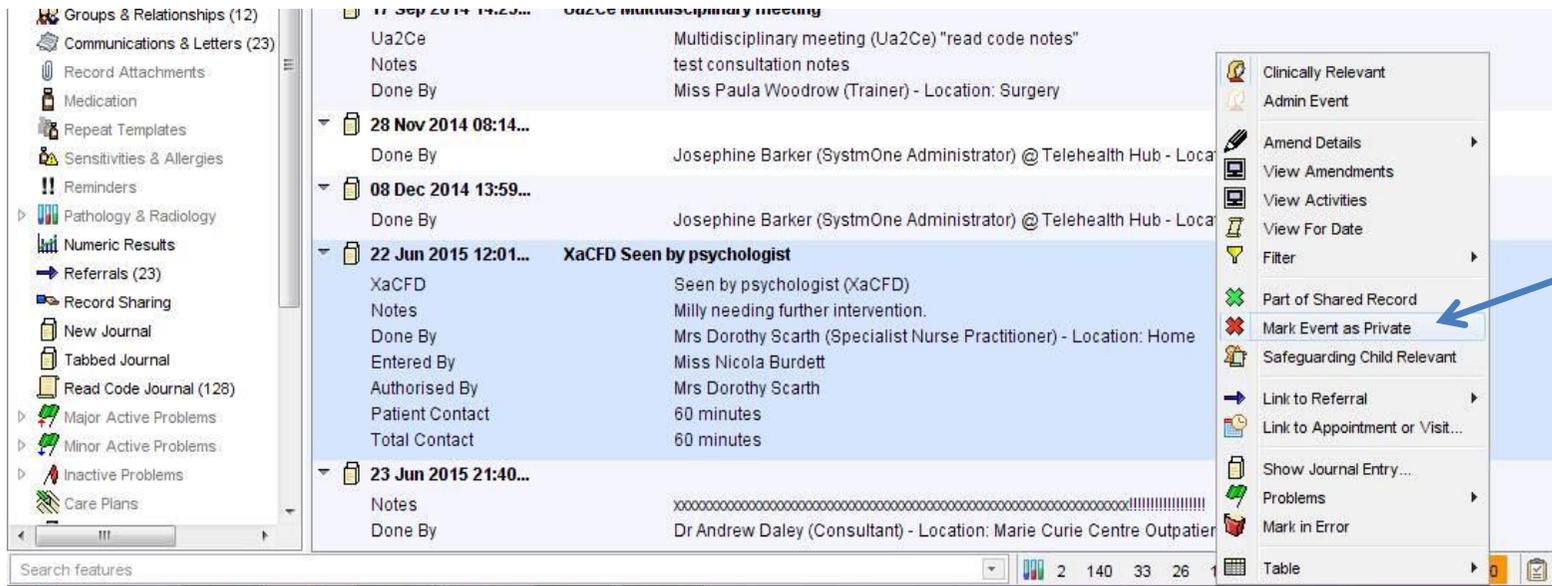
