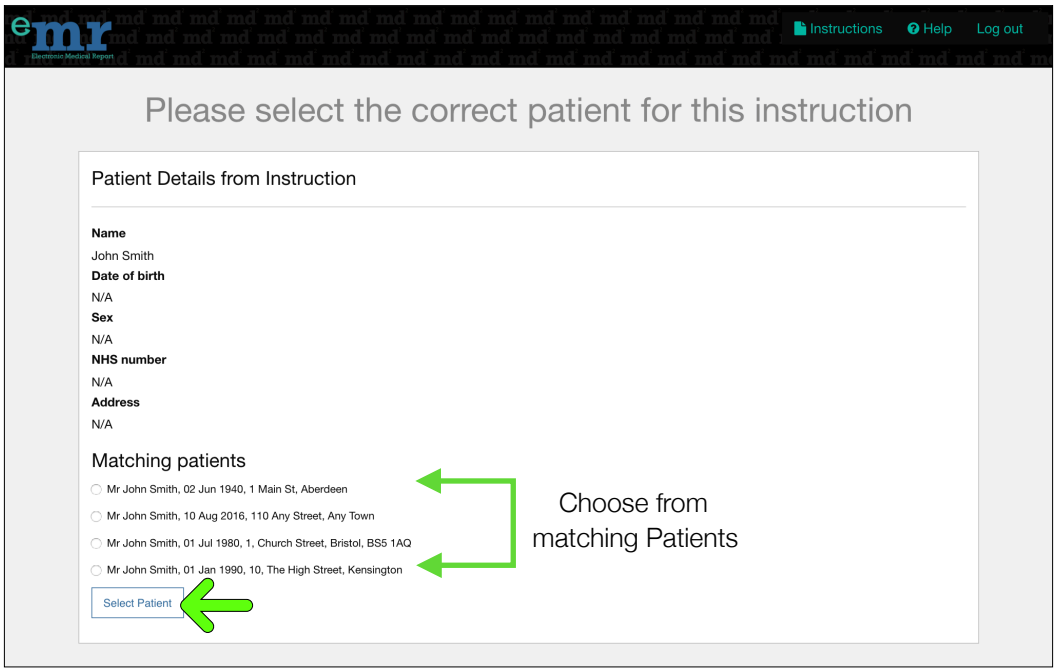
2.7.2 To pick up a new unstarted report, click the name next to the unstarted status box [Fig 7]



[Fig 7]

2.8 Select the matching Patient

The first step in starting a new report is to select the correct Patient record - depending on how much information has been supplied by the Client, there could be multiple potential matches. Select the correct Patient for your Practice and click 'Select Patient' [Fig 8]



[Fig 8]

2.9 Provisional report contents

The ‘Provisional Report Contents’ page is a powerful report builder that enables GPs to quickly create a Patient report containing the necessary information to fulfil a Client Instruction.

The eMR tool extracts relevant information from the Patient record and presents it in a user friendly way that enables speedy redaction and comprehensive report generation in PDF format.

