

# Patients

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# 1. Introduction

The **Patient** screen is the key screen in OPAS.

Only from the **Patient** screen can you add:

Patients	Care Episodes
Orders	Contacts
Notes	Patients to the waiting list
Prescriptions	

From the **Patient** screen you can look at an individual patients:

Personal details	Contacts
Orders	DNA's
Notes	Waiting list entry
Appointments	Old address history
Prescriptions	Letters sent
Care Episodes	

Also from the **Patient** screen you can:

- Make appointments
- Print HSA5 and WF1 Forms
- Print patient details
- Mail merge patient details with standard letters
- Send internal messages

## Patient Screen

There are two versions of the **Patient** screen; the 'Long' and the 'Short'. The 'short' version of the **Patient** screen has been introduced for those users that, due to the speed of their network, find moving between patient records slow. The two screens work in the same way **except** you cannot add orders, notes or prescriptions when in the 'short' version of the **Patient** screen.

To toggle between the two versions of the screen click on the 'swap' icon



(File, Swap)

# Patient Screen (Long)

**Orthotic Patient Administration System - Logged in as LINDA at 16:10 on 15/06/2008**

File Edit Data Appointments Dormant Goto Mailing Message Paslink Sort This

**Patients**

Registered: 25/02/2000 By ROOT  
 Last Update: 07/06/2008 By ROOT

**Current Care Episode Exists**

Hospital No N4454544 NHS No 999-999-9999 D O B 11/11/1924 age 83

Title Forenames Surname D O D  
 MR JAMES HERRIOT Sex M Ethnicity

Address 21 James St Mailing 21 James St  
 Address DOR YAD  
 YAD

Town Jamestown  
 County Middlesex  
 Post Code JT1 2ER  
 Home Phone 01234 567890 Mobile: Notes:  
 Work Phone 01234 654321 Fax: Service 0  
 Email james.herriot@hotmail.com GP: GIBSON PW PCT 5M6  
 G9003459

Purchaser 1 NHS TRUST  
 ConsRef: 2 Clinician  
 Referrer Direct Access GP Directorate PCT  
 Private Patient N Inpatient N Transport No transport required  
 Exempt: Until: Review  
 Comments  
 Alias  
 Occupation **Waiting List**

**All patient notes MUST be treated as confidential**

**Medical Notes**

Date	Notes	Category
07/06/2008	Appt cancelled. Session: 3298 @ 10:45 on 10/06/2008	Audit
26/11/2007	Appt cancelled. Session: 2767 @ 11:00 on 03/12/2007	Audit
25/11/2007	Appt cancelled. Session: 2870 @ 11:00 on 02/01/2008	Audit

**Orders**

Date of Or	Order No	Sup	Desc	Received	Supplied
13/01/2008	PA00048	888	Shoes	13/01/2008	13/01/2008
01/12/2007	PA00035	078	Repairs		
30/11/2007	PA00033	001	Shoes	13/12/2007	

**Appointments**

Date:	Day	Time:	At:	With:
17/06/2008	Tue	10:00	Orthotic Clinic	Mrs Orthotiste

**DNAs**

On:	At
17/06/2008	10:00:00
17/06/2008	10:00:00
17/06/2008	10:00:00

DNAs 3

**Addresses**

Add:	PC:

**Carbon Copies**

When you are in the 'long' version of the **Patient** screen, as well as being able to see the patient's personal details, there are summary tables showing brief details of that patient's

Medical Notes	Mobility
Orders	DNA's
Appointments	Address history
Archived Appointments	Carbon Copies
Prescriptions	

Each user can choose which summary tables are seen on the 'long' version of the **Patient** screen, by selecting which screen template they want to use. How to do this is explained later in this introduction.

Only a few records are shown within the tables, but there may be more. To see further records in the table, press **Alt-T** to see a list of tables available. Move the arrow cursor (using the space bar on the keyboard) until the arrow cursor is pointing at the required one.



Alternatively click inside the table with the mouse. Then use **PgDn** and **PgUp** to scroll up and down the table.

To return to the main screen press **Alt-R**, or click anywhere on the screen (where there is not a table) with the mouse.

If you want to see full details of the orders, appointments etc that are summarised in the tables, choose the relevant icon or menu option from the top of the screen. Below are the icons and menu options for accessing the tables on the **Patients** screen.

Medical Notes		(Goto, <u>N</u> otes)
Orders		(Goto, <u>H</u> istory, <u>C</u> urrent)
Appointments		(A <u>p</u> pointments, <u>C</u> urrent)
Archived Appointments		(A <u>p</u> pointments, <u>A</u> rchived)

Prescriptions (Goto, Prescriptions)

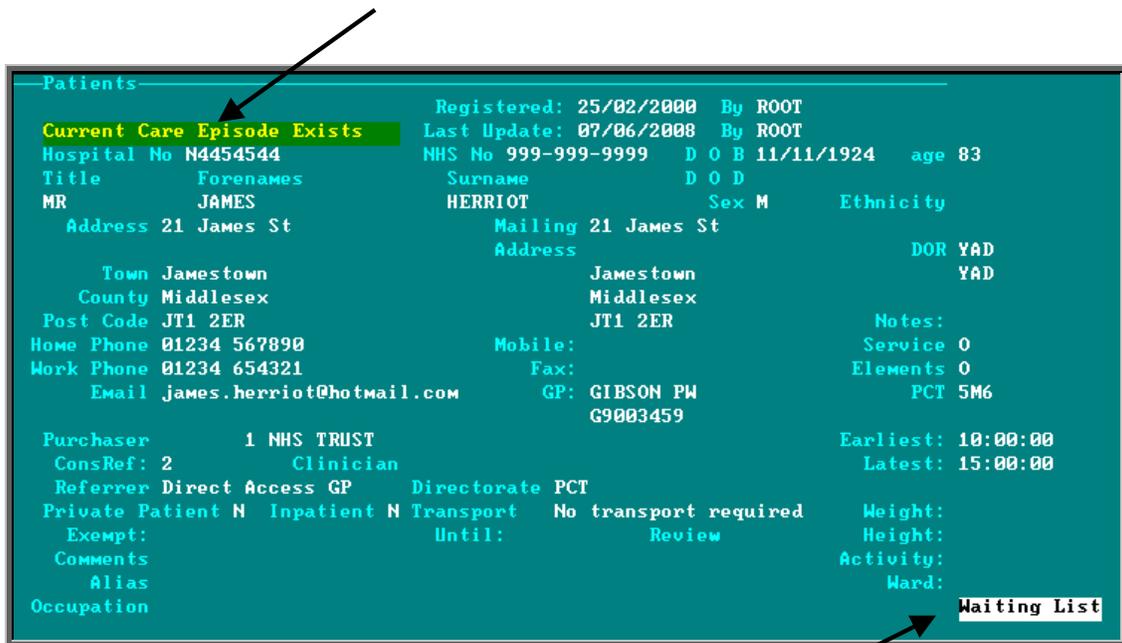
Mobility  (Goto, Mobility)

DNA's (Goto, DNAs)

Carbon Copies (Goto, Copies)

Address history (Goto, Addresses)

The **Patient** screen will also indicate if the patient has a current care episode or if they are on the waiting list.

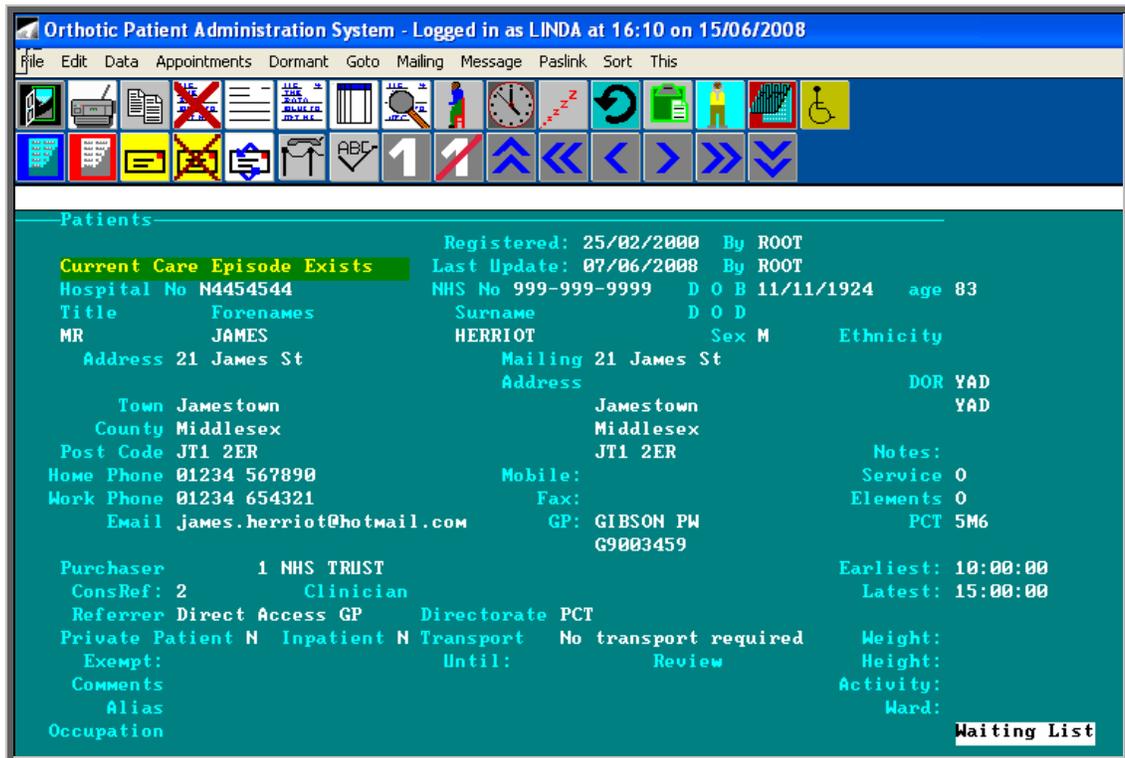


Below are the icons and menu options for accessing these from the **Patients** screen.

Care Episodes  (Goto, Care, Current)

Waiting List  (Goto, Waiting List, Current)

### Patient Screen (Short)



When you are in the ‘short’ version of the Patient screen, although you can not see the summary tables that are on the ‘long’ version of the Patient screen you can still access full details of the orders, appointments etc by choosing the relevant icon or menu option from the top of the screen.

#### Selecting ‘long’ Patient screens

Go into Utilities – Choices – Patients – Interface.

Screen	Case	Notes	Orders	Appoints	ArchAppt	Prescrip	Mobility
UERBOSE	UPPER	Yes	Yes	Yes	No	No	No
UERBOPE	UPPER	Yes	Yes	Yes	No	Yes	No
UERBOME	UPPER	Yes	Yes	Yes	No	Yes	Yes
UERBOWE	UPPER	Yes	Yes	Yes	No	No	Yes
UERPOSE	Proper	Yes	Yes	Yes	No	No	No
UERPOPE	Proper	Yes	Yes	Yes	No	Yes	No
UERPOME	Proper	Yes	Yes	Yes	No	Yes	Yes
UERPOWE	Proper	Yes	Yes	Yes	No	No	Yes
UARBOPE	UPPER	Yes	Yes	Yes	Yes	Yes	No
UARPOPE	UPPER	Yes	Yes	Yes	Yes	No	No

This screen summarises the screens, showing which tables are included.

The *Case* field indicates whether the Patients name and Address will default to UPPER or Proper case when entered.

To help you choose which screen to use, highlight an option and click on View at the top of the screen to see what it would look like.

Note: If you want to use prescriptions in OPAS, you must select a screen that includes the prescriptions table.

Once a decision has been made, click on the 'swap' icon  (Use) from the view screen or the interface summary.



You can see which screen is used for your log-in at any time, by going into Utilities – Users.

```

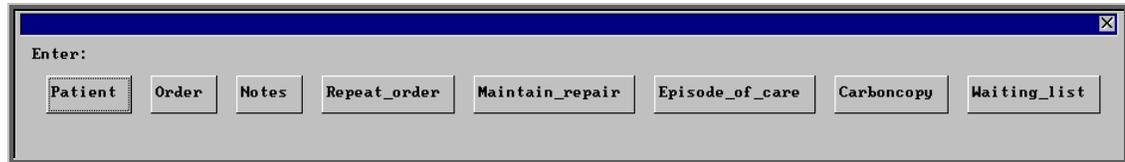
Users
-----
User ID LINDA          Password
User Name LINDA PAWSON
Default appointment letter A Print: ASHW
Assigned User Mode ADMIN   Admin
                               Start Menu MM
Patient Screen VARBOPE   Prescriptions, Archived Appoints, Upper
  
```

If the *Patient Screen* field is blank, OPAS will default to the VERBOSE screen for that user.

## 2. Entering a new patient

Menu: Patients

To add a new patient, click on the 'enter' icon  (Edit, Enter) and the box below will appear.

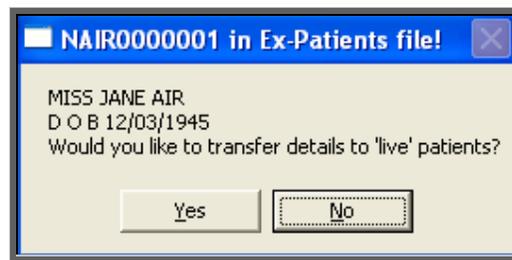


To select Patient, single click on the Patient button with the mouse, or type **P**, or press **Enter**.

At the bottom of the screen you are asked for the Hospital Number. If you know the Hospital Number for this patient, enter it; if not, type **?** and a temporary number will be allocated to this patient by the system. This temporary number can then be changed to the actual Hospital Number later by updating the patient. Temporary patient numbers are normally prefixed with TMP, but this can be changed if required ([see Utilities - Note 49. Order numbers](#)).

Once the hospital number has been entered, OPAS will check to make sure that a patient with that hospital number has not been added before. If it finds a patient with that hospital number one of two things will happen, depending whether the patient already on OPAS is a 'live' patient (by this we do not mean alive, but that they are a current patient!) or an Ex-Patient (a patient that has been archived).

- 1) If the patient is a 'live' patient you will be taken out of enter mode and the patient with that hospital number will be shown on the screen.
- 2) If the patient is an Ex-Patient you will be given the option to reinstate the patient into the 'live' patient area.



If you have entered a hospital number that is not on OPAS a blank patient screen will appear so that the patient details can be entered.