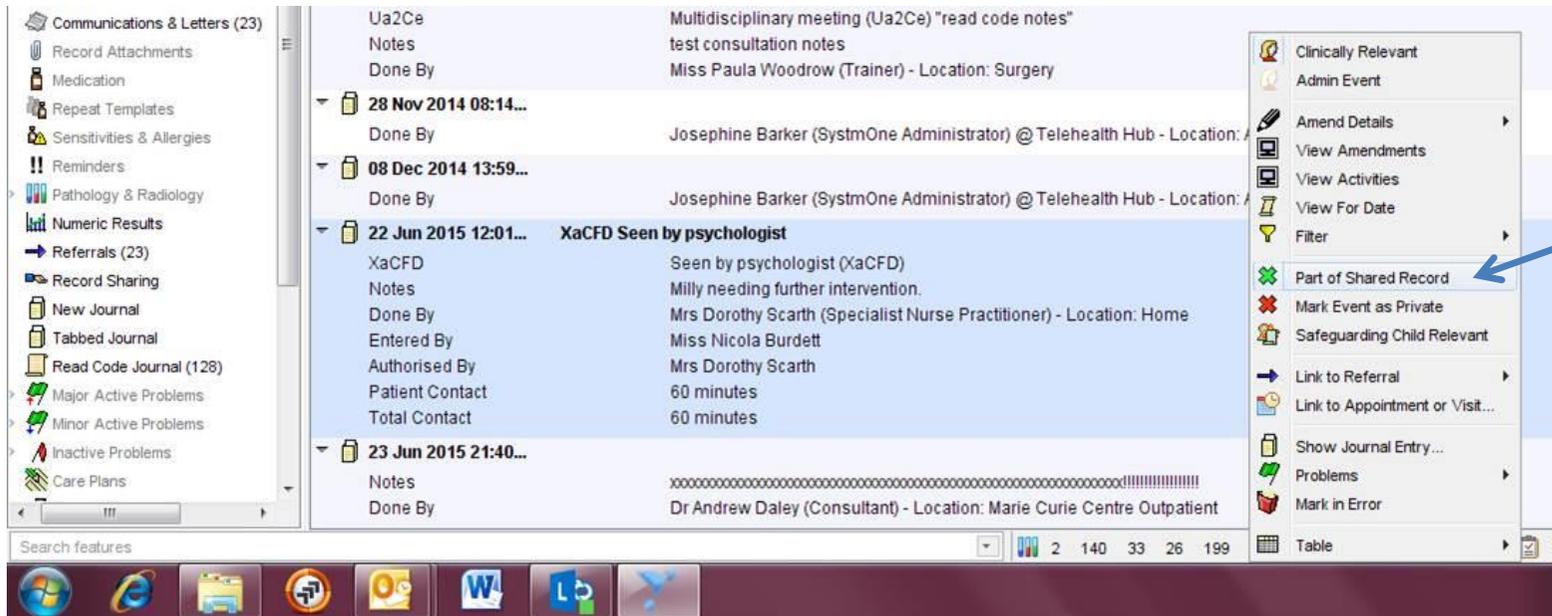