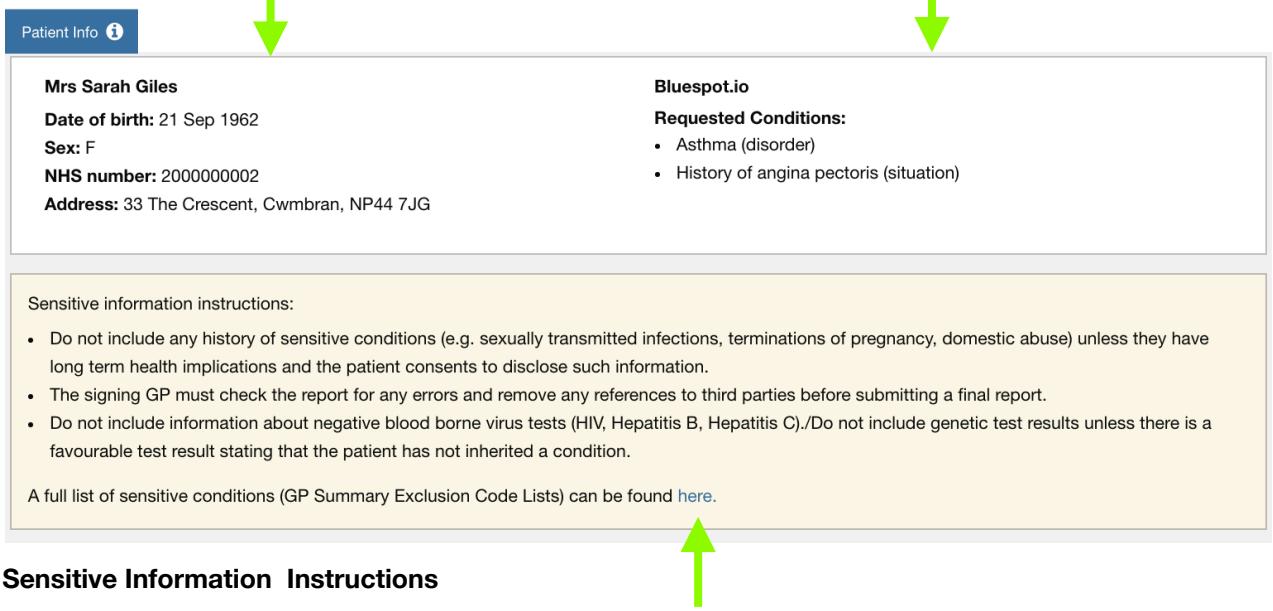
The different “Provisional Report Contents’ sections are explained below:

Patient Info

Patient identification information is displayed at the top of the screen - and is always accessible by via the ‘Patient Info’ button on the left of the screen

Client Info

Client name and the conditions included in Instructions are also always accessible by the ‘Patient info’ button.



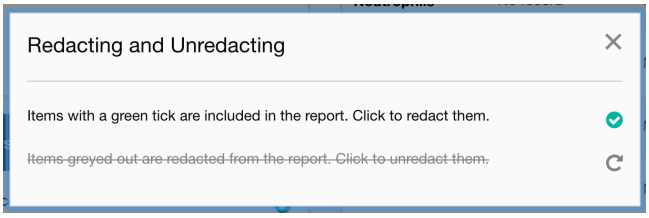
Sensitive Information Instructions

Please be sure to follow the advice and guidance concerning sensitive conditions - a link to the NHS SP summary code list is also provided.

Redacting Information

Throughout the report builder, redact-able information is indicated with this icon -

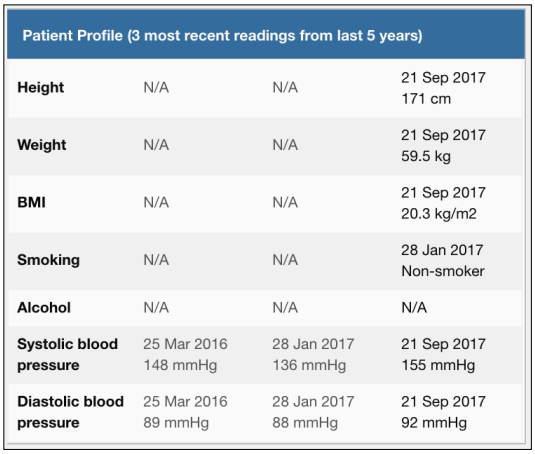
Instructions on how to redact and un-redact can be viewed at any time by clicking on the ‘info’ icon: - to display the following Instructions [Fig 9]



[Fig 9]

Patient profile

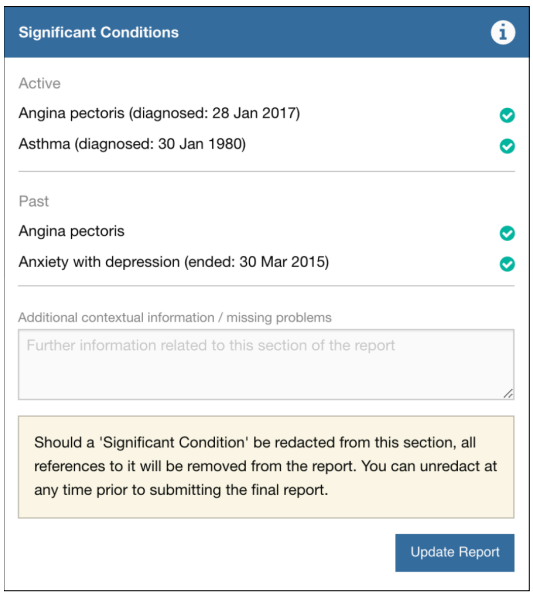
- The Patient profile is **not** redact-able.
- Contain the 3 most recent readings for each section from the past 5 years.