<i>Hospital No</i>	shows automatically as the number you entered and cannot be changed while entering a new patient. You can edit the hospital no later if you need to.
<i>Registered</i>	shows automatically as today's date and cannot be changed.
<i>By</i>	shows automatically as your login name and cannot be changed.
<i>NHS No</i>	is the patient's National Health Service number and is optional.
<i>D O B</i>	is the patient's date of birth: enter this as ddmmyyyy, e.g. 31121911. You do not need to put a / between the day, month and year – they will appear automatically.
<i>Age</i>	calculates automatically from the <i>DOB</i> and cannot be changed.
<i>D O D</i>	is the patient's date of death and at this stage is bypassed by the system. It can be entered when updating a patient's record.
<i>Title</i>	is the patient's title. You can either type this in or select from the pop-up menu (press <b>Tab</b> if necessary to see the pop-up menu). Titles to appear in the pop-up should be set up in <b>Utilities – Choices – Patients – Titles</b>
<i>Forenames</i>	e.g. <b>ALAN DAVID</b> . If you type in lower case, it is automatically converted to upper case or proper case, depending on which 'long' screen is being used.
<i>Surname</i>	e.g. <b>WILSON</b> . If you type in lower case, it is automatically converted to upper case or proper case, depending on which 'long' screen is being used.
<i>Sex</i>	is automatically shown as M or F depending on the <i>Title</i> . If it is blank (because the title could be male or female (e.g. Doctor)), type in the appropriate letter.
<i>Ethnicity</i>	press <b>Tab</b> to select from the list of ethnicities, if required. (Ethnic Origins to appear in the pop-up should be set up in <b>Utilities – Choices – Patients – Ethnicity</b> )
<i>Address</i>	gives five lines for the address. If you type in lower case, it is automatically converted to upper case or proper case, depending on which 'long' screen is being used. There is an option on the <i>Town</i> and <i>County</i> fields to press <b>Tab</b> to select from a pop-up list. (Towns and Counties to appear in the pop-ups should be set up in <b>Utilities</b>

– Choices – Patients – Towns and Utilities – Choices – Patients – Counties). Alternatively defaults can be created in Utilities – Choices – Defaults.

*Mailing Address* as you **Enter** through the mailing address fields, the details in the main address will automatically appear. If the patient has a different address for correspondence to their normal address, e.g. if they are temporarily in a convalescent home, delete the *Mailing Address* details using **F8** on each line and type the temporary address. If pop-ups have been created for Town and County on the main address, these can be used in the *Mailing Address* too.

*Home Phone* enter if required.

*Work Phone* enter if required.

*Mobile* enter if required.

*Fax* enter if required.

*Email* enter if required.

*GP* select from the pop-up menu if known.

*Purchaser* select from the pop-up menu (normally the NHS Trust). (Purchasers to appear in the pop-up should be set up in **Utilities – Choices – Purchasers**)

*ConsRef* select from the pop-up menu of Referrers. (Referrers to appear in the pop-up should be set up in **Utilities – Choices – Referrers**)

*Clinician* select from the pop-up menu if required. (Clinicians to appear in the pop-up should be set up in **Utilities – Choices – Clinicians**)

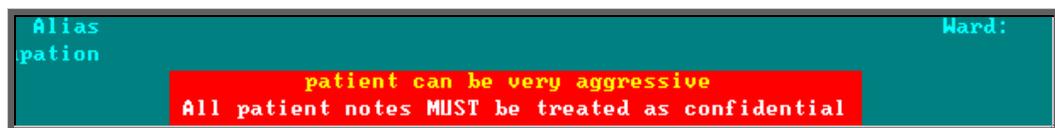
*Private Patient* type **Y** if the patient is a private patient, otherwise type **N**.

*Inpatient* type **Y** if the patient is an in-patient, otherwise type **N**.

*Transport* select from the pop-up menu the method of transport this patient normally requires. (Transport options to appear in the pop-up should be set up in **Utilities – Choices – Appointments – Transport**)

*Exempt* enter the prescription charge exemption evidence if applicable. (Exemption reasons to appear in the pop-up should be set up in **Utilities – Choices – Patients – Exempt**)

<i>Until</i>	if the exemption evidence has been entered, enter here the date of its expiry, in the format DD MM YYYY.
<i>Review</i>	enter the date the patient is to be reviewed, in the format DD MM YYYY.
<i>Comments</i>	enter any additional comments required for this patient.
<i>Alias</i>	enter any additional information regarding the patient's name i.e. maiden name or name patient may be known by other than their birth name.
<i>Occupation</i>	enter the patients occupation.
<i>Special Instructions</i>	this field is invisible until something is entered into it and then it becomes highlighted to draw your attention.



<i>DOR</i>	is District of Residence. If <i>Auto-update DOR</i> is set to <b>Yes</b> in <b>Utilities – Choices – System</b> , this will be automatically populated when you have finished entering the patient details if a valid postcode is entered in the <i>Post Code</i> field of the address.
<i>Notes</i>	indicate whether paper notes are held by entering Y(es) or N(o)  If Y is entered the patients name will be painted yellow.

Title	Forenames	Surname	D
MS	MARY	LITTLE	

<i>Service</i>	if multiple services are using OPAS, select the service the patient belongs to from the pop-up list. . (Service options to appear in the pop-up should be set up in <b>Utilities – Choices – Patients – Services</b> )
<i>Earliest</i>	enter the earliest appointment time the patient can attend.
<i>Latest</i>	enter the latest appointment time the patient can attend.
<i>Weight</i>	enter the patients weight in kilos if known.

- Height* enter the patients height in metres if known.
- Activity* enter the patients mobility on a scale of 1 to 5 (1 being low – 5 being high).
- Ward* press **Tab** to select from the list of wards, if required. (Wards to appear in the pop-up should be set up in **Utilities – Choices – Wards**)

You do not have to go through all the fields on the **Patient** screen. Once all the relevant data has been added, press **Ctrl-Enter** to save the record and to start adding the next patient.

The **Patients** screen can be customised in order to control which fields have pop-up menus appearing automatically, and which fields you have to press the **Tab** key to access the pop-up menus. Also, if you mainly enter the same details in a field i.e. *County*, this field can be set to default to the required County to cut down on typing (see [Utilities - Note 6. Choices - Defaults](#)).

### 3. Finding a patient's record

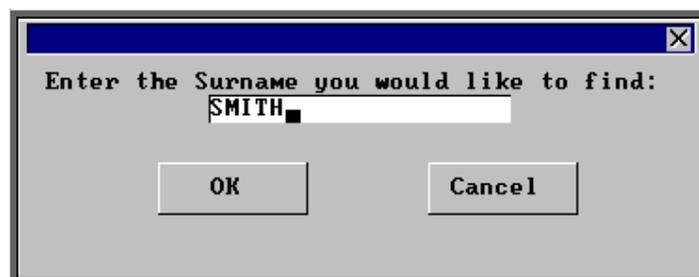
Menu: Patients



To find a patient click on the 'find' icon (Data, Find) and the menu at the top of the screen will change so that you can choose how you wish to search for the patient.



Click on the field that you wish to search by (Surname, Shortname and Hospital\_No are the most frequently used).

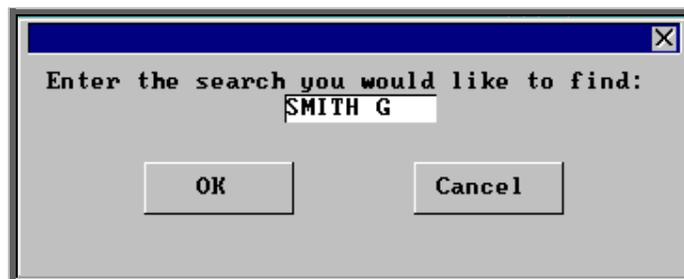


Enter your search criteria in the pop-up box, (In this example you would type the patient's Surname) and then click on **OK** or press **Enter** twice. N.B. Searching by Surname is case sensitive i.e. you must type the surname you are looking for in the same case (UPPER or Proper) as it appears on the patient record.

You will then be taken to the patient record with the nearest match. If there is more than one patient with the same surname you will see the first patient with that surname. The patient's are now in alphabetical order of their surname so by clicking

on the 'arrow' icon  (**F6**) you can step through the patients with that surname until you find the patient you are looking for. Alternatively, select the 'browse' icon  (Data, Browse) to see those records that match your search in a list. (*see Moving around OPAS - Note 6. Standard menu options*).

If you are looking for a patient with a surname that occurs frequently it may be quicker to search by Shortname as you can then specify the initial of their forename to narrow down the search. Type in the first 8 characters of the surname, a space, and then the initial of the forename. N.B. Searching by Shortname is not case sensitive i.e. it does not matter if you type the Shortname you are looking for in UPPER or Proper case.



This will then take you to the first G SMITH. If there is more than one G Smith look for the required patient by stepping through the records by clicking on the 'arrow'

icon  (**F6**), or by selecting the 'browse' icon  (Data, Browse) to see those records that match your search in a list.

## Bookmarked patients

When you want to find a patient that you know you have worked on earlier, click on

the 'back' icon  (**G**oto, **B**ookmark), and you will be presented with a list of patients that you have dealt with since you logged on. The list will be in order with the patient you worked on most recently at the top. If you have dealt with a patient on a number of occasions, there name will only appear once, and be in position of the last occurrence.

Hospital no	Title	Forenames	Surname
NTEMP000012	MR	JOHN	DOE
NTEMP000007	MISS	LIBBY	MCMANUS
N12345QWERTY	MR	KELVIN	BLOGGS
TORUS44	MISS	TESSA	SMITH
NG123456	MISS	JULIE	COLE

To go back to one of the patients in the list, click on the patient so the green

highlighter is on the correct line, and then click on the 'exit' icon  (File, Return).

A patient can be bookmarked manually if you know that you will want to go back to that record shortly. Click on This at the top of the **Patient** screen and select Bookmark.

Note: The list of bookmarked patients is cleared when you log out of OPAS, so will only show patients since you logged on.

## 4. Amending a patient's record

Menu: **Patients**

To amend a patient find the patient you wish to edit and click on the 'update' icon



(Edit, Update) and the box below will appear.

✕

Update current patient details  
or change this Hospital No.

-

Details

Hospital\_No

## Details

If you select **Details**, then you will be taken to the *NHS Number* field in the patient screen, as this is the first field that can be changed. (*Hospital No* cannot be changed here)

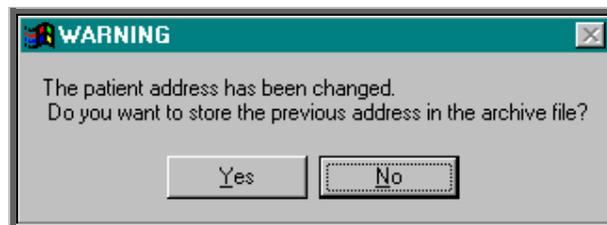
To update a particular field, either move through the fields with **F4** or **Enter**, or click on the data you want to change with the mouse.

You can use **Tab** with the following fields, to show a pop-up menu from which to choose an alternative:

*Title*  
*Ethnicity*  
*Town*  
*County*  
*GP*  
*Purchaser*  
*ConsRef* (Referrer)  
*Clinician*  
*Transport*  
*Service*  
*Ward*

When you have finished updating the patient record, press **Ctrl-Enter** to save the changes.

If any of the changes made are in the patient's address, you will be asked if you would like to keep the old address in the address archive.



Select **Yes** if you wish to keep a record of the old address.

Previous addresses of a patient can be seen by finding the patient's record and clicking on **Goto** at the top of the screen and then selecting **Addresses**.

Alternatively, a summary of their last three addresses can be seen by pressing the 'arrow' icon  (**PgDn**) to go to the bottom of the screen where the *Addresses* table is located.

<b>DNAs</b> On:   At	<b>Addresses</b> Add: 10 LITTLE CORNER	PC: PO7 6XL
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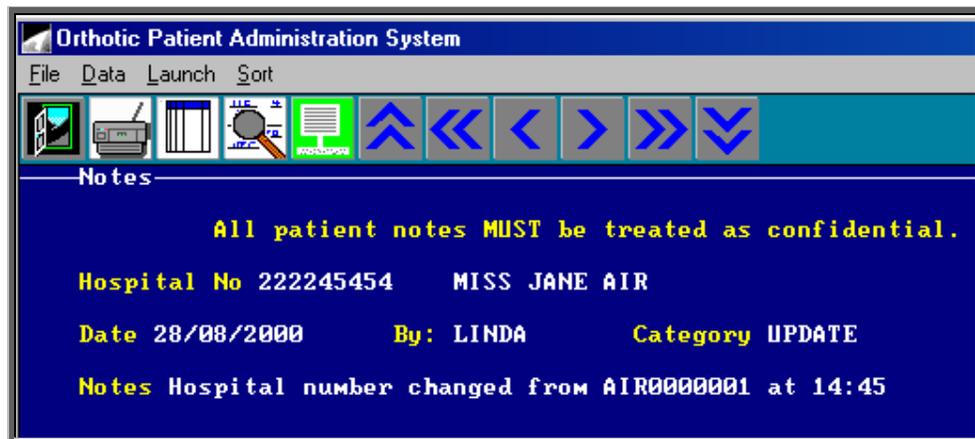
### Hospital number

If you select Hospital\_No, you are prompted to enter the new Hospital Number.

This is used to enter the correct Hospital Number for a patient who's Hospital Number was not known when they were entered onto the system and therefore a temporary number was allocated or the Hospital Number was entered incorrectly.

When you change the Hospital Number, it will automatically change all associated records for that patient, e.g. orders and appointments. Also a note will be created showing

- date and time the hospital number was changed
- who made the change
- what the original hospital number was



Whether you change the details or the hospital number, the *Last Update* field at the top of the patient record will be updated accordingly.



## 5. Changing the mailing address

Menu: **Patients**

This allows you to enter a new mailing address for the patient, or delete the current mailing address. This is used if the patient changes address temporarily, e.g. by going on holiday, so that the permanent address is retained and a temporary address for correspondence is used in the meantime.

If a temporary mailing address is shown for a patient, that address is used for letters; if not, the permanent address is used.

To add a new mailing address or to change an existing one, click on the ‘mailing’

icon  (Mailing, Input). You are prompted (in the bottom left corner of the screen) to enter each line of the new temporary mailing address in turn. The current temporary mailing address (if any) is shown and can be changed or deleted line by line using **F8** and the new temporary address typed.