Registering Carers on SystemOne

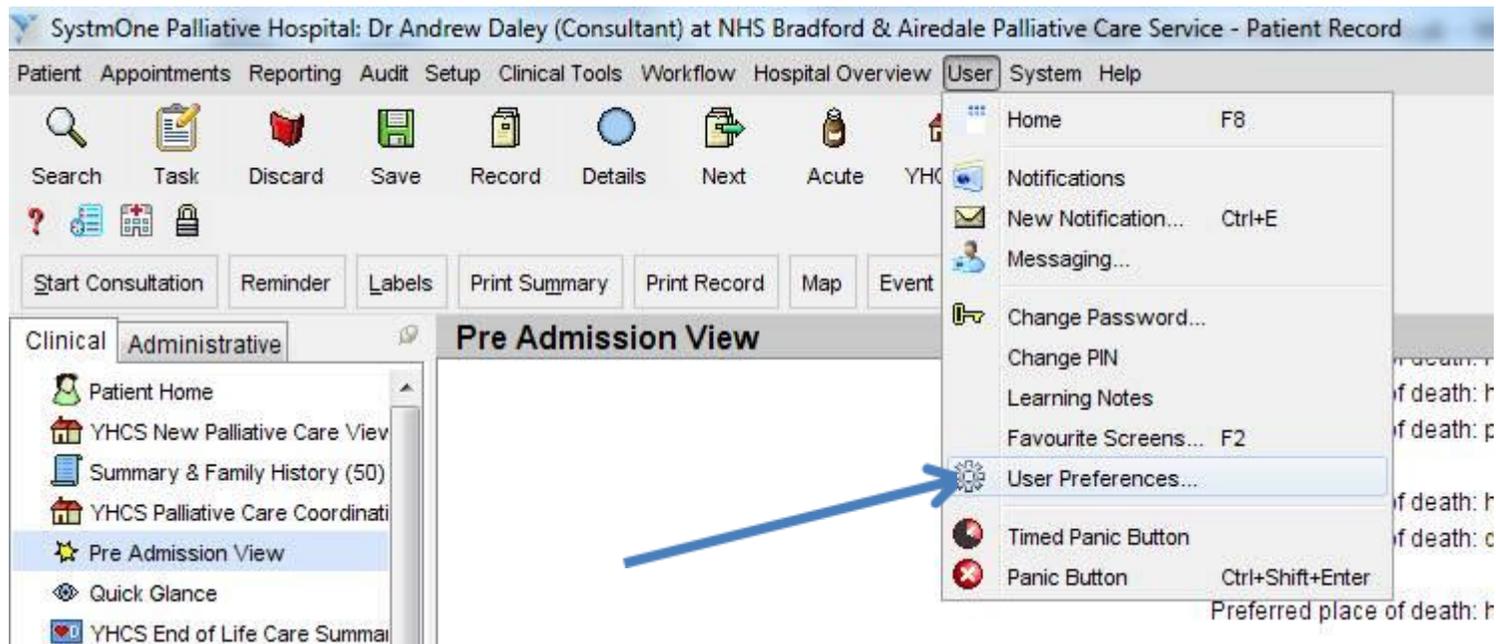
1. In order to register a carer, it is necessary to know the name and DOB of the person. The default position should be to share notes to GP and other services (assuming the person consents) but we do **not** request a share of the GP record unless the carer specifically wants this or there is a particular reason to request consent.
2. When creating the referral, select 'Bereavement Care' as the Service Offered, even if the patient is still alive and it is 'pre-bereavement work'. It's also important to ensure the referral is added to a caseload so that we can ascribe and report the activity accurately
3. Any consultation can be 'marked private'. This means it can be seen by **all** users in our pall care unit, but no one else. To do this, right click the consultation and select 'Mark Event as Private'. If required, this setting can be reversed for a particular consultation at any future time by right clicking it again and selecting 'Part of Shared Record'. See these two screenshots:



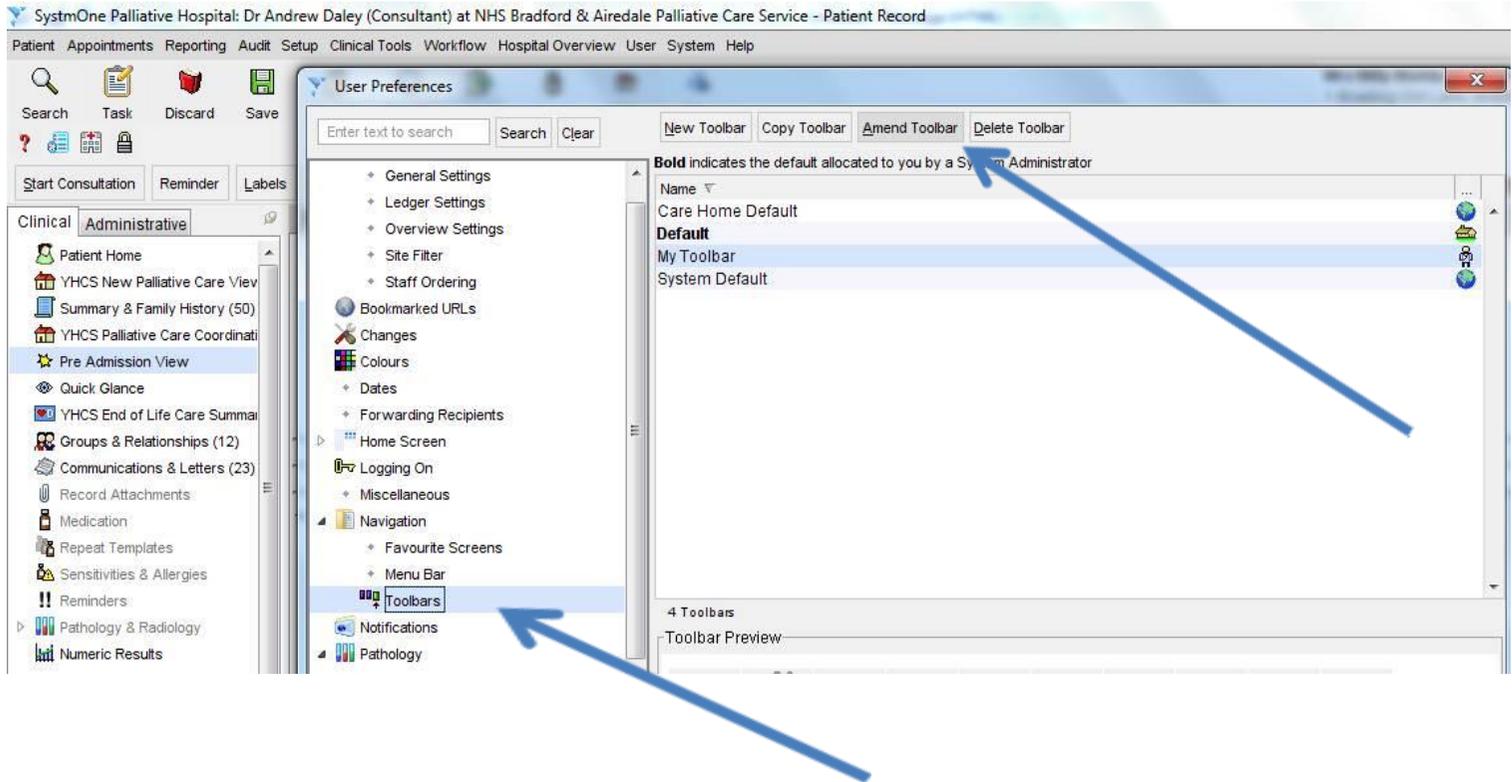


- Confidential notes. These are notes which **only the person recording them** can see. To record them, it's necessary for an individual staff member to be logged on and to add the necessary control button to their screen. This is a one-off procedure, but it is a bit fiddly. The sequence of screenshots below show how to do it:

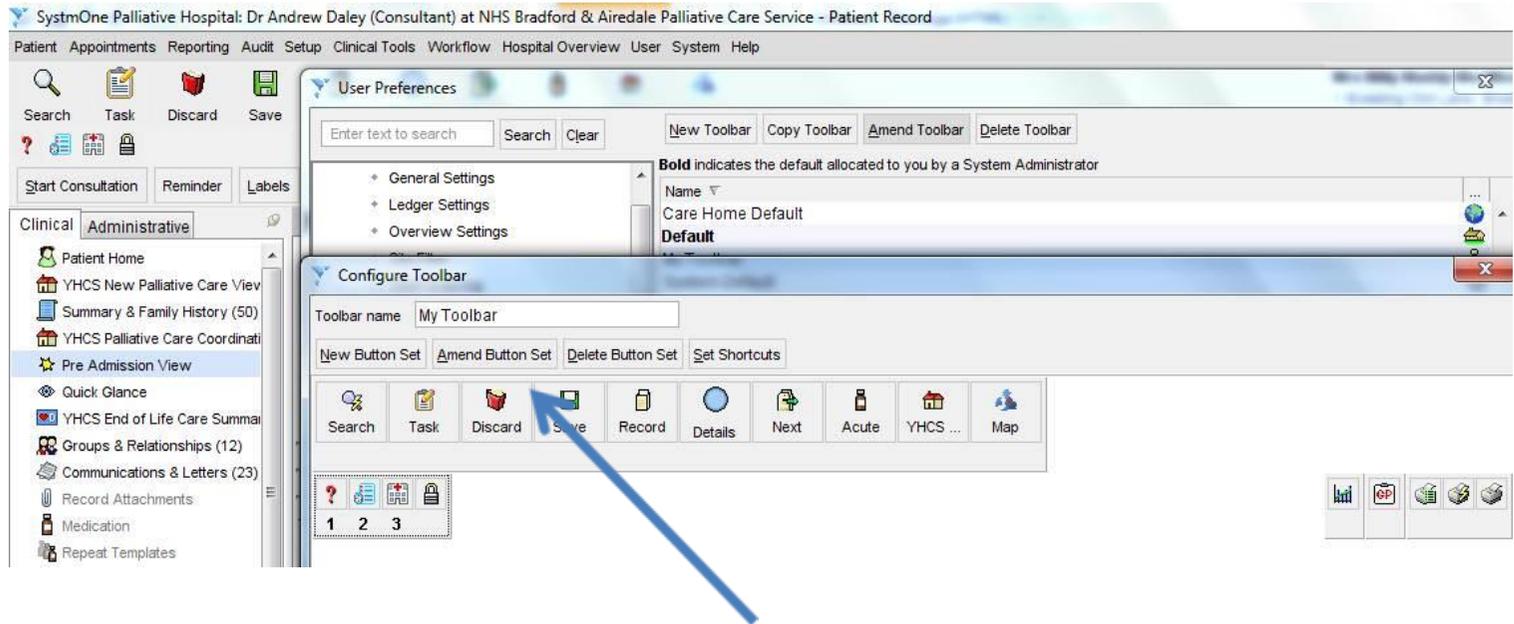
Go to **User menu > User Preferences:**



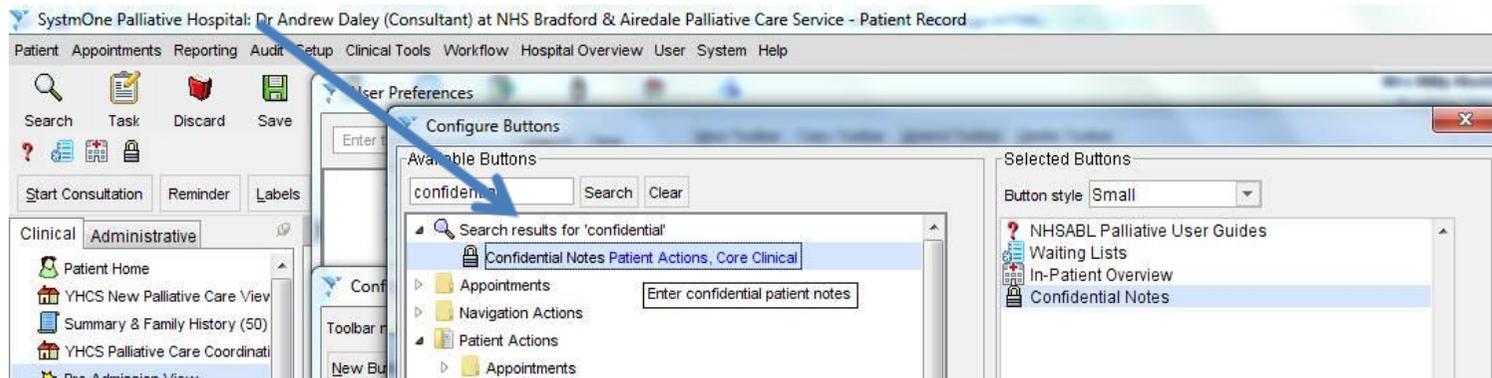
Click Amend Toolbar. Then select Toolbars under Navigation on the tree:



Click Amend Button Set:



Type confidential into search window, then 'Enter'. Double click on 'Confidential notes' and the padlock icon gets added to the buttons available:



The screenshot shows the SystmOne Palliative Hospital interface. At the top, there's a navigation bar with options like Patient, Appointments, Reporting, Audit, Setup, Clinical Tools, Workflow, Hospital Overview, User, System, and Help. Below this is a toolbar with icons for Search, Task, Discard, Save, Record, Details, Next, Acute, YHCS, and Map. A blue arrow points to the 'Discard' icon. The main area is titled 'New Journal' and shows a list of journal entries for Mrs Milly. A 'Confidential Notes' dialog box is open, displaying a warning message. The journal entries include dates and times, with some entries marked as 'Confidential Notes' in red text. A blue arrow points to the 'New Journal' option in the left-hand menu.