Patient Profile (3 most recent readings from last 5 years)			
Height	N/A	N/A	21 Sep 2017 171 cm
Weight	N/A	N/A	21 Sep 2017 59.5 kg
BMI	N/A	N/A	21 Sep 2017 20.3 kg/m2
Smoking	N/A	N/A	28 Jan 2017 Non-smoker
Alcohol	N/A	N/A	N/A
Systolic blood pressure	25 Mar 2016 148 mmHg	28 Jan 2017 136 mmHg	21 Sep 2017 155 mmHg
Diastolic blood pressure	25 Mar 2016 89 mmHg	28 Jan 2017 88 mmHg	21 Sep 2017 92 mmHg

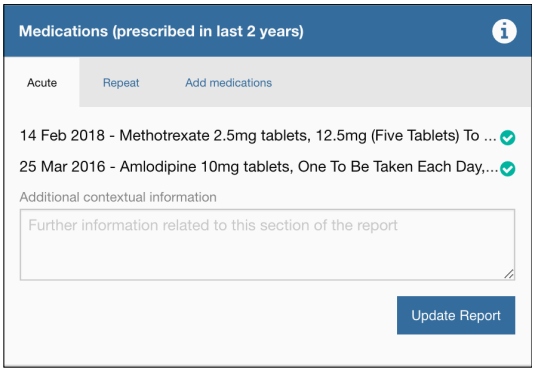
Significant Conditions

- Significant conditions **are** redact-able
- Any condition from the Patient history that matches the conditions included in the Instruction will be listed here
- Significant conditions are split into ‘Active’ and ‘Past’ with dates supplied for both
- Redacting a significant condition automatically removes **all associated** (by coding in EMIS) information from the other sections of the report
- Additional information can be added in the notes field - Please use the Update Report button to add these notes to the final report



Medications

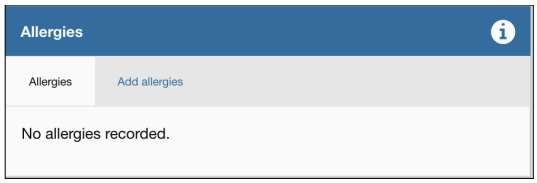
- Medications **are** redact-able
- Redacting a significant condition automatically removes **all associated** (by coding in EMIS) information from the other sections of the report
- Medications are split into ‘Acute’ and ‘Repeat’ and are viewable on different tabs in this section.
- Any missing medications can be manually added via the ‘Add Medications’ tab - mandatory fields are marked with an *
- Additional information can be added in the notes field - use the button to add these notes to the final report



Update Report

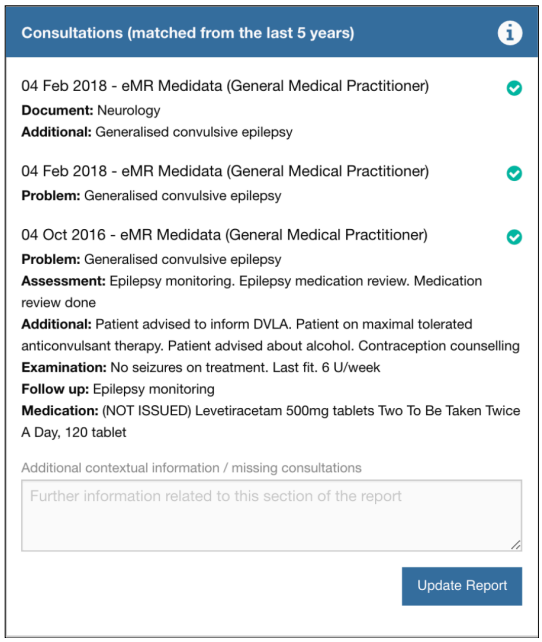
Allergies

- Allergies **are** redact-able
- All active allergies from the Patient record are included
- Any missing allergies can be manually added via the 'Add Allergies' tab - mandatory fields are marked with an *



Consultations

- Consultations **are** redact-able
- Any consultation from the Patient history that match the conditions included in the Instruction will be listed here
- Additional information can be added in the notes field - Please use the Update Report button to add these notes to the final report

