

# Care Episodes

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## 1. Introduction

A care episode is a means of grouping together orders, notes and appointments that relate to a specific episode of care. Care episodes should be used if you wish to report on:

- average costs and appointment time per patient's episode
- time from referral to first appointment
- time from referral to end of treatment

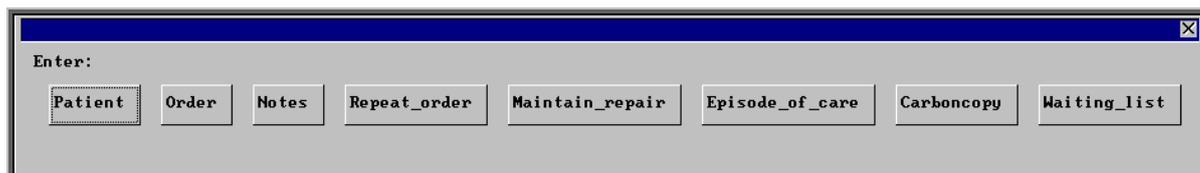
This is because care episodes can track the pathway of the referral right through to the supply of the orthosis.

Care episodes are also used for the gathering of Referral to Treatment (RTT) information as part of the 18 week journey.

## 2. Adding a care episode

Menu: Patients

Find the patient that you wish to add a care episode for and click on the 'enter' icon  (Edit, Enter).



To select Episode\_of\_care, click on the Episode\_of\_care button with the mouse, or type **E**.



Once you have confirmed that you wish to add a care episode for this patient you will be taken to the **Care Episode** screen where some of the fields will already be filled in for you.

*Case:* the next sequential number will automatically be entered in this field. You can overtype this as long as the case number you type is unique and has not been used before. This field cannot be left blank.

**NB. If you are using care episodes to send information to the main hospital system with regards to the 18 week journey, then the case number entered here must be the RTT case number issued at the start of that journey.**

*Patient:* Hospital No, patient name, address, NHS No, date of birth and age will be brought through from the patient record.

*Objectives:* free text available to outline the objectives of this care episode. **This field is mandatory.**

*Referral:* date of referral. This will default to today's date, which can be changed or taken out by pressing **F8**.

*Assessment:* date of assessment

The assessment date will not normally be known when the care episode is raised, but this field can be automatically populated when the patient attends their assessment appointment by using the word 'assess' somewhere on either the *Notes*, *Comments* or *Event* field on the appointment.

*Fitting:* date of fitting

The fitting date will not normally be known when the care episode is raised, but this field can be automatically populated when the patient attends their fitting appointment by using the word 'fit' somewhere on the *Notes*, *Comments* or *Event* field on the appointment.

*Discharge:* date of discharge

You will be given the option to discharge a care episode when marking a fitting appointment as attended.

*Consref:* Referrer will be brought through from the patient record but if you need to change it press the **Tab** key to see the list of your Referrers and make an alternate selection. Otherwise press the **Enter** key to move to the next field.

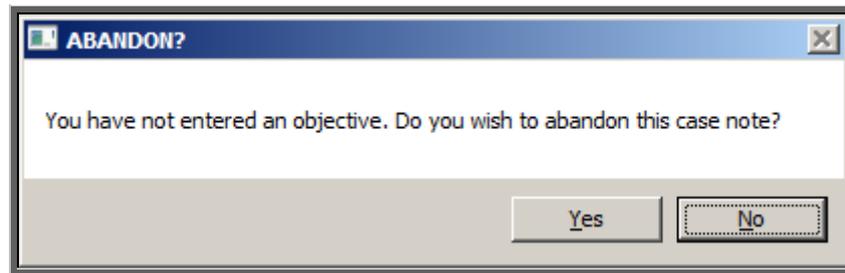
*Purchaser:* Purchaser will be brought through from the patient record but if you need to change it press the **Tab** key to see the list of your Purchasers and make an alternate selection. Otherwise press the **Enter** key to move to the next field.