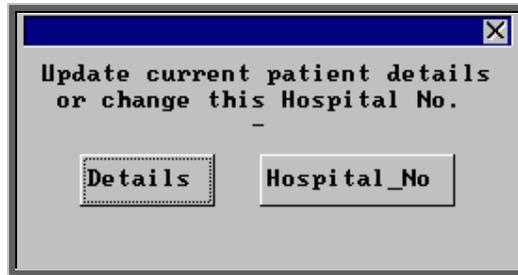
To delete a mailing address, click on the ‘delete mailing’ icon  (Mailing, Delete). You are prompted to confirm deletion and the temporary mailing address is deleted.



## 6. Deceasing a patient

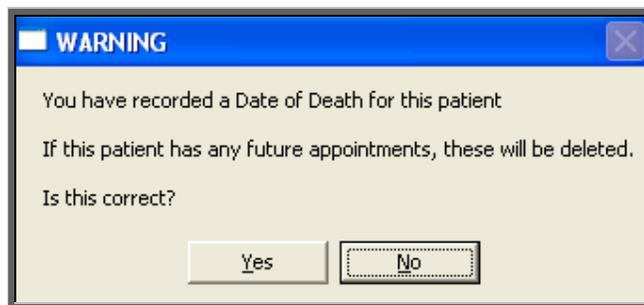
Menu: **Patients**

If a patient dies, find their patient record and click on the ‘update’ icon  (Edit, Update) and the box below will appear.



Select Details and move to the *D O D* (Date of Death) field. Input the date of death in the format DD MM YYYY. If you wish to enter today's date press the **F2** key.

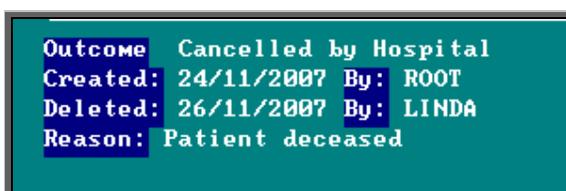
When you press **Ctrl-Enter** to save the changes OPAS will notice that a date of death has been recorded and give you the following prompt.



It is important that at this point you confirm the correct patient has been updated. Once **Yes** has been selected, OPAS will find any future appointments and cancel them, so that the slots can be freed for another patient. If OPAS can see that transport was booked for any of the appointments, then the following message will appear.



The appointment cancelled will be updated with an *Outcome* of 'Cancelled by Hospital' and a *Reason* of 'Patient deceased'. An automatic note will also be created in the patients notes.



## Orders

Once any future appointments have been dealt with, OPAS will then look to see if the patient has any orders where the goods have not yet been supplied.



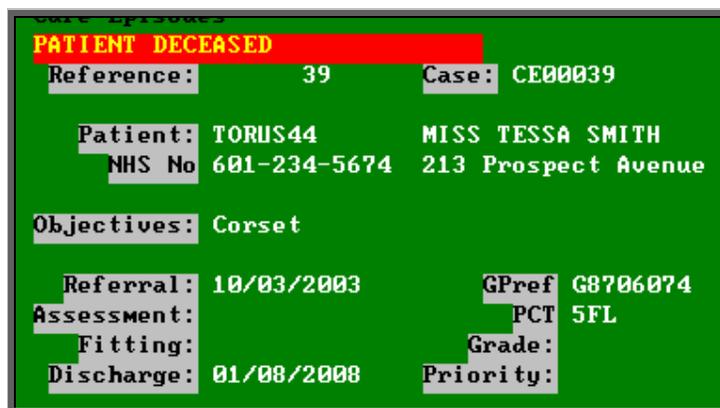
## Waiting List

If the patient is on the waiting list, they will be removed from the waiting list.



## Care Episodes

If the patient has any care episodes, they will all be marked as discharged.



The patient record will then be marked to show that they are deceased, and OPAS will not let you raise new orders, care episodes or appointments.

Patients			
<b>This patient is deceased</b>		Registered: 06/10/1998	By ROOT
		Last Update: 26/06/2008	By LINDA
Hospital No	N00361807	NHS No 462 328 2465	D O B 31/12/1889
Title	Forenames	Surname	D O D 02/03/2008
	AARON	JONES	Sex M Ethn
Address	4 CHILHAM ST	Mailing	4 CHILHAM ST

However, you do have the ability to add patient notes to a dead patient.

If an ad hoc letter note is created, the letter will be addressed to 'The Executors and Trustees of' the patient.

**Note:** Deceased patients do not move to **Ex-patients** when the **Archive** is run. The patient record still needs to be deleted if it is to be included in the **Archive**.

## 7. Deleting a patient

Menu: Patients

To delete a patient find the patient you wish to delete and click on the 'delete' icon



(Edit, Delete) and the box below will appear.



If you still want to delete this record select **Yes**. Otherwise select **No**.

On confirming deletion, that patient's record is marked as deleted and a message shows:

Patients			
<b>This patient has been deleted</b>		Registered: 24/06/1999	By ROOT
		Last Update: 20/10/2003	By LINDA
Hospital No	12345QWERTY	NHS No 623-456-7894	D O B 29/12/1956
Title	Forenames	Surname	D O D
MR	KELVIN	BLOGGS	Sex M Ethn
Address	14 Main Avenue	Mailing	14 Main Avenue

The patient remains in the file and, if deleted by mistake, can be undeleted by simply clicking on the 'delete' icon  (Edit, Delete) again.

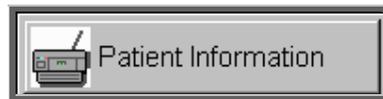
Deleting a patient does not delete any orders or appointments for that patient.

Deleted patients can be moved from the live **Patients** file into the **Ex-Patients** file by running **Utilities - Ex-patients - Archive**. You must take a back up before running the archive option and be the only user in the system. (see **Utilities - Note 26. Ex-patients**)

## 8. Printing options

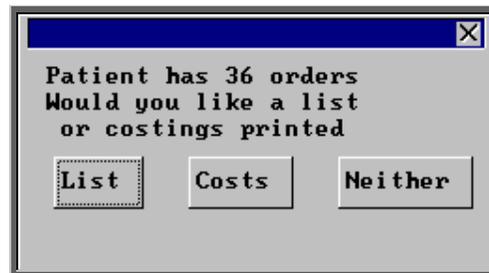
Menu: **Patients**

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



**Patient Information** prints the information for the current patient. If you are in the 'long' version of the **Patient** screen any Medical Notes for the patient will also be printed. If you are in the 'short' version of the **Patient** screen, the Medical Notes will not be printed.

You will then be told how many orders are recorded for that patient:



### List

List prints a list of orders for that patient (Order number, Date of order and the general Description for that order).

### Costs

Costs prints a more detailed list of orders for that patient (Order number, Date of order, the detailed Description for the first item on that order and total Cost of the order).

Select which orders report you require or select **Neither** if you do not require details of the patient's orders.

A box will then appear showing how many care episodes the patient has.



If you would like to print a list (showing Referral date, Assessment Date, Fitting date, Discharge date and Objectives for each episode), click on **Yes**. Otherwise select **No**.



By selecting **Custom Report** and then clicking on **This\_view**, you will see the reports that can be run from the **Patient** screen. These are designed for use in conjunction with database queries. Standard reports available from the **Reports** option are more 'user-friendly'! (see **Reports - Notes 52 to 58**)



By selecting **Letter** you will see the letters and forms that can be printed from the **Patient** screen. You have the opportunity of setting up to 26 standard patient letters that can be merged with patient information. (For further information on how to set up these letters see **Utilities - Note 15. Choices - Letters**). There are also two forms, HSA5 and WF1, set up for you (see - **Patients - Note 23. Printing HSA5/WF1 forms**).

## 9. Prescriptions

Menu: **Patients**

If you use the prescriptions facility in OPAS (i.e. you are using a patient screen that includes the prescriptions table) then prescription details has to be entered for each patient and each order/care episode is assigned to a prescription. This means that the relevant prescription must be entered onto the system before an order or care episode can be entered and assigned to it.

To enter a new prescription, find the patient that you want to add a prescription for, click on the 'enter' icon  (Edit, Enter) and the box below will appear.



If you do not use the prescriptions facility (i.e. you are using a patient screen that does not include the prescriptions table), then **Prescriptions** will not appear as an option in the box above.

To select **Prescription**, click on the **Prescription** button with the mouse.

- |                    |  |
|--------------------|--|
| <i>Hospital No</i> | Hospital No will be brought through from the patient record.   |
| <i>Patient</i>     | Patient name will be brought through from the patient record.  |
| <i>Sex</i>         | (M)ale or (F)emale will be brought through from the patient record.  |
| <i>DOB</i>         | DOB will be brought through from the patient record.   |
| <i>Purchaser</i>   | Purchaser 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 purchasers and make an alternate selection. Otherwise press the <b>Enter</b> key to move to the next field.  |
| <i>Description</i> | 50 characters available to describe in simple words what the prescription is for. This description used here will appear in the description field of any orders raised against this prescription and will ultimately will appear on appointment letters. Therefore words that will be understood by the patient should be used. As well as |

being able to free type in this field you can also select a description from a pop-up list by pressing the **Tab** key. (Standard descriptions to appear in the pop-up should be set up in **Utilities – Choices – Descriptions**)

<i>Referrer</i>	Referrer 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 referrers and make an alternate selection. Otherwise press the <b>Enter</b> key to move to the next field.
<i>Orthosis code</i>	Press <b>Tab</b> to select a code from the pop-up list. (Orthosis codes to appear in the pop-up should be set up in <b>Utilities – Choices – Orthosis Codes</b> ).
<i>Date</i>	Today's date will automatically be entered. You can overwrite with another date if required.
<i>Length</i> valid.	is entered as the number of years for which the prescription is valid.
<i>Order No</i>	is entered automatically by the system: it is a sequential number, not the number of an order raised against the prescription.
<i>Notes</i>	additional information can be entered as required.
<i>GPRef</i>	GP Ref will be brought through from the patient record and cannot be changed.
<i>PCT</i>	PCT information will be brought through from the patient record and cannot be changed.
<i>NHS No</i>	the patient's NHS number will be brought through from the patient record and cannot be changed.

### Updating prescriptions

Find the patient that the prescription relates to and click on **Goto, P**rescriptions. Find the relevant prescription if there is more than one and then click on the 'update' icon



(**E**dit, **U**date) to amend any of the details entered on the prescription.

### Cancelling prescriptions

Prescriptions should not be cancelled. If you wish to cancel a prescription, follow the steps above for updating prescriptions, and amend the *length* of the prescriptions

to '0' years. The prescription will then be no longer valid and orders and care episodes cannot be assigned against it.

### Expired prescriptions

Prescriptions are highlighted with a red banner once they have expired.

Prescriptions			
No:	Desc:	From:	For:
1	SHOES	13/01/1999	3

If you try to assign an order or care episode to an expired prescription, the following message will appear.



## 10. Adding a care episode

A care episode is a means of grouping together orders, notes and appointments that relate to a specific episode of care. Care episodes can also be used for tracking the pathway of the referral.

Menu: **Patients**

Find the patient that you wish to add a care episode.

If you are not using prescriptions move onto step 2

If you are using prescriptions you will then have to select which prescription this

care episode is going to be assigned to. To do this, press the 'arrow' icon  (PgDn) so that you can see the prescription table. Select the relevant prescription by clicking on it with the mouse so that the green highlight appears. (Alternatively press Alt-T, select Prescription and move down the list with the arrow keys.) Prescriptions are highlighted in red if they have expired. You cannot add a care episode to a Prescription if it has expired.

No:	Desc:	From:	For:
1	Test prescription for Fred	20/04/1995	2
2	Custom shoes	01/02/1998	5
3	TEST	02/09/1999	5

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

Enter:

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

Add a Care Episode for MR JAMES HERRIOT

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 overwrite 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 and patient name will be brought through from the patient record.

*Objectives:* free text available to outline the objectives of this care episode.

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

<i>Assessment:</i>	date of assessment
<i>Fitting:</i>	date of fitting
<i>Discharge:</i>	date of discharge
<i>Consref:</i>	Referrer 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 Referrers and make an alternate selection. Otherwise press the <b>Enter</b> key to move to the next field.
<i>Purchaser:</i>	Purchaser 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 Purchasers and make an alternate selection. Otherwise press the <b>Enter</b> 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>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

*Primary Assessment* 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.

To learn more about care episodes go to [Section 4 – Care Episodes](#).

## 11. Waiting List

The waiting list enables you to keep a track of those patients that are waiting for their initial or review appointment to be offered.

Menu: **Patients**

Find the patient that you wish to add to the waiting list.

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

Click on Waiting List (press W).

If you try to add a patient who is already on the waiting list, you will get the following message.



Otherwise you will be taken to the waiting list screen.

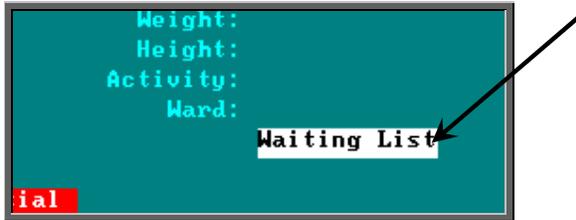
*Referral Date:* enter the date of referral. The field will default to today's date but this can be overtyped.

- Type:* select from the pop-up list by highlighting the required type and pressing the **Enter** key or by double clicking on it with the mouse.
- New:* enter **Y** if the patient is new or **N** if the patient has been seen before. Instead of entering **N**, you could further classify the appointment by entering **S** for supply, **F** for fitting or **R** for review.
- For:* gives you the opportunity to say (in 30 characters) why the patient needs to be seen.
- Orthosis Code:* select the appropriate orthosis code from the pop-up list
- 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.
- Referrer:* 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 purchasers and make an alternate selection. Otherwise press the **Enter** key to move to the next field.
- Venue:* select a venue from the pop-up list. Otherwise press the **Enter** key to move to the next field.
- Clinician* select a clinician from the pop-up list. Otherwise press the **Enter** key to move to the next field.
- Length* The length of appointment can be entered here. This is to assist when making an appointment.
- APE* Whether the patient requires an **AM**, **PM** or **Evening** appointment can be entered here.
- Service* Service will be brought through from the patient record but it can be changed to another service as long as it is a service that is assigned to the patient on the **Patient** screen.
- Tagged* this option allows a waiting list entry to be tagged. Primarily this is to enable batch printing of waiting list letters.
- Order No* an order number can be selected from the pop-up list.

If an appointment is subsequently made from the **Waiting List** screen using the

‘clock’ icon  (Appoint, Next) or the ‘autoclock’ icon  (Appoint, Quick), the fields in **red** are used.