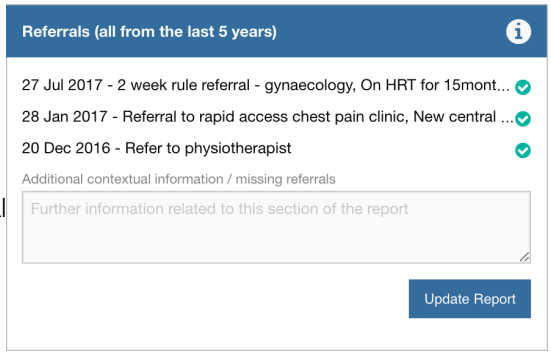


Bloods

- Bloods are **not** redact-able
- All available blood test results - 3 most recent readings - will be displayed.
- Additional information can be added in the notes field - Please use the Update Report button to add these notes to the final report

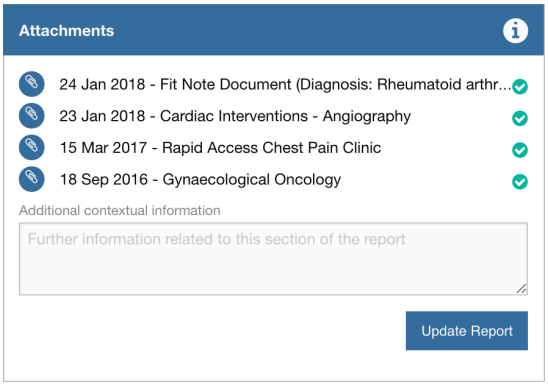
Referrals

- Referrals **are** redact-able
- All available referrals from the last 5 years will be displayed.
- Additional information can be added in the notes field - Please use the Update Report button to add these notes to the final report



Attachments

- Attachments **are** redact-able
- All attachments from the Patient history that match the conditions included in the Instruction will be listed here
- Attachments that are not redacted will be included in the final record as appendices
- The attachments can be viewed in full by clicking on the attachment icon:
- Viewing attachments will either open a new browser window or download them directly to your PC
- Additional information can be added in the notes field - Please use the Update Report button to add these notes to the final report



2.10 Updating & viewing draft report

Once you have redacted all irrelevant information and added any additional information you are ready to view the final (draft) report - being viewing the report, click the 'Update Report' button, then click the 'View Report' button [Fig 10] to be taken from the Provisional report to the Final report