<i>Clinician:</i>	Clinician will be brought through from the patient record but if you need to change it press the <b>Tab</b> key to see the list of your Clinicians and make an alternate selection. Otherwise press the <b>Enter</b> key to move to the next field.
<i>Orthosis:</i>	select an orthosis code from the pop-up list
<i>Grade:</i>	enter a grade for the episode
<i>Priority:</i>	enter a priority for the episode
<i>Inpatient</i>	whether the patient is an in or out patient will be brought through from the patient record but be changed.
<i>Private Patient</i>	whether the patient is a private patient will be brought through from the patient record but be changed.
<i>Weight</i>	the patient weight can be recorded
<i>Height</i>	the patient height can be recorded
<i>Service</i>	which service the patient is being seen by can be recorded
<i>Ward</i>	if the patient is an in-patient, the ward they are on can be selected from the pop-up list(options to appear in the pop-up should be set up in <b>Utilities – Choices – Wards</b> )
<i>Referred:</i>	select the diagnosis by the referrer from the pop-up list (options to appear in the pop-up should be set up in <b>Utilities – Choices – Diagnosis</b> )
<i>Diagnose:</i>	select the diagnosis by the hospital from the pop-up list (options to appear in the pop-up should be set up in <b>Utilities – Choices – Diagnosis</b> )
<i>Intervention Type:</i>	select the intervention type from the pop-up list (options to appear in the pop-up should be set up in <b>Utilities – Choices – Intervention</b> )
<i>Initiator:</i>	select an initiator from the pop-up list (options to appear in the pop-up should be set up in <b>Utilities – Choices – Initiators</b> )
<i>Primary Source</i>	select the original referrer of the patient from the pop-up list
<i>Primary Date</i>	enter the original referral date
<i>Primary Assessment</i>	enter the date of the assessment made by the original referrer

It is unlikely that you will be able to complete all the fields when you first enter a care episode. Typically, the only information you will know initially is the objective and referral date.

When you have finished entering the information, press **Ctrl-Enter** to save and proceed.

If you have not entered anything into the *Objectives:* field you will be given the option to abandon the Care Episode.



### 3. Updating a care episode

As the episode of care progresses you will have additional information to enter in the care episode e.g. assessment or fitting date.

#### a) Updating Manually

Menu: **Patients** or

Menu: **History – Care** (if you know the patient's hospital number)

Find the patient whose care episode you wish to update.

Click on the 'care episode' icon  (Goto, Care, Current). If the patient has more than one care episode, use the 'arrow' icon  (**F6**) to find the care episode you wish to edit.

Click on the 'update' icon  (Edit, Udate) and you will be taken to the *Objectives:* field.

To update a particular field, either move through the fields with **F4** or **Enter**, or click on the data you want to change.

The following fields have pop-up lists available, so press the **Tab** key to see the list of available options.

<i>Referrer:</i>	<i>Service</i>
<i>Purchaser:</i>	<i>Ward</i>
<i>Clinician:</i>	<i>Referred:</i>
<i>Orthosis</i>	<i>Diagnose:</i>
<i>Inpatient</i>	<i>Intervention Type:</i>
<i>Private Patient</i>	<i>Initiator:</i>
<i>Weight</i>	<i>Primary Source</i>
<i>Height:</i>	<i>Primary Date/Assessment</i>

When you have finished updating the information, press **Ctrl-Enter** to save the changes, or **Esc** then **N** to abandon the changes.

## b) Automatic Updates

Where appointments are linked to care episodes, when an appointment is logged as attended, you will be prompted to:

- update the *Assessment:* field on the care episode, if the word ‘assess’ appears on the appointment in the *Notes:*, *Comments:* or *Event:* field
- update the *Fitting:* field on the care episode, if the word ‘fit’ appears on the appointment in the *Notes:*, *Comments:* or *Event:* field

**Note: Care Episodes cannot be deleted.**

## 4. Printing care episode details

Menu: **Patients**

Find the patient whose care episode you wish to print.

Click on the 'care episode' icon  (Goto, Care). If the patient has more than one care episode, use the 'arrow' icon  (**F6**) to find the care episode you wish to print.

Click on the 'print' icon  (File, Print).

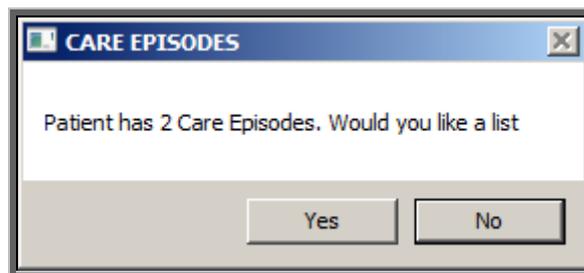
Two pages will be printed. This first is a summary of the care episode with details of any orders, and the second page contains notes linked to the episode.