When a patient has been added to the waiting list a flag will appear on the patient record to show that they are on the waiting list. This flag will disappear once they have been removed from the list.



To access the waiting list screen from the **Patient** screen, click on the 'waiting list'

icon  (Goto, Waiting List, Current).

To learn more about the waiting list go to [Section 5 – Waiting List](#).

## 12. Adding an Order

Menu: Patients

To add an order, find the patient that you want to add the order for.

If you are not using prescriptions move onto step 2

If you are using prescriptions you will then have to select which prescription this

order is going to be assigned to. To do this, press the 'arrow' icon  (PgDn) so that you can see the prescription table. Select the relevant prescription by clicking on it with the mouse so that the green highlight appears. (Alternatively press Alt-T, select Prescription and move down the list with the arrow keys.) Prescriptions are highlighted in red if they have expired. You cannot add an order to a Prescription if it has expired.

No:	Desc:	From:	For:
1	Test prescription for Fred	20/04/1995	2
2	Custom shoes	01/02/1998	5
3	TEST	02/09/1999	5

Click on the 'enter' icon  (Edit, Enter) and the box below will appear. ←

Enter:

To select Order, click on the Order button with the mouse, or type **O**.

**Note:** If Order is not an available option you are in the 'short' Patient screen. To change back to the 'long' Patient screen, click on the 'swap' icon  (File, Swap)

Add an order for MR JOSEPH KING

You are asked to confirm that you wish to add an order for this patient. If you have forgotten to find the patient before trying to add an order, this is your opportunity to abandon entering an order.

If you select **Yes** a new order will appear on the screen for you to complete.

Some of the fields will already be filled in for you. The fields below in red **must** be completed. The other fields are optional.

- Hospital No*      Hospital No will be brought through from the patient record.
- Patient*            Patient name will be brought through from the patient record.
- Sex*                (M)ale or (F)emale will be brought through from the patient record.
- DOB*                DOB will be brought through from the patient record.

<i>Purchaser</i>	Purchaser 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 purchasers and make an alternate selection. Otherwise press the <b>Enter</b> key to move to the next field.
<i>Date of Order</i>	Today's date will automatically be entered. You can overwrite with another date if required.
<i>Order Number</i>	The next sequential number will automatically be entered in this field if an order number formula has been created (see <b>Utilities – Note 31. Order numbers</b> ). You can overwrite this as long as the order number you type is unique (i.e. has not been used before and is unlikely to be automatically offered on a future order).
<i>Supplier</i>	Select the supplier you are ordering the goods from. (If the supplier does not appear in the pop-up list they will need to be added in <b>Utilities – NSI – Suppliers</b> .)
<i>Cross Ref or Hsp Order No</i>	This is an optional field where you may wish to quote a supplier's reference number or an internal reference number. If a blanket order number has been assigned to the supplier, this will appear automatically in this field.
<i>Description</i>	50 characters available to describe in simple words what the order is for. This description can appear in appointment letters so should be terminology understood by the patient. As well as being able to free type in this field you can also select a description from a pop-up list  by pressing the <b>Tab</b> key. (Standard descriptions to appear in the pop-up should be set up in <b>Utilities – Choices – History – Descriptions</b> )
<i>Orthosis Code</i>	This is a mandatory field. You must select a code from the pop-up list. (Orthosis codes to appear in the pop-up should be set up in <b>Utilities – Choices – Orthosis Codes</b> )
<i>Referrer</i>	Referrer 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 Referrers and make an alternate selection. Otherwise press the <b>Enter</b> key to move to the next field.
<i>In-patient</i>	Type <b>N</b> for No or <b>Y</b> for Yes.
<i>Paid</i>	If the patient has to pay for the goods, (e.g. the orthosis incurs a prescription charge) the date they pay can be entered here in the format DD MM YYYY. To leave this field blank press the <b>Enter</b> key.
<i>Receipt</i>	If the patient has to pay for the goods, the receipt number can be entered here.

*Amount* If the patient has to pay for the goods, the amount they paid can be entered here.

*Expected* This date will be calculated from the Orthosis Code that was entered

*Supply Date* above. When the Orthosis codes are set up there is the opportunity to say how long that type of item takes to be delivered. If an Orthosis Code has been set up with a delivery of 7 days, the *Expected Supply Date* will show as 7 days from today's date. If the delivery field is not used when the Orthosis Code is set up, the *Expected Supply Date* will show as today's date. The date that appears can be overtyped with another date if required.

*ACO* What you enter here will determine what OPAS will do when you book the goods in as being received.

**A** if the order will need an appointment to be made for fitting. When the order is received from the supplier, the system will automatically make an appointment.

**C** if the order is to be collected but does not need an appointment: when the order is received from the supplier, the system will generate a collection letter to advise the patient that the order is ready for collection.

**E** if the order will be fitted during an existing appointment for that patient. The system will check the existing appointments for the patient and link the appointment to the order by automatically entering the order details onto the appointment and inserting the date of the existing appointment into the *Appointment* field on the order. If the patient has more than one future appointment you will be asked to select which appointment you wish to link the order with.



OPAS will also check that the appointment date is after the expected supply date on the order. If it is not, you will get the following message:



**T** if the order needs to be taken to a ward. The information will appear at the bottom of the next clinic and can appear on the clinic list if required.

**O** for any other circumstance: the system will not take any particular action when the order is received.

- Time* If you enter **A** in the *ACO* field, you must indicate how long an appointment the patient will need. The default length of your appointments (as set in **Utilities – Choices – System**) will automatically appear in the *Time* field but this can be overtyped.
- Clinic* If you enter **A** or **C** in the *ACO* field, you must say which clinic venue they need to attend or collect the goods from. A pop-up list will give you your available options. (Clinic venues to appear in the pop-up should be set up in **Appointments – Venues**)
- Clinician* If you enter **A** in the *ACO* field, you can state which Clinician they need to see. If the patient can see any Clinician then leave this field blank. If you have entered a Clinician on the Patient record, this will show through onto the order. If you need to add/edit the Clinician, press the **Tab** key to see the list of options.
- Day* If necessary, a day of the week can be specified for the appointment. Press the **Tab** key to see the list of options. If you enter a day here, when the goods are booked in and OPAS finds the next available appointment, it will only look for available appointments on that day. Therefore, care should be taken that you do not enter a mismatch here i.e. by saying that they need to see Mr Clinician on a Monday when Mr Clinician only has a clinic on a Friday.
- APE* If you enter **A** in the *ACO* field, you can specify whether the appointment made should be an **AM**, **PM** or **Evening** appointment.
- Letter* If you enter **A** or **C** in the *ACO* field, you can state which letter type will be required. The field will default to your default standard appointment/collection letter (as set in **Utilities – Users/Appointments – Venues**).

*Transport* If you enter **A** in the *ACO* field, you can state which type of transport the patient needs, if any. If you have entered Transport details on the Patient record, this will show through onto the order.

*Prescription No* If you are using prescriptions, the prescription number will show automatically in this field.

*Care Episode* If a care episode has been created for this patient, the order can be linked to the care episode by entering the care episode reference number. Press the **Tab** key to see the list of care episodes for the patient. If the pop-up list is empty, there are no current care episodes for the patient.

More than one order can be linked to a care episode. When the goods are booked in against an order, if the *ACO* field has been set to **A** (Appointment) or **C** (Collection) an appointment or collection letter will not be produced until all the orders quoting that care episode have been received.

Once the above fields have been entered you will be taken into the **Detail** box where details of the items to be ordered are shown.

*Code* Press the **Tab** key to see the list of items held in OPAS. This will show a combination of OPrice items, Non Scheduled Items (NSI) and stock items.

CODE	DESCRIPT
A014	ADDITIONAL CHARGE FOR BRIDGED OR ARHED WAIST
A015	ANY ADDITIONAL PADDING TO ONE SINGLE ITEM OF FOOTWEAR
A016	HIGH OR ELONGATED STIFFENER UP TO 150MM
A017	HIGH BOOT UPPERS EACH ADDITIONAL 25MM
A018a	LAMBSWOOL LINING UP TO 150MM
A018b	LAMBSWOOL LINING EACH ADDITIONAL 25MM

Start typing the item that you are looking for and the pop-up list will go to those items that match your search criteria.

Position the green highlight on the item you require and press the **Enter** key.

If the item you are looking for is not in the list, press the **Esc** key to make the pop-up list disappear and leave the code field blank. If the item is not in the pop-up list and it is an item you order regularly you can add the item as a Non Scheduled Item (**Utilities – NSI – Items see Utilities - Note 29. NSI**) so that it appears in the pop-up list in future.

*Description* If you have selected a schedule number in the *Code* field the description will automatically appear. If not, the description entered in the *Description* field above will appear.

*Orthosis Code* The Orthosis Code entered earlier on the order will automatically appear here. On most occasions this will be correct and pressing the **Enter** key will take you to the next field. However, if you are ordering more than one item it may be that the Orthosis code entered earlier is not correct for both items. If you need to change the code on any of the order lines, press the **Tab** key to see the list of Orthosis codes available and make an alternate selection.

*(V)AT* V shows the rate of VAT for that item, as

**S** standard  
**E** exempt  
**Z** zero-rated  
**R** reclaim.

The VAT field will default to the vat code held against the item code but you can overtype this with an alternate VAT rate. If you have not entered an item code, the VAT code will default to S.

*Qty* Enter the quantity to be ordered. This will default to 1 but can be overtyped. (The default *Qty* can be changed in **Utilities – Choices – Defaults**)

*Price* If you have selected a schedule number in the *Code* field and there is a price in OPAS for the item from the supplier named above, then the price will automatically appear.

If the price does not appear automatically it will have to be entered manually. If this is an item you order regularly you can add the price as a Non Scheduled Price (**Utilities – NSI – Prices see Utilities – Note 29. NSI**) so that the price will appear automatically in future.

Enter as many lines in the detail section as are needed, but you **must** press **Enter** after entering the *Price*, so that the highlight moves on

to the next line. If you don't, background calculations are not carried out by the system and problems may occur in the calculation of VAT. Once you have entered the last line it is safest to press **Enter** to move the highlight into *Code*, then **Enter** again to move it into *Description* then **Enter** again to move it into *Notes*.

*Notes* Any additional information can be entered here.

*Technician* If required, a Technician can be specified for the order. This is for those hospitals with an internal workshop. Press the **Tab** key to see the list of options. The Technicians seen in the pop-up list are created in **Utilities – Choices – History – Technicians**.

*Ward* If the patient is an in-patient the Ward they are in can be entered here. Press the **Tab** key to see the list of options. The Wards seen in the pop-up list are created in **Utilities – Choices – Wards**.

Once you have finished entering data into the required fields, press **Ctrl-Enter** to save the order and to return to the patient record.

If you have instant print switched on, the order will print automatically at this point.

To learn more about orders go to **Section 6 – Orders**.

## 13. Re-printing individual orders

If you have lots of orders to print it is best to print them in batch (*see Orders - Note 7. Printing/faxing orders in batch*), as this is much quicker. There are occasions however, when you want to print/reprint just one order.

Menu: **Patients**

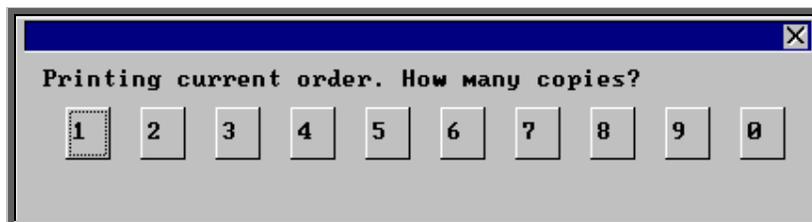
Find the patient whose order you wish to print.



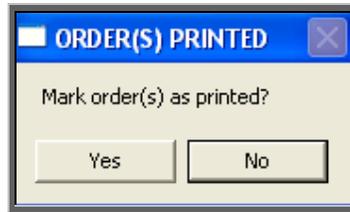
Click on the 'orders' icon (Goto, History, Current) to show the current orders for that patient.



Find the relevant order, click on the 'print' icon (File, Print), and select **Orders** from the print menu.



After the required number of copies have been sent to the printer, you are asked whether to mark these orders as having been printed:



If you select **Yes** to mark the order as printed, the order will not be selected for printing when you next batch print orders from **History – Orders**.

You can print an individual order as many times as you need. The fact that it has been printed before, or that it has been marked as printed will not prevent you from printing a single order from the **Patient** screen.

## 14. Re-faxing individual orders

Before being able to fax orders directly from OPAS you need to:

- 1) Enter the fax driver information in the *Fax printer* field in the system parameters screen (**Utilities – Choices – System**). (see **Utilities - Note 24. Choices - System**)
- 2) Identify those suppliers you wish orders to be faxed to in **Utilities – Choices – History – Fax**.

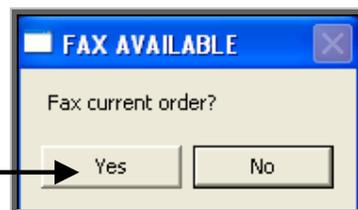
Find the patient whose order you wish to fax.



Click on the 'orders' icon (Goto, H<sup>istory</sup>, C<sup>urrent</sup>) to show the orders for that patient.

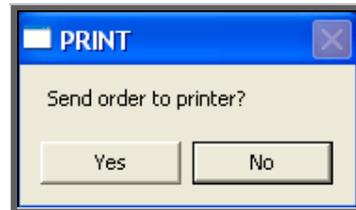


Find the relevant order, click on the 'print' icon (F<sup>ile</sup>, P<sup>rint</sup>), and select **Orders** from the print menu.



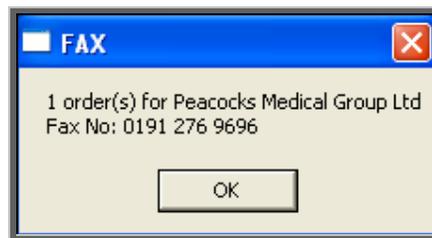
The above prompt will appear unless the supplier on the order is an internal stock supplier. If the supplier is **Stock** you will only be able to print the order and you will be asked how many copies are required.

If you do not want to fax the current order, and say **No**, the following prompt will appear.



On selecting **Yes** you will then be given the print box where you can choose how many copies you would like to print.

If, however, you select **Yes** a prompt will appear giving the fax number for the supplier on the order.



On clicking **OK**, your fax software will be launched. The fax number can then be typed into the send fax screen of your fax software.