To enter confidential notes, click the padlock icon and type notes **directly** into the window which opens (see above). **Importantly, it doesn't appear possible to mark notes 'confidential' retrospectively. It also doesn't appear possible to make them public again in the future.**

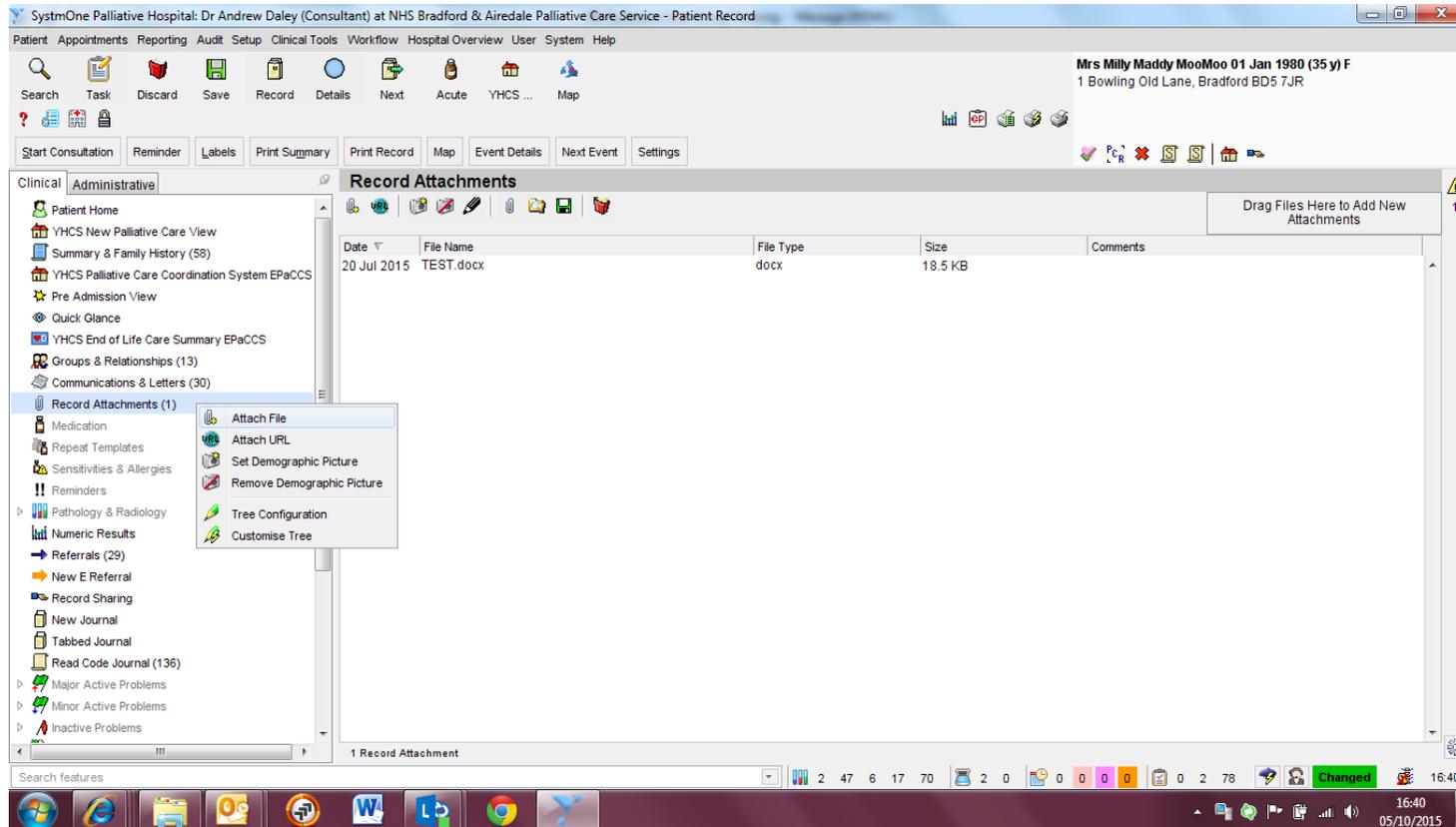
Confidential notes permanently appear in red when the person recording them views the New Journal or Tabbed Journal (see above). They don't appear at all to anyone else. And strangely, **they don't appear at all on our normal Palliative Care view, not even to the user who has recorded them.**

If **the recording user** prints out the New Journal or Tabbed Journal, their confidential notes are included in the Word document which is generated – it would be easy to delete these rows if required. If anyone else prints the record, the confidential notes won't appear.