**Note:** If there are no medical notes for the care episode, the second page will not print.

Care Episode Record		Case: CE00039		
Hospital No:	<b>TORUS44</b>			
	<b>MISS TESSA SMITH</b>			
	213 Prospect Avenue TF10 7JF			
Objectives:	<b>Provide better fitting shoes</b>			
Referral Date:	<b>10/03/2003</b>			
Assessment Date:				
Fitting Date:				
Discharge Date:				
No	Dated	Sup Description	Received	Supplied
MC301107	30/11/2007	078 Made to measure shoes	15/12/2007	

The care report layouts (careform.dfr and careNote:dfr) can be altered to your requirements.

You will also be given the opportunity to print a list of care episodes when printing the patients demographics (**Print - Patient Information**).



This will show all care episodes for this patient, including those that have been discharged.

Care Episodes MISS JENNY WREN						
Case:	Objectives:	Referral:	Assessment:	Fitting:	Discharge:	
CE00124	Shoes	13/06/2010				
CE00096	Shoes	20/11/2009	20/12/2009	02/02/2010	02/02/2010	
CE00095	Back support	20/11/2009			14/04/2010	

## 5. Linking records to care episodes

Notes, orders and appointments can be made from the patient record and linked into a care episode by entering the case number into the care episode field on the individual records. It is, however, easier to raise notes, orders and appointments from the **Care Episode** screen, so the link is made automatically.

Menu: **Patients**

Find the patient whose care episode you wish to work on.

Click on the 'care episode' icon  (Goto, Care, Current). If the patient has more than one care episode, use the 'arrow' icon  (**F6**) to move through the records.

To add a note click on the 'enter' icon  (Edit, Enter) and select Notes.

To add an order click on the 'enter' icon  (Edit, Enter) and select Order.

To make an appointment click on the 'next appointment' icon  (Appoint).

## 6. Care Episode jump to's

From the **Care Episode** screen, you can look at the orders, notes and appointments in full (like you can from the **Patient** screen), but you will only see those orders, notes and appointments that relate to the care episode you are looking at.

To look at orders click on the 'order' icon  (Goto, History).

To look at notes click on the 'notes' icon  (Goto, Notes).

To look at current appointments click on the 'appointment' icon  (Goto, Appointments, Current).

To look at archived appointments click on Goto, Appointments, Archived.

From the **Appointment** and **Order** screen, you can jump to the associated care episode using the 'care episode' icon  (Goto, Care).

## 7. Discharging care episodes

Once a care episode is complete the *Discharge*: date field should be updated.

### a) Manual Discharge

Menu: **Patients** or

Menu: **History – Care** (if you know the patient's hospital number)

Find the patient whose care episode you wish to update.

Click on the 'care episode' icon  (Goto, Care, Current). If the patient has more than one care episode, use the 'arrow' icon  (**F6**) to find the care episode you wish to edit.

Click on the 'update' icon  (Edit, Uppdate), move to the *Discharge:* field and enter the discharge date. If you wish to enter today's date press the **F2** key.

Press **Ctrl-Enter** to save the changes.

## b) Discharge on Supply

Menu: **History – Orders**

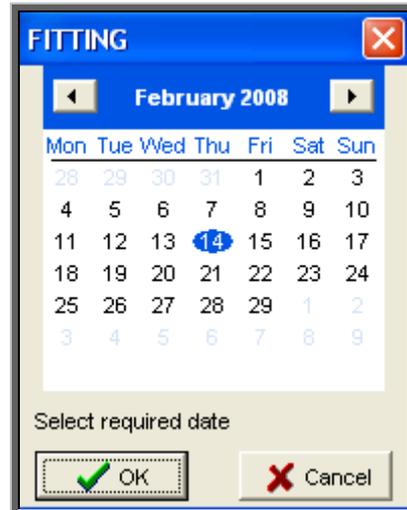
Find the relevant order and then click on the word Goods at the top of the screen, and then select Supply from the drop down menu.

Today's date will be entered into the *Supplied* field and the *Status* changed from In Stock to Supplied.

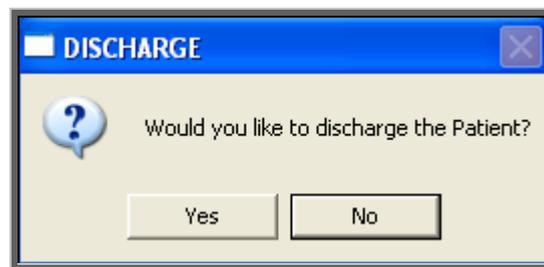
If the order is linked to a care episode, you will be given one of the following two prompts, depending whether there is already a fitting date entered on the care episode.