The supplier number should remain at the bottom of the **Order** screen until the fax is sent. We are aware though that some fax software clears the fax number from the **Order** screen prematurely, so it would be advisable to make a note of the fax number when the above box appears in case this should happen. Once you know that the number remains, you will not have to make a note of the number in future.

Once the fax has been sent, you will be asked if you wish to mark the order as faxed. If you select **Yes** today's date will be entered in the *Printed* field on the Order and the order will not be faxed again when the orders are next printed in batch.

## 15. Entering medical notes

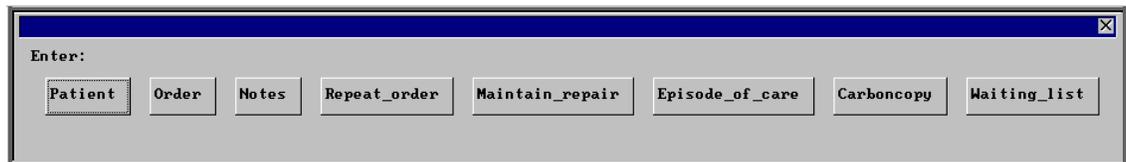
Medical notes can be added directly to the patient record, or, if a care-episode has been set up for the patient (*see Patients - Note 10. Adding a care episode*), notes can be attached to a specified episode of care.

**Note: Medical notes cannot be deleted or amended (unless entered as a temporary note) so take care that the note you are adding is accurate and for the correct patient.**

Menu: Patients

### 1. Adding a medical note to the patient

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



To select **Notes**, click on the **Notes** button with the mouse, or type **N**.

You will then be taken to the **Notes** screen where some of the fields will already be filled in for you.

*Hospital No* Hospital No and patient name will be brought through from the patient record.

*Date* Today's date will automatically be entered. You can overtype with another date if required.

*Category* Select a category from the pop-up list (Categories to appear in the pop-up should be set up in **Utilities – Choices – Note Categories**)

A category of 'dictionary' has already been set up for you. If you choose this category when adding a note you will be presented with a list of medical conditions (previously set up in **Utilities – Choices – Medical Conditions**) for you to choose from.

A category of 'video' has already been set up for you. Choose this category when attaching a video as a Note:

A category of 'picture' has already been set up for you. Choose this category when attaching a photograph/picture as a Note:

A category of 'scanned' has already been set up for you. Choose this category when attaching a scanned image as a Note:

A category of 'document' has already been set up for you. Choose this category when attaching a document (e.g. MS Word document) as a Note:

A category of 'SOAP' has already been set up for you. Choose this category if adding a SOAP Note:

A category of 'temp' has already been set up for you. Choose this category if adding a note which you may need to edit.

*Episode* This field is by-passed. It is for use when adding a note to a care episode.

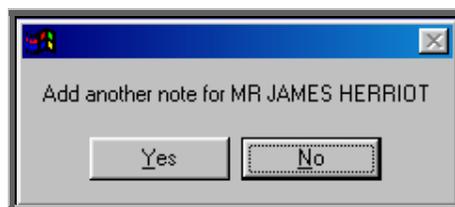
*Note* Adding a standard Note

When typing text for the notes, remember that the first line of the note is shown in the list of medical notes on the patient's screen, so consider making the first line a summary of the content of the Note:

As you type the note and get to the end of the line, the text will scroll onto the next line automatically. There is no need to press **Enter** to go onto the next line, unless you wish to start a new line before the line you are on is full.

Having finished typing the note, check that you are happy with the content. **You cannot edit this note later unless it has been entered as a 'Temp' Note:** If there is anything you wish to change, move the cursor with the arrow keys and change the text accordingly. If additional text is added in the body of the note the text will not scroll at the end of the line automatically as it did initially. However, by pressing **F7** the text will be realigned for you.

When you happy that the note is correct, press **Ctrl-Enter** to finish and save the record. You will be asked if you wish to add another note for the same patient.



Select **NO** to return to the main patient screen, or **Yes** if you wish to add another Note:

### Adding a Note using the 'Video' category

In the *Note* field type the file name (including it's extension) and path of the video file you wish to attach as a Note:

### Adding a Note using the 'Picture' category

In the *Note* field type the file name (including it's extension) and path of the picture file you wish to attach as a Note:

### Adding a Note using the 'Scanned' category

In the *Note* field type the file name (including it's extension) and path of the scanned file you wish to attach as a Note:

### Adding a Note using the 'Document' category

In the *Note* field type the file name (including it's extension) and path of the document file you wish to attach as a Note:

### Adding a Note using the 'SOAP' category

Rather than the note text being entered into one *Notes* field, it can be entered over four SOAP note fields (*Subjective*, *Objective*, *Action* and *Plan*).

Selecting this category will jump you past the standard *Note* field and into the *Subjective* field. Once the subjective note has been typed, press the **F4** key to move to the *Objective* field. Continue to do this with each field. Press **Ctrl-Enter** when finished.

In the **Notes** summary table on the **Patient** screen, the first line of the *Notes* field is shown. As this is empty on a SOAP note, a description of SOAP note is entered here.

Medical Notes	
Date	Notes
03/04/2008	SOAP note

### Adding a Note using the 'Temp' category

In the *Note* field press **Ctrl-Enter** or **F10** to be taken to the Text Editor. The patient's name and hospital number will already be

entered at the top of the text editor, so that if you choose to print the temporary note to be checked later you will know who the note belongs to. (You will want to take this out before you finally commit the Note: This can be done quickly by positioning the cursor on the line you wish to delete and pressing **F8**.)

Type in the note, again remembering that the first line of the note is shown in the list of medical notes on the patient's screen, so consider making the first line a summary of the content of the Note:

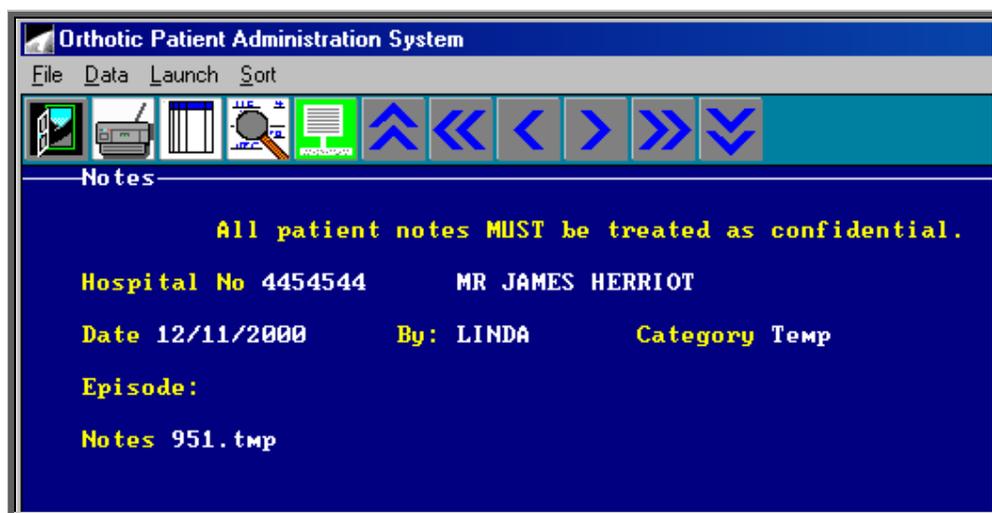
If you wish to print the temporary note press **Alt-P**

When the note is complete, press **F10** to exit the Text Editor, and you will be given the opportunity to commit the Note:



If you select **Yes**, the text entered in the Text Editor will be copied into the Note field of the note and saved. **You will not be able to edit this note later.**

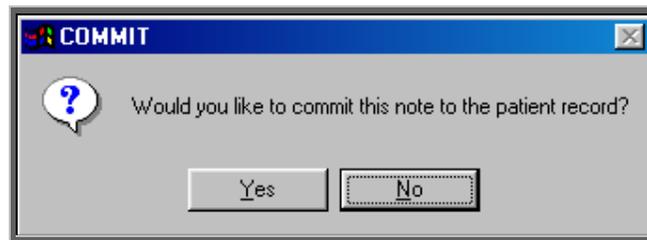
If you select **No**, the information typed in the Text Editor will be allocated a sequential temporary note number and this number will show in the *Note* field.



## Editing a note entered with a 'Temp' category

Find the note you wish to amend (by finding the patient record and then clicking on the 'notes' icon  (Goto, Notes). Use the 'arrow' icon  (F6) to find the note you wish to edit).

Click on the 'launch' icon  (Launch) to be taken to the Text Editor. Edit the text accordingly. If you are intending to commit the note you will want to take out the patient's name and hospital number from the top of the text editor. This can be done quickly by positioning the cursor on the line you wish to delete and pressing (F8.) Press (F10) when you have finished, to exit the Text Editor, and you will be given the opportunity to commit the Note:



If you select **Yes**, the text entered in the Text Editor will be copied into the *Note* field of the note and saved. **You will not be able to edit this note again.**

If you select **No**, the changes will be saved against its temporary note number, but the note can still be amended again later. The note will continue to be available for editing until you commit the note to the patient record (by selecting **Yes** to the above prompt).

## Adding a Note using the 'Letter' category

In the *Note* field press **Ctrl-Enter** to be taken to the Ad hoc letter screen.

Letter: Select which of the 26 available letter templates is to be used

Copies: Select the number of copies required. This will default to 1 but can be overtyped

para1-para9: Type in the required text in as many of the paragraph sections that are required. Move down the

paragraph fields using either the **F4** key or **Down-Arrow** key.

Press **Ctrl-Enter** when finished.

In the **Notes** summary table on the **Patient** screen, the first line of the *Notes* field is shown. As this is empty on a **Letter** note, a description of **Ad Hoc letter sent** is entered here.

When you are looking at a letter note, click on the 'letter' icon



(Letter) to see the letter text.

If you wish to reprint the letter, click on the 'letter' icon



(Letter) to see the letter text.

## 2. Adding a medical note to a care episode

Find the patient that you wish to add a note and click on the 'care episode' icon

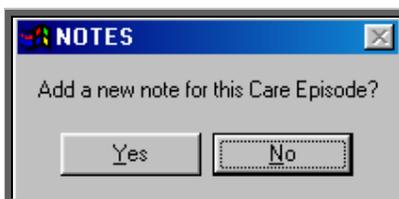


(Goto, Care)

Find the care episode you wish to add a note and click on the 'enter' icon



(Edit, Enter)



Select **Yes** to continue, or **NO** to abandon adding a Note:

You will then be taken to the **Notes** screen where some of the fields will already be filled in for you.

*Hospital No* Hospital No and patient name will be brought through from the patient record.

*Date* Today's date will automatically be entered. You can overtype with another date if required.

*Category* Select a category from the pop-up list (Categories to appear in the pop-up should be set up in **Utilities – Choices – Note Categories**)

A category of ‘dictionary’ has already been set up for you. If you choose this category when adding a note you will be presented with a list of medical conditions (previously set up in **Utilities – Choices – Medical Conditions**) for you to choose from.

A category of ‘video’ has already been set up for you. Choose this category when attaching a video as a Note:

A category of ‘picture’ has already been set up for you. Choose this category when attaching a photograph/picture as a Note:

A category of ‘scanned’ has already been set up for you. Choose this category when attaching a scanned image as a Note:

A category of ‘document’ has already been set up for you. Choose this category when attaching a document (e.g. MS Word document) as a Note:

A category of ‘SOAP’ has already been set up for you. Choose this category if adding a SOAP Note:

A category of ‘temp’ has already been set up for you. Choose this category if adding a note which you may need to edit.

*Episode* The care episode reference number will be brought through from the care episode record.

*Note* Adding a standard Note

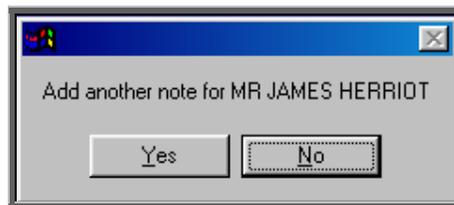
When typing text for the notes, remember that the first line of the note is shown in the list of medical notes on the patient’s screen, so consider making the first line a summary of the content of the Note:

As you type the note and get to the end of the line, the text will scroll onto the next line automatically. There is no need to press **Enter** to go onto the next line, unless you wish to start a new line before the line you are on is full.

Having finished typing the note, check that you are happy with the content. **You cannot edit this note later unless it has been entered as a ‘Temp’ Note:** If there is anything you wish to change, move the cursor with the arrow keys and change the text accordingly. If additional text is added in the body of the note the text will not scroll at the end of the line automatically as it did

initially. However, by pressing **F7** the text will be realigned for you.

When you happy that the note is correct, press **Ctrl-Enter** to finish and save the record. You will be asked if you wish to add another note for the same patient.



Select **No** to return to the main patient screen, or **Yes** if you wish to add another Note:

### Adding a Note using the 'Video' category

In the *Note* field type the file name (including it's extension) and path of the video file you wish to attach as a Note:

### Adding a Note using the 'Picture' category

In the *Note* field type the file name (including it's extension) and path of the picture file you wish to attach as a Note:

### Adding a Note using the 'Scanned' category

In the *Note* field type the file name (including it's extension) and path of the scanned file you wish to attach as a Note:

### Adding a Note using the 'Document' category

In the *Note* field type the file name (including it's extension) and path of the document file you wish to attach as a Note:

### Adding a Note using the 'SOAP' category

Rather than the note text being entered into one *Notes* field, it can be entered over four SOAP note fields (*Subjective*, *Objective*, *Action* and *Plan*).

Selecting this category will jump you past the standard *Note* field and into the *Subjective* field. Once the subjective note has been typed, press the **F4** key to move to the *Objective* field. Continue to do this with each field. Press **Ctrl-Enter** when finished.

In the **Notes** summary table on the **Patient** screen, the first line of the *Notes* field is shown. As this is empty on a SOAP note, a description of SOAP note is entered here.



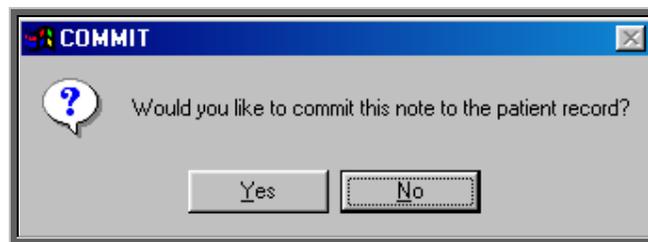
Medical Notes	
Date	Notes
03/04/2008	SOAP note

### Adding a Note using the 'Temp' category

In the *Note* field press **Ctrl-Enter** or **F10** to be taken to the Text Editor. The patient's name and hospital number will already be entered at the top of the text editor, so that if you choose to print the temporary note to be checked later you will know who the note belongs to. (You will want to take this out before you finally commit the Note: This can be done quickly by positioning the cursor on the line you wish to delete and pressing **F8**.)