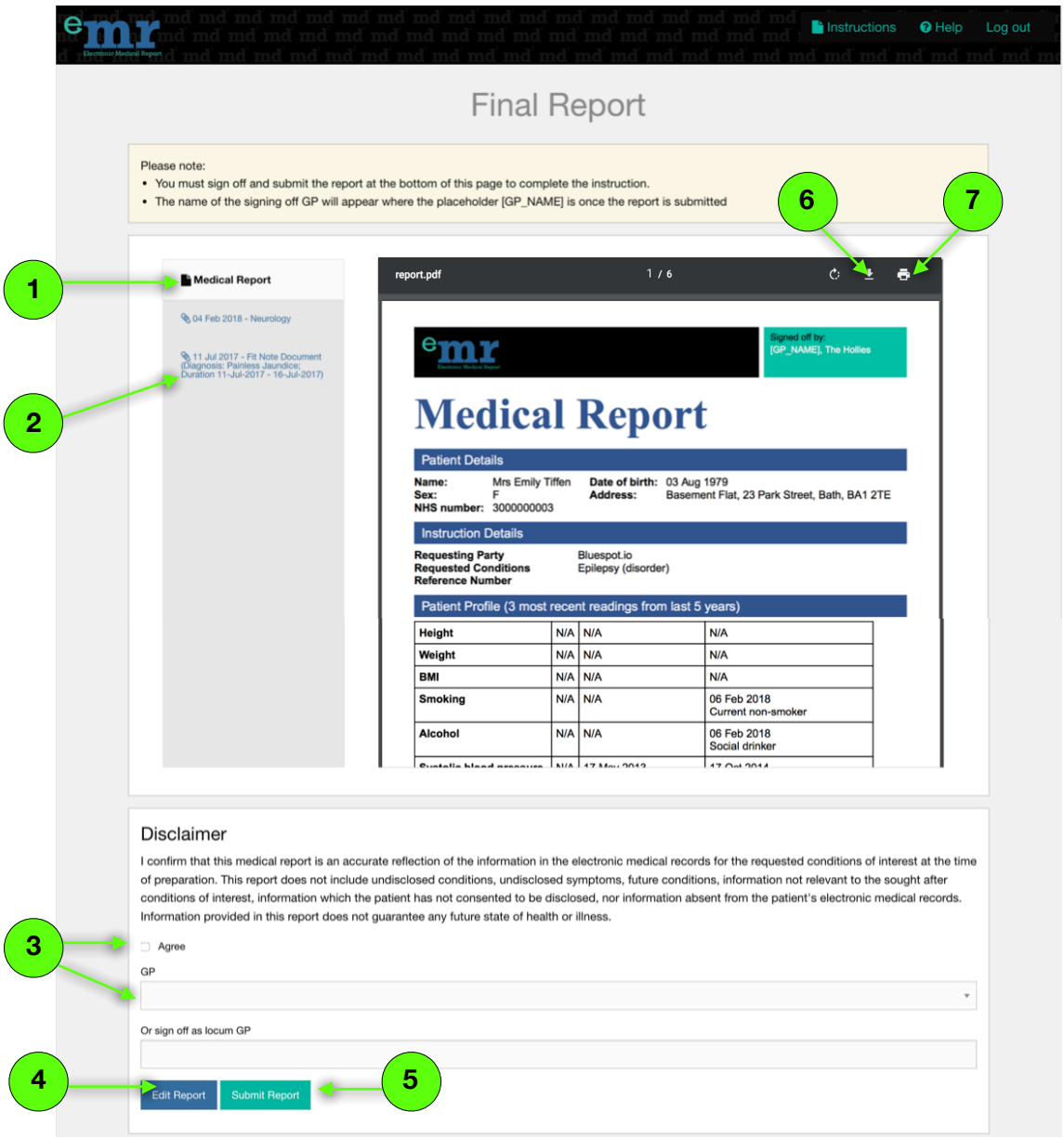
[Fig 10]

2.11 Final medical report

4.12.1 The final medical report is still viewable inside the application along with any additional attachments as appendices.

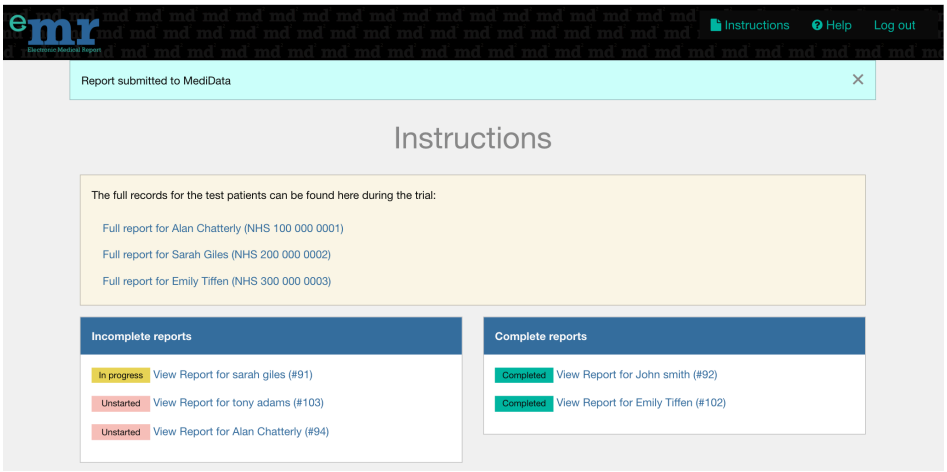
The report viewer has the following functionality shown below [Fig 11]

1. Return to full medical report (if viewing additional attachment)
2. View individual attachments
3. Disclaimer - this **must** be completed before the report can be submitted - tick 'agree' and add name of person completing the report
4. Edit report button - takes you **back** to the 'Provisional Report Contents' page
5. Submit button - send the finished medical report to the Client
6. Download PDF medical report
7. Print medical report



[Fig 11]