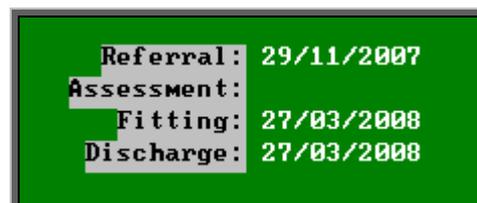
If you choose to update the fitting field, the calendar prompt will appear, so that a date can be selected. The calendar will default to today's date.



You then have the option to discharge the patient.



If Yes is selected, then the fitting date selected will also be entered into the *Discharge:* field on the care episode.



### c) Discharge by Attendance

Menu: **Appointments – Current – Sessions** or

Menu: **Patients**

If you log an appointment with an outcome of **Attended** and there is an order linked to the appointment, you will be asked if you wish the *Supplied* field on the order be updated with today's date.

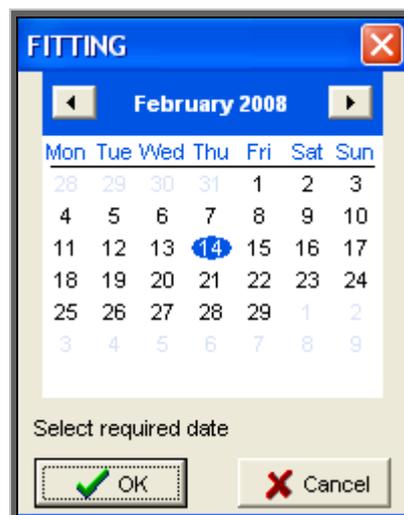


If **Yes** is selected and the order is attached to a care episode, you will then be asked whether you would like to update the *Fitting* field on the care episode.

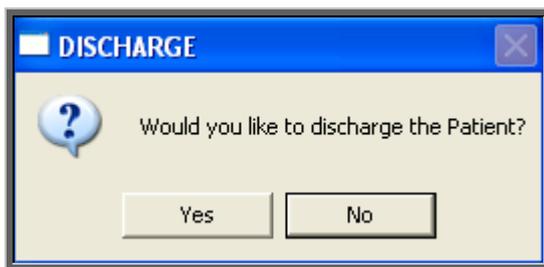
You will be given one of the following two prompts, depending whether there is already a fitting date entered on the care episode.



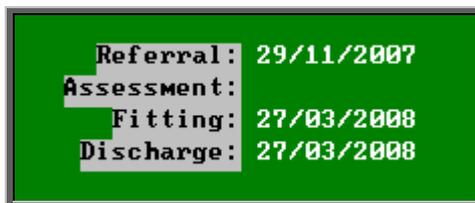
If you choose to update the fitting field, the calendar prompt will appear, so that a date can be selected. The calendar will default to the date of the appointment that has just been marked as **Attended**.



You then have the option to discharge the patient.



If Yes is selected, then the fitting date selected will also be entered into the *Discharge:* field on the care episode.



d) Discharge by Outcome

This would enable care episodes that are linked to a appointment to be Discharged when the appointment outcome is entered.

To do this, go to **Utilities – Choices – Appointments – Appointment Outcome**, and click on the ‘update’ icon  (Edit, Update) and move down to the *RTT:* field.

## e) Discharged care episodes

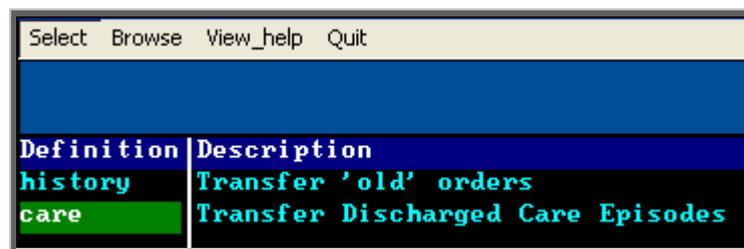
Once a care episode is updated as discharged, the Care Episode banner will disappear from the **Patient** screen as it is no longer active, but it will stay as a **Current** care episode until it is archived.