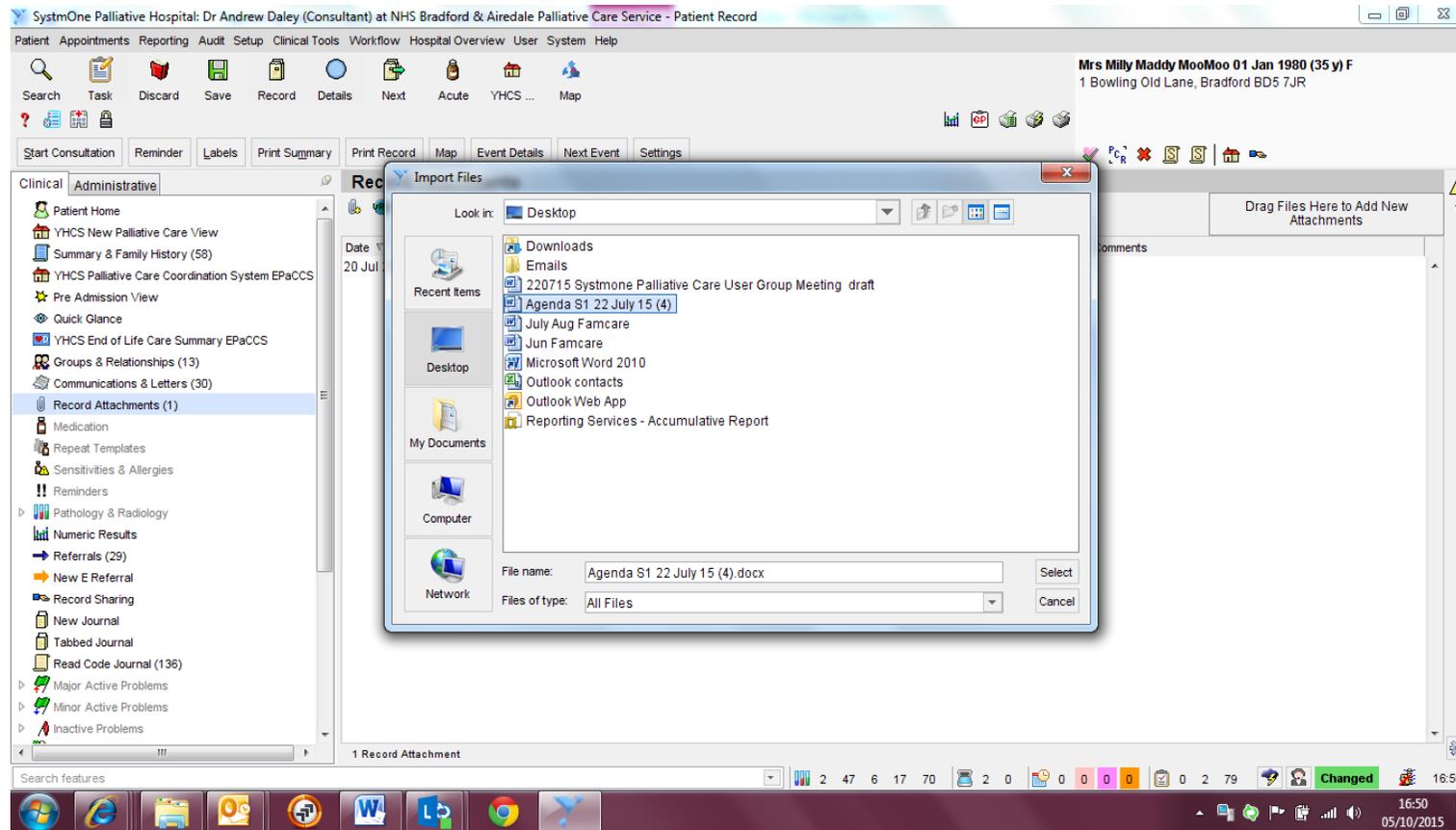
5. Attaching a Word document to a patient record.

Some services elsewhere have agreed that a group of their staff (eg psychologists) write notes in a password protected Word document which is then attached to the record. Access to the notes is then restricted to staff who are provided with the password.

To attach a Word document to a patient record, Right click on 'Record Attachments' and select 'Attach File'



Browse to the location of the file and click 'Select':



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