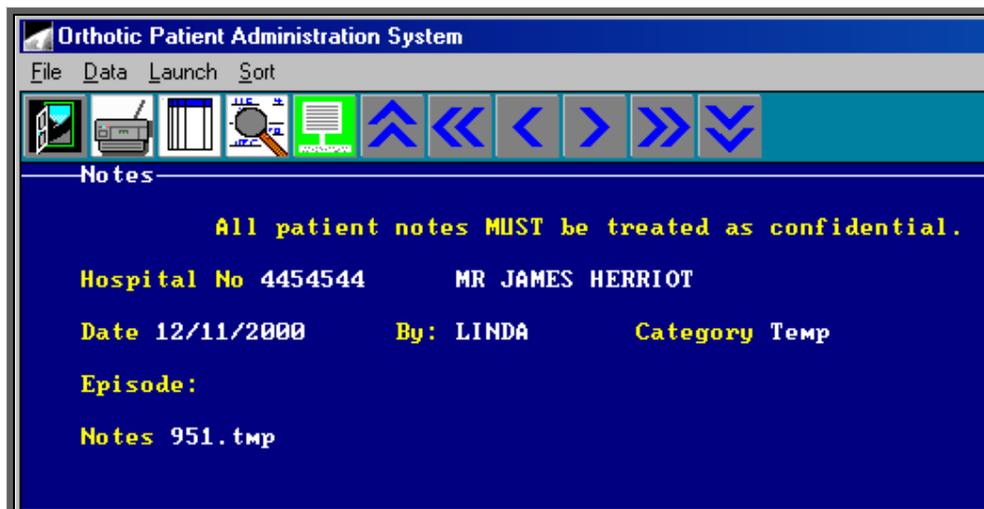
Type in the note, remembering that the first line of the note is shown in the table of medical notes on the patient's screen. Consider making the first line a summary of the content of the Note:

If you wish to print the temporary note press **Alt-P**  
When the note is complete, press **F10** to exit the Text Editor, and you will be given the opportunity to commit the Note:



If you select **Yes**, the text entered in the Text Editor will be copied into the Note field of the note and saved. **You will not be able to edit this note later.**

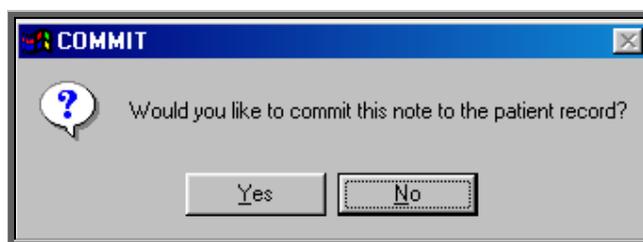
If you select **No**, the information typed in the Text Editor will be allocated a sequential temporary note number and this number will show in the *Note* field.



### Editing a note entered with a 'Temp' category

Find the note you wish to amend (by finding the patient record, clicking on the 'notes' icon  (Goto, Notes). Use the 'arrow' icon  (F6) to find the note you wish to edit).

Click on the 'launch' icon  (Launch) to be taken to the Text Editor. Edit the text accordingly. If you are intending to commit the note you will want to take out the patient's name and hospital number from the top of the text editor. This can be done quickly by positioning the cursor on the line you wish to delete and pressing **F8**. Press **F10** when you have finished, to exit the Text Editor, and you will be given the opportunity to commit the Note:



If you select **Yes**, the text entered in the Text Editor will be copied into the *Note* field of the note and saved. **You will not be able to edit this note again.**

If you select **No**, the changes will be saved against its temporary note number, but the note can still be amended again later. The

note will continue to be available for editing until you commit the note to the patient record (by selecting **Yes** to the above prompt).

### Adding a Note using the 'Letter' category

In the *Note* field press **Ctrl-Enter** to be taken to the Ad hoc letter screen.

**Letter:** Select which of the 26 available letter templates is to be used

**Copies** Select the number of copies required. This will default to 1 but can be overtyped

**para1-para9** Type in the required text in as many of the paragraph sections that are required. Move down the paragraph fields using either the **F4** key or **Down-Arrow** key.

Press **Ctrl-Enter** when finished.

In the **Notes** summary table on the **Patient** screen, the first line of the *Notes* field is shown. As this is empty on a **Letter** note, a description of Ad Hoc letter sent is entered here.

When you are looking at a letter note, click on the 'letter' icon



(**L**etter) to see the letter text.



If you wish to reprint the letter, click on the 'letter' icon (**L**etter) to see the letter text.

## 16. Verifying notes

Verifying notes, gives the Orthotist the opportunity to check notes added by other personnel and mark that they are correct.

Anyone needing to verify notes needs to set up a verification password. This should be different to your log-in password and should be kept secure.

## a) Creating a verification password

Menu: Utilities – Passwords - Verification



If you do not have a verification password (or if you have forgotten it and the OPAS administrator has reset it) type in your log-in password.

Then you will be asked to type in your new verification password.

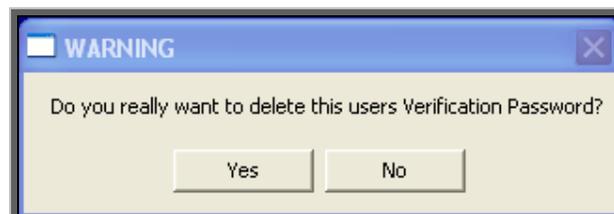


You will be asked to type your new verification password again, before confirming that your password has been stored.

## b) Resetting a verification password

**No one** has the ability to look up a verification password (not even Linda or Martin at Wynnldodge). If somebody forgets their verification password, then a user with administrator access has to reset it so they can go through the steps in (a) again. To reset verification passwords go into **Utilities – Users**. Once you are looking at the

relevant user record, click on the 'cancel verification' icon  (File, Clean\_Up, Verification).



Click on **Yes** to continue.

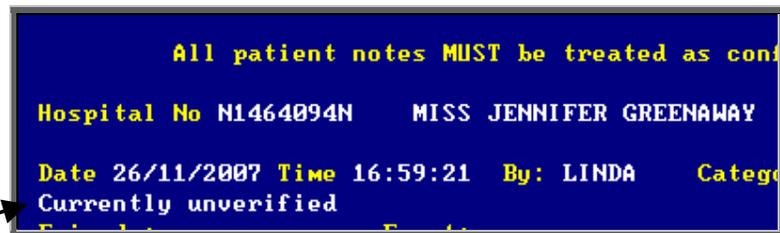
You will then be asked to enter your own password, to confirm that you are the administrator.



### c) Verifying notes

To verify a patient's notes, find the patient record and go to their notes by clicking on

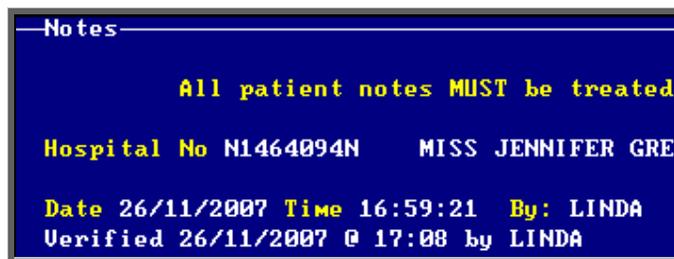
the 'notes' icon  (Goto, Notes).



Any notes that have not been verified will show the message 'Currently unverified' underneath the *Date* of the Note:

To verify the note, click on the 'verify' icon  (Verify). You will be asked to type in your Verification password. As soon as you have typed all the characters of your password, the note will be updated with the date, time and name of the verifier.

There is no need to press the **Enter** key after the password. If you need to press **Enter** then the password is incorrect and the note will remain unverified.



#### d) Adding and Verifying notes

If you are set up with a verification password, when you add a note you will have the option after finishing the note to verify the note straight away.



#### e) Additional information

- Audit notes created by OPAS can not be verified (why would you want to)
- Temporary notes can not be verified until they have been committed

## 17. Printing medical notes

Menu: **Patients**

### 1. Patient demographics

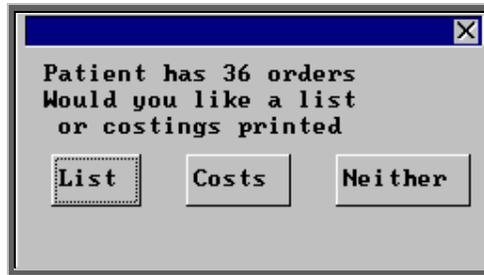


Click on the 'print' icon (File, Print) and select **Patient Information**.

Patient demographics will then be printed, showing the patient's personal details and any notes that have been entered for them. This will include both general notes entered directly against the patient record and those entered against a care episode.

(N.B If you print the Patient demographics from the 'short' **Patient** screen then medical notes will not be included on the print out.)

From this option you will then be asked if you would like details of the patient's orders.



### List

List prints a list of orders for that patient (Order number, Date of order and the general Description for that order).

### Costs

Costs prints a more detailed list of orders for that patient (Order number, Date of order, the detailed Description for the first item on that order and total Cost of the order).

Select which orders report you require or select **Neither** if you do not require details of the patient's orders.

A box will then appear showing how many care episodes the patient has.



If you would like to print a list (showing Referral date, Assessment Date, Fitting date, Discharge date and Objectives for each episode), click on **Yes**. Otherwise select **No**.

## 2. Individual notes

### a) General or care episode notes

Find the note you wish to print (by finding the patient and clicking on the

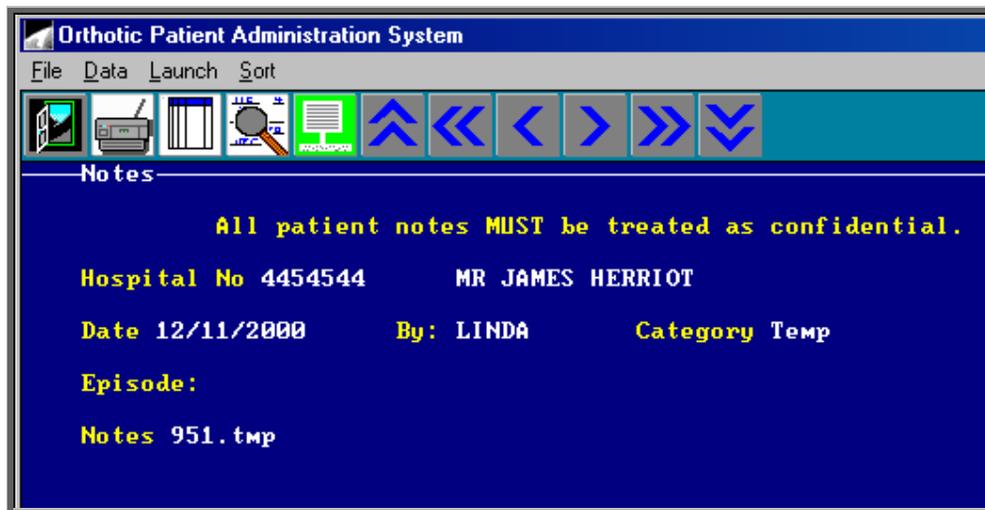
'notes' icon  (Goto, Notes)).

Now click on the 'print' icon  (File, Print).

## b) temporary notes

Find the temporary note you wish to print (by finding the patient and clicking

on the 'notes' icon  (Goto, Notes)).



Click on the 'launch' icon  (Launch) to be taken to the Text Editor.

Press **Alt-P** to print the text.

Press **F10** to exit the Text Editor, and you will be given the opportunity to commit the Note:

If you select **Yes**, the text entered in the Text Editor will be copied into the *Note* field of the note and saved. **You will not then be able to edit this note later.**

## c) Letter notes

Find the letter note you wish to print (by finding the patient and clicking on the

'notes' icon  (Goto, Notes)).

When you are looking at a letter note, click on the 'letter' icon  (Letter) to see the letter text.

If you wish to reprint the letter, click on the 'letter' icon  (Letter) to see the letter text.

## 18. Making an appointment

Appointments can be made from the **Patient** screen. This is an alternative way of making an automatic appointment when there is not an order (e.g. assessment appointment) or if you want to make the appointment before the goods have arrived.

Menu: **Patients**

Find the relevant patient using the 'find' icon  (Data, Find).

Click on the 'next appointment' icon  (Appointment, Next), to load the appointment selection screen below.



Contents of the *Comments* field on the main patient record are shown here in case they are relevant to the appointment being made

The fields below in red **must** be completed. The other fields are optional.

**Clinic** select the clinic venue you wish to make the appointment for (from the pop-up list)

**Clinician** if you have a preference as to which Clinician the patient is seen by then select a Clinician from the pop-up list. If the patient can see any Clinician that has a clinic at the venue selected then leave this field blank by pressing **Esc** to remove the pop-up list, and then press **Enter** to move to the next field.

**Day** if you have a preference as to which day of the week the patient is seen then select a day from the pop-up list. If the patient can attend any day when there is a clinic at the venue selected then leave this field blank by pressing **Esc** to remove the pop-up list, and then press **Enter** to move to the next field.

**AM/PM** if you have a preference as to whether the patient is seen in the morning, afternoon or evening then enter **A** for morning, **P** for afternoon or **E** for evening. If the patient can be seen any time when there is a clinic at the venue selected then press **Enter** to leave this field blank and move to the next field.

This function will only work effectively if your clinic sessions are set up as half-day sessions. All day sessions are classed as AM sessions so you may wish to change any full day sessions you have into two separate sessions (one for the morning and one for the afternoon) so that you can make full use of this functionality.

**New** enter **Y** if the patient is new or **N** if the patient has been seen before.  
Instead of entering **N**, you could further classify the appointment by entering **S** for supply, **F** for fitting, **R** for review or **C** for cast

**Duration** will default to your standard appointment length (as set up in **Utilities – Choices – System**) but can be changed to the length of appointment required.

**From** will default to tomorrows date but can be changed to the date you wish to start looking for available appointments. This is useful when you wish to make a review appointment some time into the future.

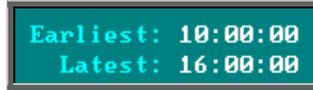
**For** enter the reason for the appointment. This will then be put into the *Notes:* field on the new appointment for you.