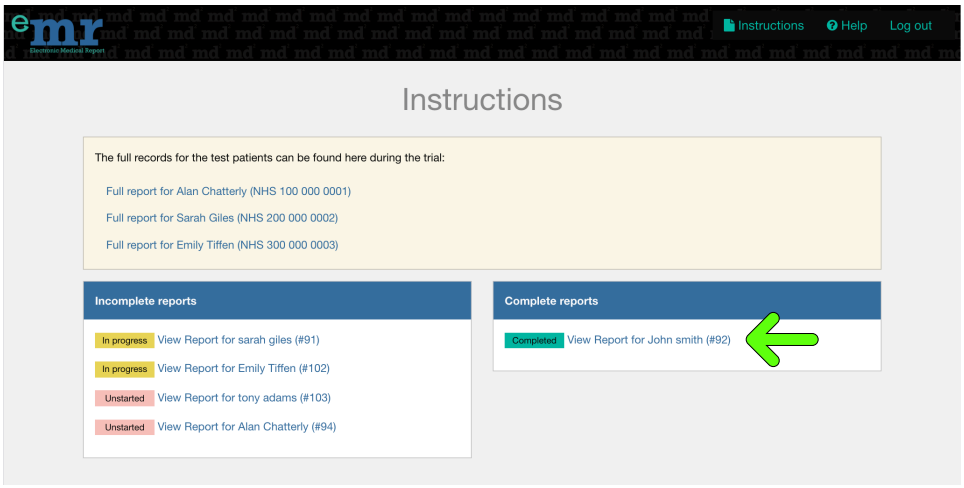
4.12.2 Following a submission of a completed medical report you will be redirect back to the ‘Instruction’ homepage and a ‘Report submitted to MediData’ confirmation message will be displayed. The submitted medical report will be listed in the ‘Completed Reports’ section [Fig 12]



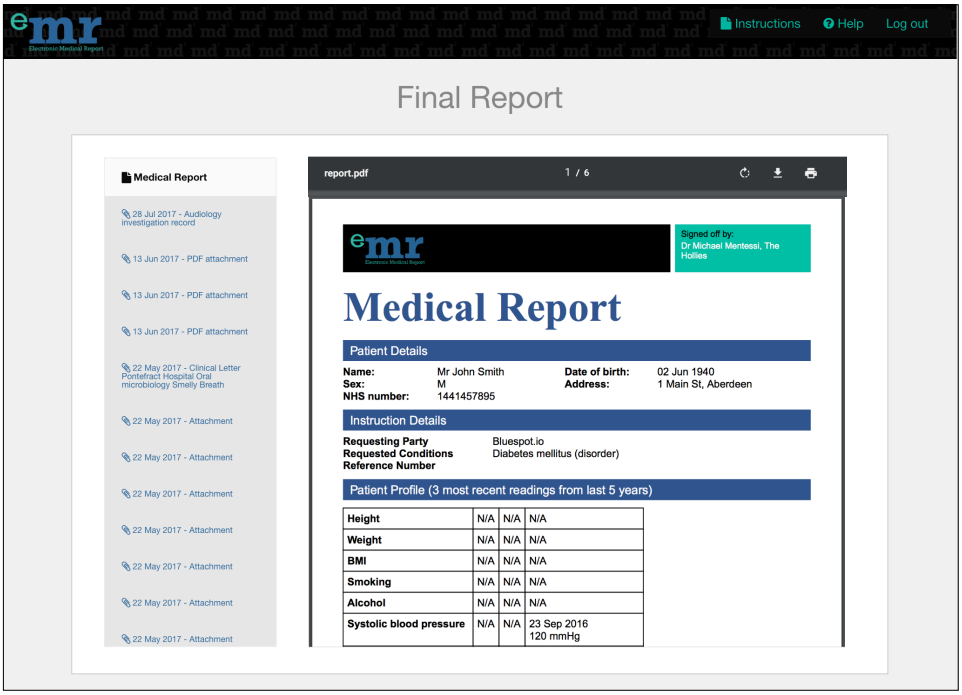
[Fig 12]

2.12 Viewing submitted medical reports

Although a medical report can still be viewed by a GP after it has has been completed, as the disclaimer has been signed and the final report has been submitted to the Medidata, it will no longer be in a editable format. To view completed medical reports, visit and click the Patient name in the ‘Completed Reports’ section [Fig 13], this will take you to the report view page [Fig 14]



[Fig 13]



[Fig 14]