## 8. Archiving care episodes

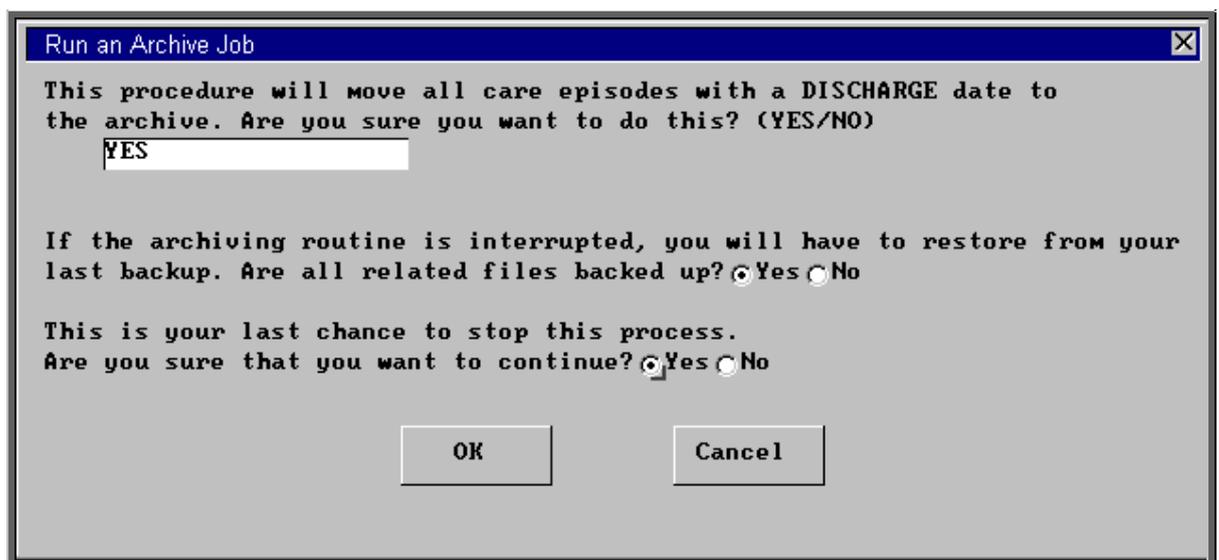
To move discharged care episodes into the archive and aid with reporting, the care episode archive should be run on a regular (e.g. monthly) basis.

Menu: **History – Archive – Run**

From this screen, options are available for archiving orders and care episodes.



Ensure the **care** definition is highlighted and click on 'select' at the top of the screen.



OPAS needs confirmation that you definitely want to archive the discharged care episodes.

- Type **YES** into the first question box if you wish to continue
- Confirm that OPAS is backed up (if you are not sure, check with your IT department), by clicking with the mouse on the **Yes** button
- Confirm that you wish to continue by clicking with the mouse on the **Yes** button

Click on OK if you still wish to continue.

Once the query has performed, you will be asked if you wish to print or view the audit report. The report is generated automatically, but serves little purpose other than to show how many care episodes were archived.



Click on View if you wish to avoid wasting paper. Do not worry that the header says Error Report as long as the bottom section reports that the 'records compared OK'.

```

- Error Report
Error Report - Archive job : care
                Directory  :

Query for archive records started at 07:39:04

Partial archive option was used.

Variable settings:

    $$answer1 = YES
    $$answer2 = 0
    $$answer3 = 0
    $$default1 =
    $$default2 =
    $$default3 =

Performing query.
5 found. Query ended at 07:39:04
Processing primary driver file care
    Time started      : 07:39:07
Appending records from care to old_care
Append or 5 records finished at 07:39:07.
    Verify started    : 07:39:07
    Verify percent    : 100%
    5 records compared OK
Deactivating source records
  
```

Press **Esc** to clear the report from the screen.

## 9. 18 Week Journey

As Care Episodes are used to track a patient's episode, it is natural that this is where the Referral to Treatment (RTT) is monitored.

On the **Care Episode** screen, there is a table at the bottom to show any RTT actions.

RTT				
Action:	Date:	At:	Start	Stop
30	24/03/2008	08:52	N	Y
10	10/02/2008	12:00	Y	N

The NHS defined RTT codes have been entered into OPAS. However, if your Trust has any additional codes, these can be added by going into **Utilities – Choices – Appointments – RTT Status**.

These codes (within the RTT table) are used to track your element of the 18 week journey.

There are a number of ways in which the tracking of the 18 week journey can be carried out.

### a) Manually

Menu: **Patients**

Find the patient whose care episode you wish to update.

Click on the 'care episode' icon  (Goto, Care, Current). If the patient has more than one care episode, use the 'arrow' icon  (**F6**) to find the relevant care episode.

