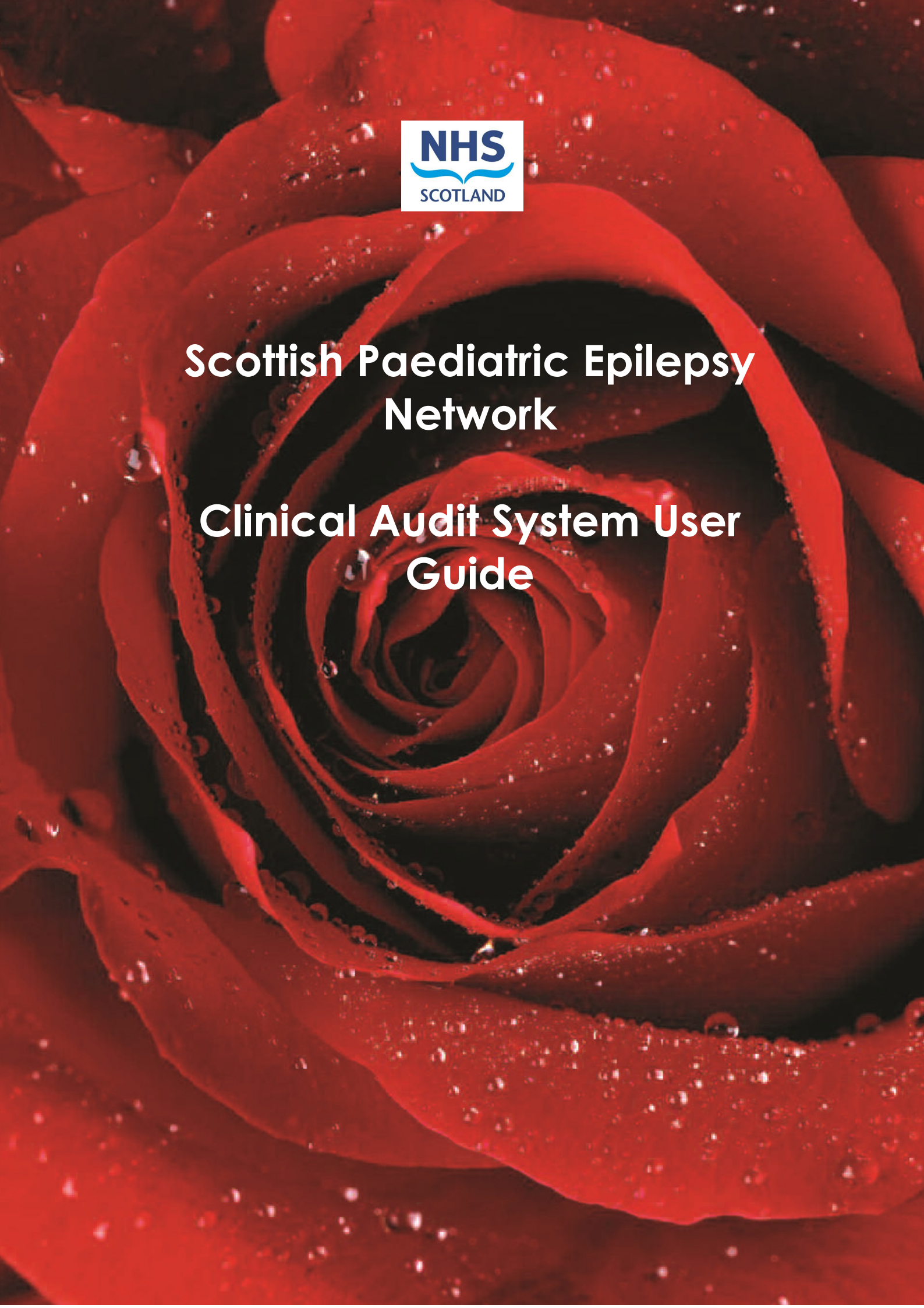


Scottish Paediatric Epilepsy Network

Clinical Audit System User Guide

Contents

SPEN Clinical Audit System

Reporting issues

It is very important to report all issues that you are having with the system so that they can be taken forward with the appropriate groups. Please let us know about anything that is causing you difficulties, even if it seems minor.
Please report any issues/ problems using this system to either:

- James Thom, Data Manager – 0141 232 1850 (81850), james.thom@ggc.scot.nhs.uk
- Karyn Robertson, Network Manager – 0141 201 0704 (80704), Karyn.robertson@nhs.net

How to record new patients with epilepsy on the Clinical Audit System

Informing the patient

If you see a new patient with epilepsy to be recorded on the clinical audit system, you should give them the leaflet "SPEN Clinical Audit System, Patient and Family Information Leaflet". If the patient/ parent does **not** want their information to be included, they should be given the Opt Out Form. Once completed a copy of the opt out form should be kept in the case notes and a copy sent to Karyn Robertson, Network Manager, SPEN, RHSC, Dalnair Street, Glasgow, G3 8SJ.