The system will now look for the first available slot from the date selected. If the patient already has a future appointment, then you will be shown the existing appointment and asked if it will do, or whether you need to make another appointment.



If you do wish to make another appointment, or if there was no existing appointment for the patient, you will be told the first available appointment based on the criteria entered in the appointment selection screen and also information held on the patient record

On the **Patient** screen, there are two fields that are connected with making appointments.



If times are entered into either or both of these fields, the time of the offered appointment will be restricted accordingly. In the above example, no appointments will be offered before 10am or after 4pm.



The screen behind the message box above will be showing you the session screen for that clinic, so that you can see what appointments have already been made.

When the first available appointment is offered, you initially have 3 options.

- Accept** If you are happy with the first date/time offered click on the Accept button with the mouse (type **A**).
- Later** If you would like an appointment on the date offered but would like it later in the day click on the Later button with the mouse (type **L**). If however, there are no more available appointments on this date you will be offered an appointment on the next date there is availability.
- Next** If the first date found is not suitable and you would like to find the next date there are appointments available, click on the Next button with the mouse (type **N**).

If you wish to abandon finding an appointment press **Esc**

If you select Later and/or Next two more options become available.



**Previous** Click on Previous (type **P**) to go back to the previous date offered.

**First** Click on First (type **F**) to go back to the First date/time that was offered.

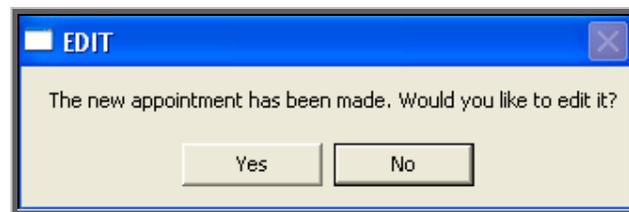
Once you have accepted an appointment date/time you will be asked if the patient requires an appointment letter.



If the patient requires transport, you are reminded to arrange it:



You will then be given the opportunity to edit the appointment.



There are a number of reasons why you may want to do this.

- to allocate a different letter type other than the standard letter
- to add additional information in the comments field
- to add an event

If you do not wish to edit the appointment, click on **No** and you will return to the patient screen. If you do wish to edit the appointment, click on **Yes** to be taken into the appointments screen, where you can make the necessary alterations.

When you have finished editing, press **Ctrl-Enter** to save and return to the patient record.

To learn more about care episodes go to [Section 8 – Appointments](#).

## 19. Amending an appointment

### Finding the Appointment to be Amended

To amend an appointment, you first need to find the appointment you wish to amend. There are three ways to find a specific appointment. These are listed below, with the quickest method first.

1. **Patients.** Find the patient record and then click on the ‘appointment’ icon



(Appointments, Current)

2. **Appointments – Current – Sessions.** Go to the session the appointment



is for and click on the ‘maintain’ icon (Appointments, Maintain).

3. **Appointments – Current – Appointments.** Find the appointment by searching on the patient’s hospital number.



Having found the appointment you wish to amend, click on the ‘update’ icon (Edit, Uppdate).

The following fields may be updated. Those in **red** have a pop-up available. Press **Tab** to access the pop-up, if you need to select an alternate option.

*Duration*

*Advised*

(entering a date in here will stop an appointment letter being printed – taking the date out will enable the letter to be printed again)

*Letter*

*Type*

*New*

*Referral*

*Referrer*

*Purchaser**Notes**Comments**Event**Care Episode**Grade**Priority**Full and Partial**Order**Outcome**Booked*

(entering a date in here will stop the transport memo being printed – taking the date out will enable the memo to be printed again)

*Reminder*

(entering a date in here will stop a reminder letter being printed – taking the date out will enable the letter to be printed again)

**The patient cannot be amended. If you wish to offer the appointment time to another patient, the original appointment should be cancelled, and another one made for the new patient.**

## 20. Cancelling an appointment

### Finding the Appointment to be cancelled

To cancel an appointment, you first need to find the appointment you wish to cancel. There are three ways to find a specific appointment. These are listed below, with the quickest method first.

- a) **Patients.** Find the patient record and then click on the ‘appointment’ icon



(Appointments, Current)

- a) **Appointments – Current – Sessions.** Go to the session the appointment



is for and click on the ‘maintain’ icon (Appointments, Maintain).

- b) **Appointments – Current – Appointments.** Find the appointment by searching on the patient’s hospital number.

## Cancelling the Appointment

1. Having found the appointment you wish to cancel, click on the 'cancel' icon



(C)ancel).

2. You will then be asked to enter the reason for cancelling.
3. Type in the reason (leave blank if you wish to) and click on OK to continue. If you wish to abandon cancelling the appointment, click on **Cancel**.
4. After you have entered the reason for the cancellation, you will be asked whether the Hospital or Patient cancelled the appointment.

- If Patient is selected the *Outcome* field on the appointment will be automatically populated with Could not Attend.
- If Hospital is selected the *Outcome* field on the appointment will be automatically populated with Cancelled by Hospital.

In order for this to work you must ensure that the two outcomes are set up in **Utilities – Choices – Appointment – Appointment Outcome**. The Could not Attend outcome should already exist, but you may need to add a new outcome of Cancelled by Hospital. (For how to add appointment outcomes [see Utilities - Note 2. Choices - Appointment](#))

Once the two outcomes have been defined, they need to be entered into the system parameter screen. Select **Utilities – Choices – System** and press the **Pg-Dn** key. Enter the relevant outcome reference numbers next to the *CNA:* and *CBH:* lines.

Appointment Outcome:	1	Attended
DNA:	2	Did not Attend
CNA:	3	Could Not Attend
CBH:	5	Cancelled by Hospital

5. If transport was required, you will be told so that the arrangements with the ambulance service can be cancelled.



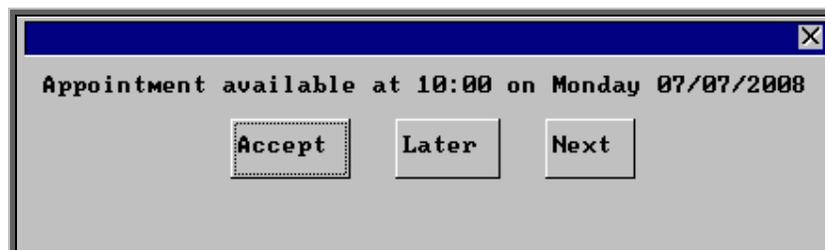
**Warning.** Cancelled appointments cannot be un-cancelled. If an appointment is cancelled by mistake you will need to make the appointment again.

### Making a Replacement Appointment

Once the appointment has been cancelled, you will be asked if you would like to make a new appointment for the patient.



If you select **Yes**, OPAS will search for the next available appointment, looking at appointment dates 7 days before the cancelled appointment or from tomorrow's date (whichever is the later). You will be offered a new date/time that is for the Venue and Clinician that the original appointment was for. If the appointment relates to an order where you specified the day the appointment needed to be on, then only appointments for that day will be offered.



The screen behind the message box above will be showing you the session screen for that clinic, so that you can see what appointments have already been made.

When the first available appointment is offered, you initially have 3 options.

**Accept** If you are happy with the first date/time offered click on the Accept button with the mouse (type **A**).

**Later** If you would like an appointment on the date offered but would like it later in the day click on the Later button with the mouse (type **L**). If however, there are no more available appointments on this date you will be offered an appointment on the next date there is availability.

**Next** If the first date found is not suitable and you would like to find the next date there are appointments available, click on the Next button with the mouse (type **N**).

If you wish to abandon finding an appointment press **Esc**

If you select Later and/or Next two more options become available.



**Previous** Click on Previous (type **P**) to go back to the previous date offered.

**First** Click on First (type **F**) to go back to the First date/time that was offered.

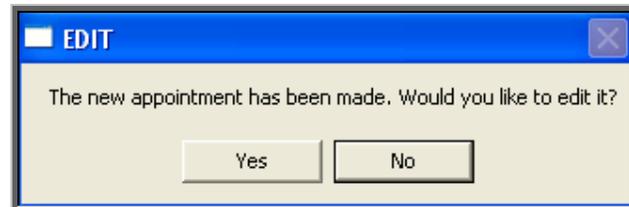
Once you have accepted an appointment date/time you will be asked if the patient requires an appointment letter.



If the patient requires transport, you are reminded to arrange it:



You will then be given the opportunity to edit the appointment.



The appointment information that was entered when the original appointment was created will be copied into the new appointment e.g. Notes, Order number etc

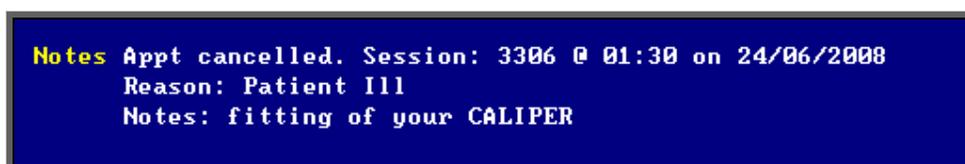
If you do not wish to edit the appointment, click on **NO**. If you do wish to edit the appointment, click on **Yes** to be taken into the appointments screen, where you can make the necessary alterations.

When you have finished editing, press **Ctrl-Enter** to save and return to the appointment that has just been cancelled.

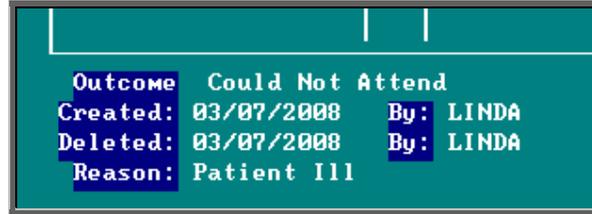
### Recording Cancelled Appointments

When an appointment has been cancelled a note is automatically entered on the patient record giving the details of the cancelled appointment. Looking at the note in

full (clicking on the 'note' icon  (Goto, Notes)) will show why the appointment was cancelled, by whom and the reason for the original appointment.



Also, the appointment that was cancelled will show why the appointment was cancelled.



Also, within the system parameters (**Utilities – Choices – System**) there is an option that can be set to either **Keep** or **Remove** cancelled appointments. If this parameter is set to **Remove**, all references to the cancelled appointment will be removed. The only evidence of the cancelled appointment is the note that is automatically entered on the patient record (see above), and in **Appointments – Current/Archived - Appointments**. If the parameter is set to **Keep**, the cancelled appointment will stay on the session screen and patient record, but will be highlighted in red so that it is clear that it has been cancelled. It will also stay on the clinic list, but marked as cancelled.

Appointments				
Date:	Day	Time:	At:	With:
28/03/2001	Wed	10:00	Appliance Department	Mrs Orthotiste
03/04/2001	Tue	09:30	Appliance Department	Mr Orthotist

However, whether the parameter is set to **Remove** or **Keep**, when an appointment is cancelled, that appointment time becomes available again so that another patient can be offered it. Cancelled appointments will also be taken into the archive when run, so that they can be incorporated into reports.

## 21. Carbon Copies

Carbon Copy gives you the ability to send copies of the appointment letter internally to individuals who need to be notified of the appointment (e.g. a physiotherapist involved with the patient's care, or an interpreter who needs to be in attendance), by adding them as a contact on the **Patient** record.

### a) Setting up the contacts who may need to be copied on a letter

Menu: **Utilities – Choices – Contacts**.

To add a new **Contact** click on the 'enter' icon  (Edit, Enter)

To update an existing **Contact**, find the **Contact** you wish to change and click on the 'update' icon  (Edit, Udate).

*Reference*            *Reference* is entered automatically

*Name*                enter the contacts name

*Position*            enter their position/job title e.g. Physiotherapist

*Location*            enter the department where they work e.g. Rehabilitation

*Add1*                4 additional address lines are available for those contacts that  
*Add2*                are external  
*Add3*  
*Add4*

Press **Ctrl-Enter** when you have finished entering the names you require. You can come back to this screen at any time to add additional names as they arise.

## b) Adding contacts to the patient record

Menu: **Patients**

Find the relevant patient.

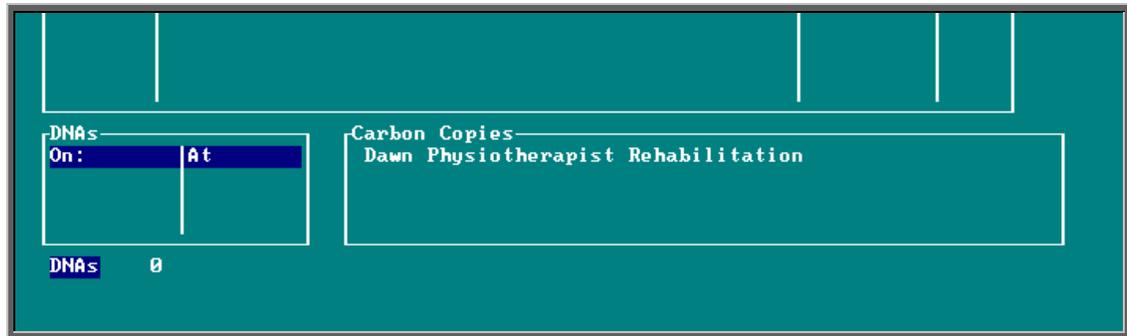
Click on the 'enter' icon  (Edit, Enter)

Click on **Carboncopy** (type **C**)

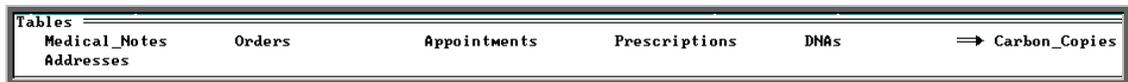
You will be shown the names you have previously set up in **Utilities – Choices – Contacts**. Highlight the name required and press **Enter** (double click with the mouse on the required name).

You will then be asked if you wish to add another carbon copy recipient. If you do, click on **Yes** and continue as above. Once you have added all the recipients you wish to, then select **No** and you will return to the **Patient** screen.

To see which names have been added to a patient, page down the screen where you will find a **Carbon Copies** table underneath **Prescriptions**.



This table is only a summary and will only show up to three names. If you believe there may be more names that you wish to see then press **Alt-T** to see a list of tables available and select **Carbon\_Copies**.



Then use **PgDn** and **PgUp** to scroll up and down the table.

To return to the main screen press **Alt-R**, or click anywhere on the screen (where there is not a table) with the mouse.

### c) Deleting contacts from a patient record

Menu: **Patients**

Find the relevant patient.