Click on the 'RTT clock' icon  (**R**TT) and selecting the action from the pop-up list provided.

## b) Using Events

Events are used in appointments to categorise the type of appointment.

Against each Event, an RTT action can be assigned against the attendance of the appointment (*RTT*: field) and the non-attendance of the appointment (*DNA*: field).

You can set up as many event/RTT links as you need.

Menu: **Utilities – Choices – Appointments – Events**



Click on the 'enter' icon (Edit, Enter).

*Event*      enter the name of the event

*RTT*:        select the appropriate RTT action for the attendance of this type of appointment from the pop-up list provided

*DNA*:        select the appropriate RTT action for the non-attendance of this type of appointment from the pop-up list provided

Events			
Event	Assess		
RTT:	20 Subsequent activity - further activities anticipated	Start	Stop
		N	N
DNA:	33 Failure to attend	N	Y
Questions			
Question		Many	

An example would be to create an event called 'Assess' and attach RTT codes 20 and 33 against it (see above).

This would then mean that if an appointment

- was linked to a Care Episode
- had an event of 'Assess'
- *Outcome* field updated to **Attended**

the RTT table would be updated with a code 20

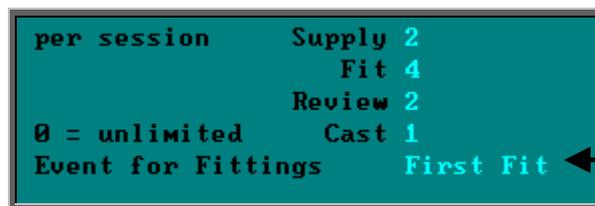
or if an appointment

- was linked to a Care Episode
- had an event of 'Assess'
- *Outcome* field updated to Did not Attend

the RTT table would be updated with a code 33 (unless the patient was a child).

Another example would be to create an event called 'First Fit' that would stop the clock if they attended.

To ensure that fitting appointments made from the **Order** screen are marked automatically with the relevant event, set your System parameter screen (**Utilities – Choices – System**) appropriately.



## b) Using Outcomes

RTT actions can be linked to appointment outcomes.

This would enable appointments that are linked to a care episode, to have the RTT table updated when the appointment outcome is entered.

To do this, go to **Utilities – Choices – Appointments – Appointment**

**Outcome**, and click on the 'update' icon  (Edit, Update) and move down to the *RTT*: field.

Outcome	Did not Attend
Attended:	<input type="checkbox"/>
RTT:	<input type="checkbox"/>
Description:	<input type="text"/>
Start:	<input type="text"/>
Stop:	<input type="text"/>
Discharge:	<input type="text"/>

### c) Automatic updates

Some actions within OPAS will automatically create an RTT action in the care episode for you.

Enter a new care episode – Code 10

DNA an appt for a child – Code 12

### d) Feeds

If you need RTT information to be transferred from OPAS into other hospital software, ask your IT department to contact the OPAS helpdesk. OPAS can send the data in Batch (e.g. overnight) or in Realtime (as the information is being produced). The System parameter screen should be set accordingly.

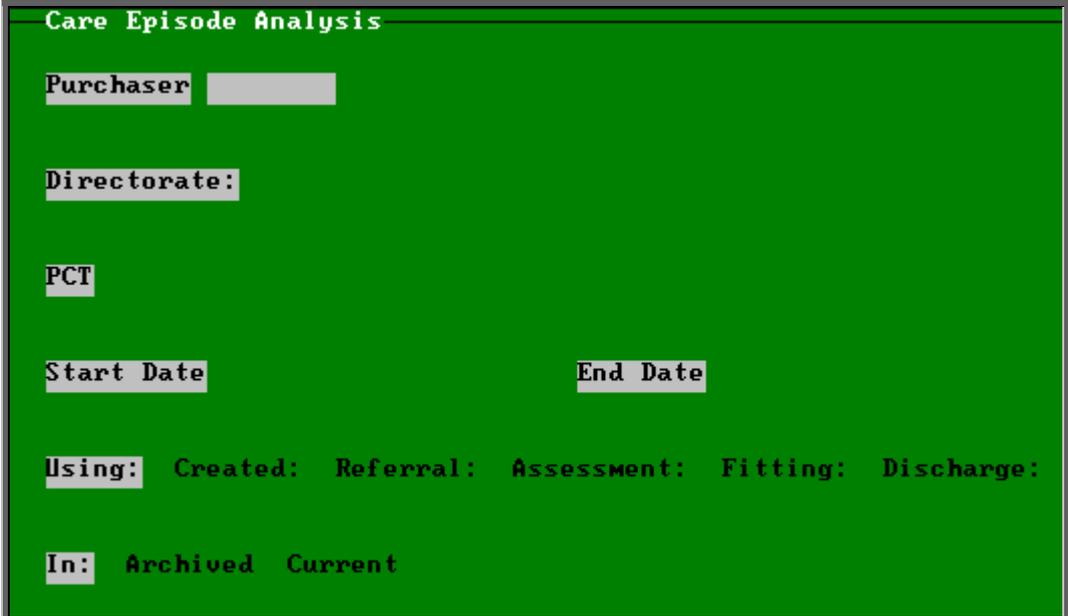
RTT actions export	None	Batch	<b>Realtime</b>
RTT path	Q:\OPAS\RTT\		