Accessing the System

If you have seen a new patient with epilepsy they should be recorded on the clinical audit system. If you have been trained and have a login for the system you can access it by:

- Going to the webpage www.mcn-cas.scot.nhs.uk
- Select Epilepsy on the Network Selection menu
- Click the box for Epilepsy Instance

This will take you to the login screen.
Enter your username (usually this will be your first initial and your surname) and password.

If you have not been trained and do not have a login, please let Margaret Wilson or Sameer Zuberi know about the patient. If you think you should have access to the system, please complete the authorisation form and return to Karyn Robertson, Network Manager, SPEN, RHSC, Dalnair Street, Glasgow, G3 8SJ.

Password

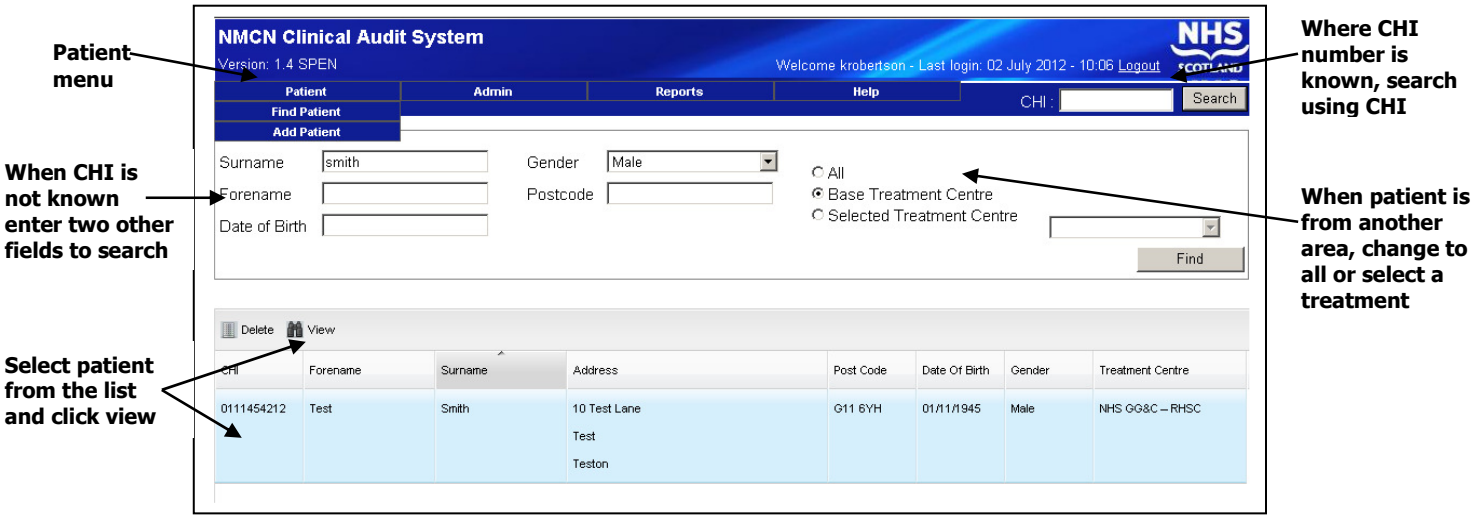
If you do not remember your password you can click on the Forgotten password link underneath the log-in boxes. The system will ask for your username and the answer to the security question you have set up. Once you have submitted these a new password will be sent to the e-mail address registered for you in the system. To return to the log-in screen click on the login link in the top right hand corner of the screen. You can then use the temporary password that has been e-mailed to you to login. The system will ask you to select a new password. Once you have successfully submitted a new password use the menu bar at the top to navigate the system.

If you have tried unsuccessfully to login three times your account will be locked. To unlock your account you can contact James or the NISG helpdesk (0141 282 2100).