Click on **Goto - Copies** at the top of the patient screen to look at the contents of the Carbon Copy table. If there is more than one contact assigned to the patient,

use the 'arrow' icon  (**F6**) to find the contact you wish to delete. Then

click on the 'delete' icon  (**Edit, Delete**).

### d) Adding the Carbon Copy field to your appointment letters

Menu: **Utilities – Choices – Letters**.

Find the appointment letter(s) that you use by paging down the list of letters. (Most of you will be using LETTERA) Note: the list is in alphabetical order of *Short Name*.

Once you have highlighted the relevant letter click on the ‘paper and pencil’

icon  (WP) to see the letter. Then click on the ‘four coloured squares’

icon  (Wordprocessor) to be able to edit the letter.

Move to the bottom of the letter using the arrow keys or page down, and add the carbon copy field as follows.

CC {{+cc}} (will give you the contact name)

CC {{+cc}}- {{pos}} (will give you the contact name and position)

CC {{+cc}}- {{pos}} - {{loc}} (will give you the contact name, position and location)

CC {{+cc}}- {{pos}} - {{loc}}  
 {{+ccadd1}} (will give you the contact name, position,  
 location and address details)  
 {{+ccadd2}}  
 {{+ccadd3}}  
 {{+ccadd4}}

To type the opening squiggly brackets press **Ctrl-J**.

To type the closing squiggly brackets press **Ctrl-K**.

To come out of the letter once you have finished, click on the ‘exit’ icon



(File, Exit), and then click on the ‘exit with a question mark’ icon  (Return). You will be asked if you wish to save the current document. If you are happy with the changes that you have made then choose Yes. If you want to leave the letter as it was when you first opened it then choose No.

When you print your appointment letters, having gone through the steps above, additional copies of the letter will automatically be printed for each carbon copy recipient, with their name printed at the foot of the copy that is for them. i.e. if a patient has 2 carbon copy recipients on his patient record (e.g. Dr Smith and Nurse Jones) then when appointment letters are printed you will get one copy as usual for the patient, one copy with CC Dr Smith at the foot of the letter and another copy with CC Nurse Jones at the foot of the letter.

This functionality will also apply to DNA letters if you apply step (d) to your DNA letters.

## 22. This

Menu: Patients

There are occasions when you would want to send a preset letter to just one patient.

Clicking on the 'isolate' icon  (This, Isolate) isolates the patient that you are looking at, so that when you request a letter it will only be produced for 'this' one patient.

To get all your patient records back when you have finished, either click on the

- 'unisolate' icon  (This, Unisolate)
- or
- click on the 'ABC' icon  (Sort, Physical)

### Bookmarking

You can manually bookmark a patient at any time by clicking on This, Bookmark at the top of the **Patient** screen.

When you want to find a patient that you know you have worked on earlier, click on

the 'back' icon  (Goto, Bookmark), and you will be presented with a list of patients that you have dealt with and/or manually bookmarked since you logged on .

## 23. Sending patient letters

Menu: Patients

Letters can be produced from the **Patients** screen using either pre-defined templates or creating one-off letters with personalised text.

## a) Using pre-defined templates

While you are in the **Patients** screen, you have the ability to send a preset letter (26 different Patient letters can be set up – [see Utilities - Note 23. Choices - Letters](#)) to the patient or their referrer. To do this find the patient that requires a letter and:

Click on the ‘print’ icon  (File, Print)

Select **Letter** from the print menu

Highlight the PATLET you wish to produce from the list provided

Select the number of copies required

Highlight **Yes** to continue and press **Enter**

## b) Creating one-off letters

The note category of **Letter** gives you the ability to send ad hoc (one off) letters to patients or their referrer/GP.

To create an ad hoc letter find the patient that the letter is regarding and click

on the ‘enter’ icon  (Edit, Enter) and select **Notes**.

**Date**                    enter the date to appear on the letter (this field will default to today’s date)

**Category**            select **Letter** from the pop-up

**Notes**                    leave the *Notes* field blank and press **Ctrl-Enter**.

You will then be taken to the Ad Hoc letter screen.

**Letter:**                    Select which of the 26 available letter templates is to be used

**Copies**                    Select the number of copies required. This will default to 1 but can be overtyped

**para1-para9**            Type in the required text in as many of the paragraph sections that are required. Move down the paragraph fields using either the **F4** key or **Down-Arrow** key.

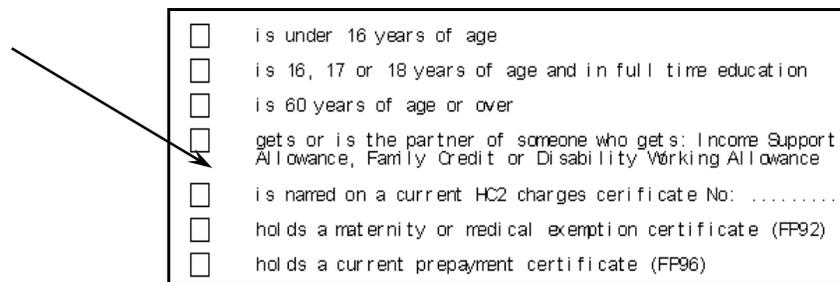
Press **Ctrl-Enter** when finished.

Whichever way a letter is produced, a log of its creation will be entered into the patient's letter log (Goto, Letters).

## 24. Printing HSA5/WF1 Forms

HSA5 (Supply of Drugs and Elastic Hosiery to NHS Hospital Outpatients) and WF1 (Supply of Wigs and Fabric Supports to NHS Hospital Outpatients) forms can be printed from OPAS automatically inserting the patient's details.

In order for the form to be able to print the tick boxes on the form you need a font called



A screenshot of a form with seven tick boxes. An arrow points to the fourth box. The text next to the boxes is as follows:

- is under 16 years of age
- is 16, 17 or 18 years of age and in full time education
- is 60 years of age or over
- gets or is the partner of someone who gets: Income Support, Allowance, Family Credit or Disability Working Allowance
- is named on a current HC2 charges certificate No: .....
- holds a maternity or medical exemption certificate (FP92)
- holds a current prepayment certificate (FP96)

Webdings. If you print the form and get a 'c' where you would expect to see the box, then you have not currently got Webdings on your computer.

In case you haven't, we have included the font in OPAS and it can be found in q:\opas\font\webdings.ttf. Ask your IT department to copy the font into the location that fonts are held on your computer.

### Menu: Patients

Find the patient you wish to produce a HSA5 or WF1 form for.



Click on the 'isolate' icon (This, Isolate) at the top of the screen. If you do not isolate the patient first, OPAS will think you want to send the letter/form to all your patients. Don't worry, there is a safety net in the System parameter screen to set the maximum number of patients allowed on a mail merge and if you did forget to isolate the patient, you would get the following message.



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

Select **Letter**

Highlight the form you wish to produce from the list provided

Select the number of copies required

Highlight **Yes** to continue and press **Enter**

Once you have completed the merge you will be taken back to the patient record.

To be able to see all the patient records again click on the 'unisolate' icon  (This, Unisolate).

At any time you can look at the patient's letter log, to find what letters have been sent and when. Simply click on Goto, Letters at the top of the **Patient** screen.

Date	Filename	Hospital No	description
25/11/2007	WF1	NG54367	Wig letter
23/11/2007	LETTERA	NG54367	Appointment letter type A

## 25. Paslink

If the hospital has bought some additional software from Wynnldodge Limited called Paslink, this option can be used for downloading patient information from the main

hospital database. The option can be selected by clicking on the 'paslink' icon  (Paslink). As hospital databases vary, the instructions for using Paslink are site specific and individual instructions will be provided to those hospitals using this.

## 26. GP

Menu: Patients

By clicking on the 'GP' icon  (Goto, GP) you will be taken to a screen which will show the full details of the GP that has been entered on the patient's record that you are looking at. This will include information about which Practice he works at and which PCG the Practice belongs to.

While you are in the GP screen, you have the ability to send a preset letter (26 different GP letters can be set up – [see Utilities - Note 23. Choices - Letters](#)) to the GP regarding the patient whose record you are in. To do this,

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

Select **Letter** from the print menu

Highlight the GPLET you wish to produce from the list provided

Select the number of copies required

Highlight **Yes** to continue and press **Enter**

## 27. Mobility

If you wish to use OPAS to keep track of wheelchairs, contact Wynnlogde for more details of this option.

## 28. Dormant patients

Menu: Patients

The Dormant option is a facility to find patients that have not had any orders or appointments for a while. It will look for all the patients that have had orders/appointments that are dated earlier than the dormant period, and those who have never had an order/appointment and the patient was entered onto OPAS before the dormant period.

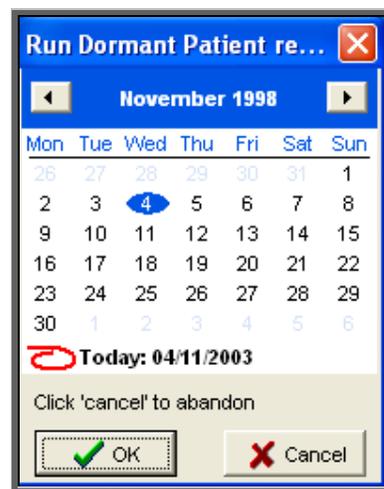
e.g. If your dormant period is set to 3 years and you run dormant patients on the 1 September 2000 it will find all the patients whose last order/appointment was before 1 Sep 1997 **and** those patients that were entered (and therefore have a registered date) before 1 Sep 1997 that have had no orders at all.

Within the system parameters you can show the number of years you classify as a dormant period. (When OPAS is installed this is set to 5 years but you can change this by going into **Utilities – Choices – System** (see [Utilities - Note 24. Choices - System](#))

The dormant patients option should be run regularly (e.g. annually), once you have been using OPAS for several years, in order to clear out old patients.

To run the Dormant option click on the 'dormant patients' icon  (Dormant).

A calendar in the middle of the screen will inform you of the start date of your dormant period.



To abandon the Dormant option click on Cancel

If you wish to change the start date, overtype with an alternate date. However, if you change the date to a more recent date, you will be shown which patients fall into that criteria but you will not have the ability to mark those patients found for archiving.

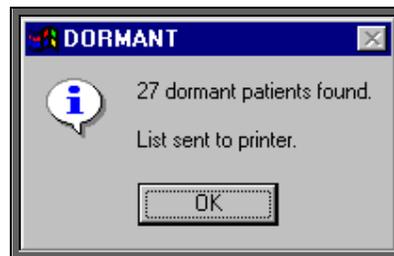
Click on OK.

One of three possible outcomes will then occur.

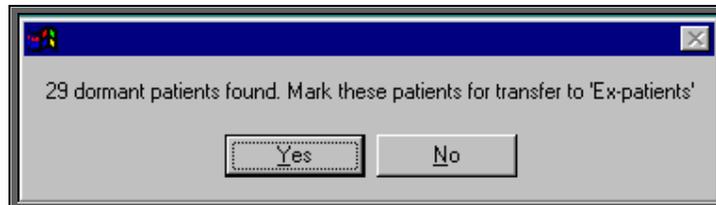
1. If all your patients have had orders within the dormant period the following message will appear.



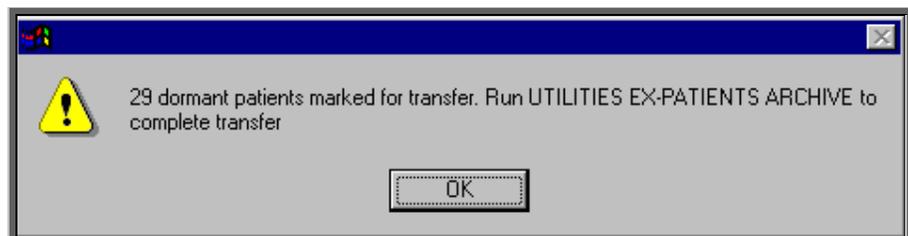
2. If you overtype the start date and patients are found that have not had orders between then and today, a list of these patients will be printed.



3. If you leave the start date as the true dormant period and patients that have not had orders in that period are found, a list will be printed, and you will be asked if you wish to mark the patients found for transfer to **Ex-Patients**. (It does this by marking the patient record as deleted)



- Look at the report produced and decide whether you would like them all to be marked for transfer.
- If you do, then click on the **Yes** button (type **Y**) and those patients will be marked as deleted.



- If you would like to transfer the majority of them, then click on the **Yes** button (type **Y**) and then undelete those patients you do not want to transfer

by clicking on the 'delete' icon  (Edit, Delete) for each patient you do not wish to transfer.

- If you would like to transfer just some of the patients listed, then click on the No button (type **N**). Then mark those patients you do want to transfer

by clicking on the 'delete' icon  (Edit, Delete) for each patient you wish to transfer.

Below is an example of the dormant report, which shows the date of the last order and appointment for each patient, or informs you if they haven't had an appointment and/or order.

Dormant patients report printed 05/07/2008 No activity since 05/07/2003				
Hospital No	Name	Last Order	Last Appt	
1442400	MR ROGER MCCORMICK	NO ORDERS	NO APPTS	
G0612265	MH FRUITHOF	NO ORDERS	NO APPTS	
G1621310	JC PARKES	NO ORDERS	NO APPTS	
N00361807	AARON JONES	NO ORDERS	30/04/2001	
N03/00000	KING	NO ORDERS	NO APPTS	
N03/KING	KING	NO ORDERS	NO APPTS	
N1134939	MRS ANGIE WATTERSON	NO ORDERS	NO APPTS	
N123456789	TESSA YOUNG	NO ORDERS	NO APPTS	
N123EWQ432	TESSA YOUNG	29/09/2000	NO APPTS	
N3243423	MRS JANE BERRY	NO ORDERS	NO APPTS	
N34532532432	MRS JILLY COOPERT	06/10/2000	16/10/2000	
N345689098	DR JAMES BROWN	04/08/2000	14/08/2000	
N353523423	MR JAMIE OLIVER SMITH	NO ORDERS	NO APPTS	
N4544	MRS SUSAN NICHOLSON	19/07/2000	11/09/2000	

To move the deleted patients from the active **Patient** area to **Ex-Patients** you need to run **Utilities – Ex-Patients – Archive**.

**Note:** Depending on the size of your patient database and the speed of your network, this may take quite a considerable time to run. You may wish to set

this running overnight, but if you do, please ensure that the PC doing the archive will not get switched off accidentally. It is strongly advised that you take a back up before running this option and you **MUST** be the only person logged on to OPAS.

See [Utilities - Note 26. Ex-patients](#) for more details on Ex-Patients and archiving.