## 10. Reports

### a) Analysis

This report can be used to interrogate either current or archived care episodes. Separate report definitions are used, so you can have different layouts for your archived and current care episode reports.

Menu: Reports – Care Episodes – Analysis



Care Episode Analysis

Purchaser

Directorate:

PCT

Start Date  End Date

Using: Created: Referral: Assessment: Fitting: Discharge:

In: Archived Current

- select the Purchaser required from the pop-up list. Alternatively press **Esc** to make the pop-up list disappear without making a selection. Leaving the Purchaser field empty will result in all purchasers being selected
- select the Directorate: required from the pop-up list to find all those patients which belong to that directorate. Alternatively press **Esc** to make the pop-up list disappear without making a selection. Leaving the Directorate: field empty will result in all directorates being selected
- select the PCT required from the pop-up list to find all those patients which belong to that PCT. Alternatively press **Esc** to make the pop-up list disappear without making a selection. Leaving the PCT field empty will result in all PCTs being selected

- enter the **Start date** of the required date range in the format DD MM YYYY
- enter the **End date** of the required date range in the format DD MM YYYY
- select whether the date range selected should look at the care episodes Created, Referral, Assessment, Fitting or Discharge date
- select whether you want to interrogate **Current** or **Archived** care episodes



You will be shown how many care episodes OPAS has found and ask if you want to see the information in **Detail** i.e. a line for each waiting list entry or just **Totals-only**



Once the data has been found you have the option to see the report on screen, to be printed or sent to a file for exporting into Lotus 123 or MS Excel

### Screen

If the report is sent to the screen, you will initially be shown the first page of the report. Press the **F6** key to move to the next page. **F5** will go back a page.

If the report is too small to read, press the **F8** key to magnify. **F7** will make the text smaller again.

Press **Esc** to abandon looking at the report on screen. You will then have the option to re-select **Screen**, **Printer** or **File**. Make another selection or press **Esc** again to return to the menu.

### Printer

The report will be sent to the printer. You will then have the option to re-select **Screen**, **Printer** or **File**. Make another selection or press **Esc** again to return to the menu.

Below is an example of the **Analysis** report selecting **Detail**.

Hospital No	Patient	Appoi nts	Time	Order s	Net :	Gross :
NAH280965	MR JAMES BROWN	0	0:00	1	64.00	64.00
12345QWERTY	MR KELVIN BLOGGS	10	1:45	1	123.45	145.05
NTEMP000010	MR MARTIN CRAVEN	1	0:15	1	220.00	220.00
NDR543387	MR GEORGE SMITH	1	0:15	1	197.00	231.48
8776877	Mr Sylvester Stal one	2	0:00	3	168.95	198.51

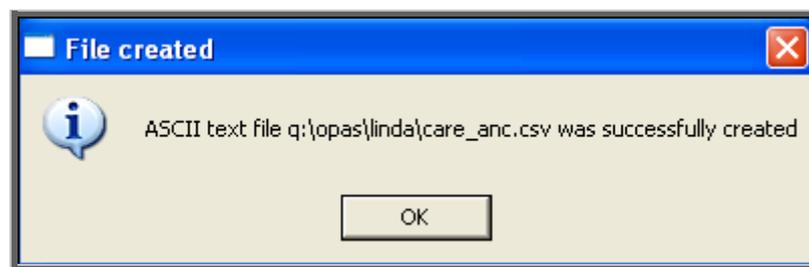
Page 1 dated 17/06/2008  
 Printed by LINDA  
 care\_ana.dfr - Archived Care Episodes

The footer in the bottom left corner of the report will indicate whether the report is on current or archived care episodes

The report layouts (`care_ana.dfr` and `care_anc.dfr`) can be altered to your requirements. Please contact the OPAS helpdesk.