Adding a Patient

- Select Add Patient from the Patient menu in the top left hand corner.
- Enter the patient's CHI Number in the appropriate box and click on the Import link
- This will bring up the patient's details from SCI Store
- If these are correct, click Add to populate the patient's demographics

Recording information about a patient



- To find a patient's record, select Find Patient from the patient menu in the top left hand corner.
- Enter either the CHI Number and click on Search or, if not known, two alternative fields in the Search Parameters box and click on Find. The system will check your base centre unless you change the treatment centre to all
- If you are using the fields in the Search Parameters box to find the patient, the system will show a list of all patients that match the search criteria. Select the appropriate patient and click on the View button at the top of the list.
- You will now see the patient's demographic details and along the top there are links to the other screens:
  - Demographics
  - Referrals
  - Conditions
  - Comorbidities
  - Encounters
  - Results
  - Medications
  - Interventions
  - Family History
  - Core Dataset
- Select the appropriate screen and click on Add. Enter the appropriate data and then click on Save.

- Any fields that have a yellow background are mandatory and must be completed to allow you to save the information on that page.

Data to be entered for new patients

The key information that should be entered for new patients is:

- Demographics – populated from SCI Store as described above
- Referrals – details of the referral should be recorded. All fields with a yellow background must be completed.
- Conditions – condition details should be recorded.
- Encounter – details of the current encounter should be added. All fields with a yellow background must be completed.

Information can be added into other screens if desired.

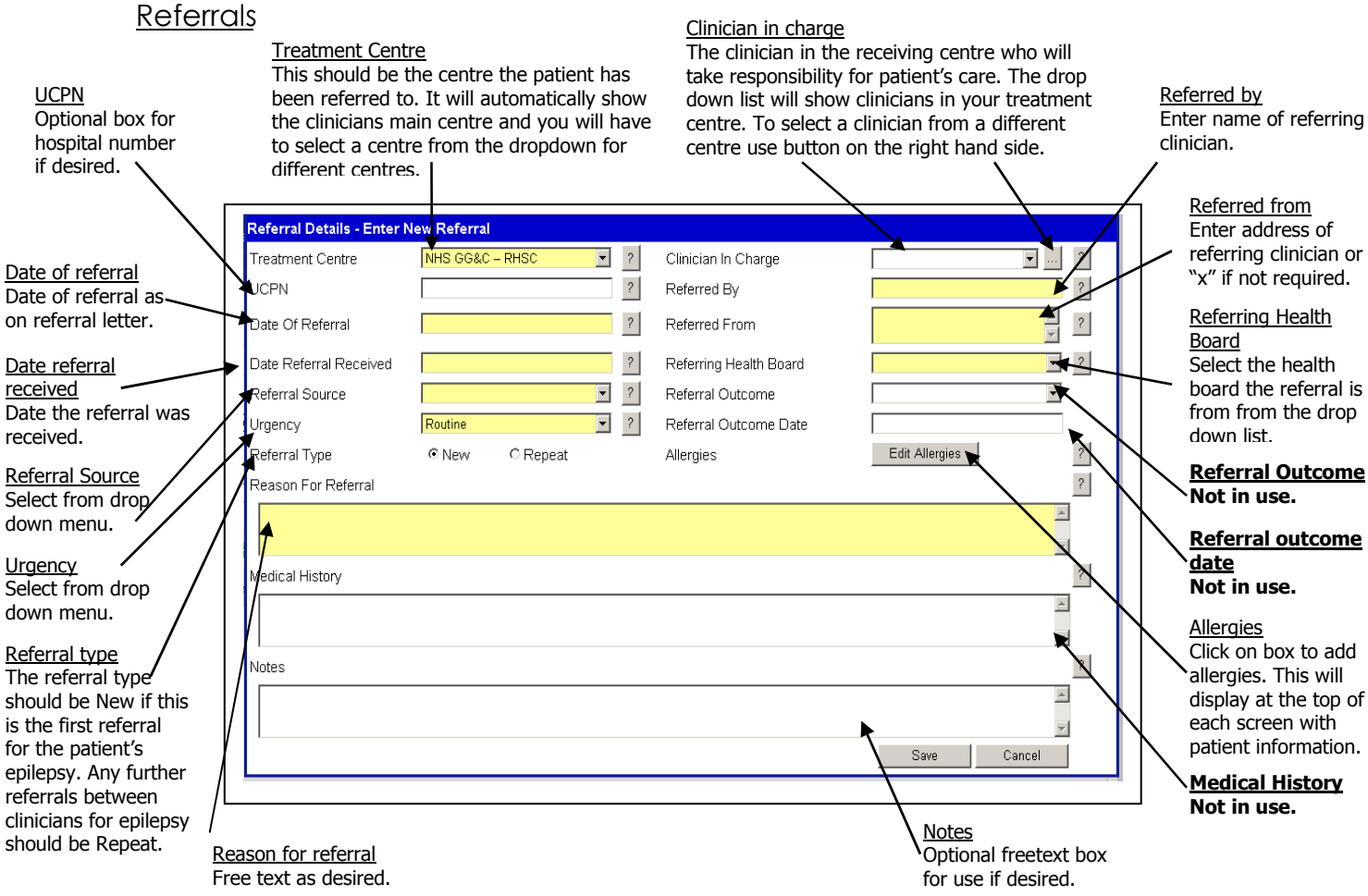
Subsequent data entry

Once patients' have been entered onto the CAS system, the Encounter screen should be completed at each further contact. Other screens can be updated as appropriate.