## File

A comma separated variable file will be created called `care_anc.csv` if analysing current care episodes and `care_ana.csv` for the archived care episodes. This will be saved in your personal directory within OPAS. This can be exported into Lotus123 or MS Excel.



### b) Current

This report interrogates your current care episodes and finds those that are still active (i.e. there is no date of discharge entered).

Menu: **Reports – Care Episodes – Current**



Once the data has been found you have the option to see the report on screen, to be printed or sent to a file for exporting into Lotus 123 or MS Excel

### Screen

If the report is sent to the screen, you will initially be shown the first page of the report. Press the **F6** key to move to the next page. **F5** will go back a page.

If the report is too small to read, press the **F8** key to magnify. **F7** will make the text smaller again.

Press **Esc** to abandon looking at the report on screen. You will then have the option to re-select Screen, Printer or File. Make another selection or press **Esc** again to return to the menu.

### Printer

The report will be sent to the printer. You will then have the option to re-select Screen, Printer or File. Make another selection or press **Esc** again to return to the menu.

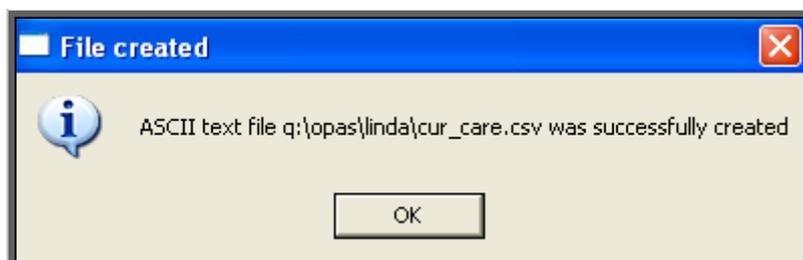
Below is an example of the **Current** report.

Case :	Hospital No	Patient	Referral :	Assessment :	Target Date :	Weeks wait to date
CE00049	NQWE345768	MR JOHN SMYTHE	13/01/2008		18/05/2008	3
CE00051	67567	Mr Phil Oakey	13/01/2008	04/02/2008	18/05/2008	3
CE00050	432523	Mr John Brown	13/01/2008		18/05/2008	3
CE00052	NAH280965	MR JAMES BROWN	04/02/2008		09/06/2008	0
Total for NHS TRUST		13				
CE00011	NTEMP000009	MS MARY LITTLE	02/09/1999		06/01/2000	440
CE00015	NQ123432	MR TONY JACK	20/12/1999		24/04/2000	424
CE00022	NA61848	MR PAUL LAKE	31/05/2000		04/10/2000	401
Total for Primary Care Group		3				

The report layout (care.dfr) can be altered to your requirements. Please contact the OPAS helpdesk.

File

A comma separated variable file will be created called cur\_care.csv. This will be saved in your personal directory within OPAS. This can be exported into Lotus123 or MS Excel.



c) RTT

This report will provide a list of patients who have an active RTT status (ie care episodes that have not been discharged (or discharged within the last 7 days) where the clock is still ticking).

Menu: Reports – Care Episodes – RTT

The report can be printed or sent to file. The file produced is called rtt.csv.

Below is an example of the RTT Report.

Care Episodes/RTT									
Created	Hospital No	Patient	Referral:	Assessment:	Target Date:	Weeks wait	Weeks wait	Assess	to date
weeks	Treated	Already	Exceed	Exceed	Exceed	Exceed	Exceed	Exceed	Exceed
> 18 weeks		Exceed	in 1 wk	in 2 wk	in 4 wk	in 6 wk	in 8 wk	in > 8 wk	
41	NTMF000018	ALF HARTIGAN	17/11/2007	22/03/2008	X X X	141			
0	0	1	0	0	0	0	0	0	0
43	NG0229841	MR IR BEALE	25/11/2007	30/03/2008	X X X	140			
0	0	1	0	0	0	0	0	0	0
49	NQWE345768		13/01/2008	18/05/2008	X X X	133			
0	0	1	0	0	0	0	0	0	0
50	492523	Mr John Brown	13/01/2008	18/05/2008	X X X	133			