Entering the data

This section provides reference information on what data to record on each screen.

Referrals

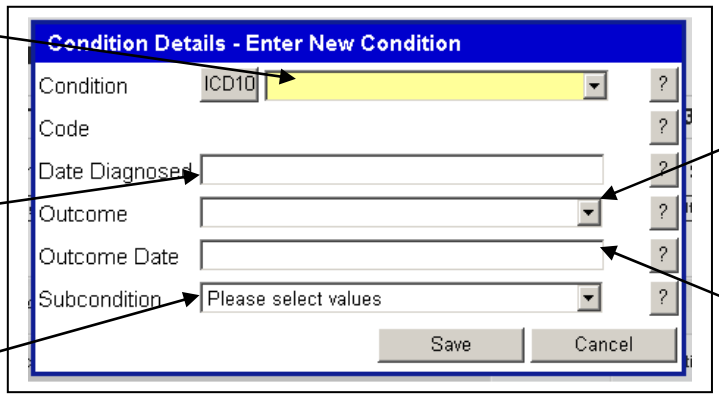


Condition

<u>Condition</u>
Enter the syndrome where known or "Not known". To add neurological co-morbidities select "Neurology – not epilepsy".

<u>Date Diagnosed</u>
The date diagnosed refers to the condition and subconditions.

<u>Subcondition</u>
Select the types of seizures that the patient is having from the dropdown list. Multiple seizure types can be selected. For neurological co-morbidities a separate list will show.



<u>Outcome</u>
This should be used in conjunction with outcome date to document when a diagnosis of epilepsy was made. Select from the dropdown list when appropriate.

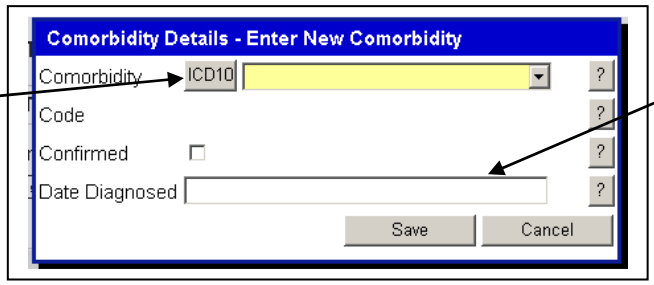
<u>Outcome Date</u>
Enter the date relating to the diagnosis in outcome.

- For new patients with epilepsy a syndrome type should be selected from the dropdown menu of syndromes or "Not known" where the syndrome is not known. It will not be possible to add any seizure types until a condition has been selected.
- If at a subsequent appointment a syndrome is identified this must be added as a new entry with a new diagnosis date reflecting the date the syndrome was identified. **Please do not edit the original entry**.
- If at a subsequent appointment additional seizure types are identified this must be added as a new entry with a new diagnosis date. **Please do not edit the original entry.**
- The ICD10 code should not be used on this screen. If you have patients with neurological conditions that you think are not appropriately catered for in the dropdown menus please let Karyn know (Karyn.robertson@nhs.net).

Comorbidities

The comorbidities screen should be used to record non neurological comorbidities and pregnancy.

<u>Comorbidity</u>
Click on the ICD10 box to bring up a search box. Enter details and click on search. Select the most appropriate description from the list and click OK. This will now appear in the comorbidity box.
For pregnancy use dropdown menu.



<u>Date Diagnosed</u>
Enter the date the comorbidity was diagnosed if known. If not known this box can be left blank.

Encounters

This should be used to record each contact with the patient.

Start date
Enter the date of the encounter. Time can be recorded if desired.

Treatment Centre
If the encounter took place at a different hospital from your base you will need to select an appropriate treatment centre from the dropdown list. For encounter types that do not involve the patient's attendance at hospital, the treatment centre should be the patient's usual hospital.

Patient Attendance
For planned encounters, select an option from the dropdown list to indicate whether or not the patient attended.

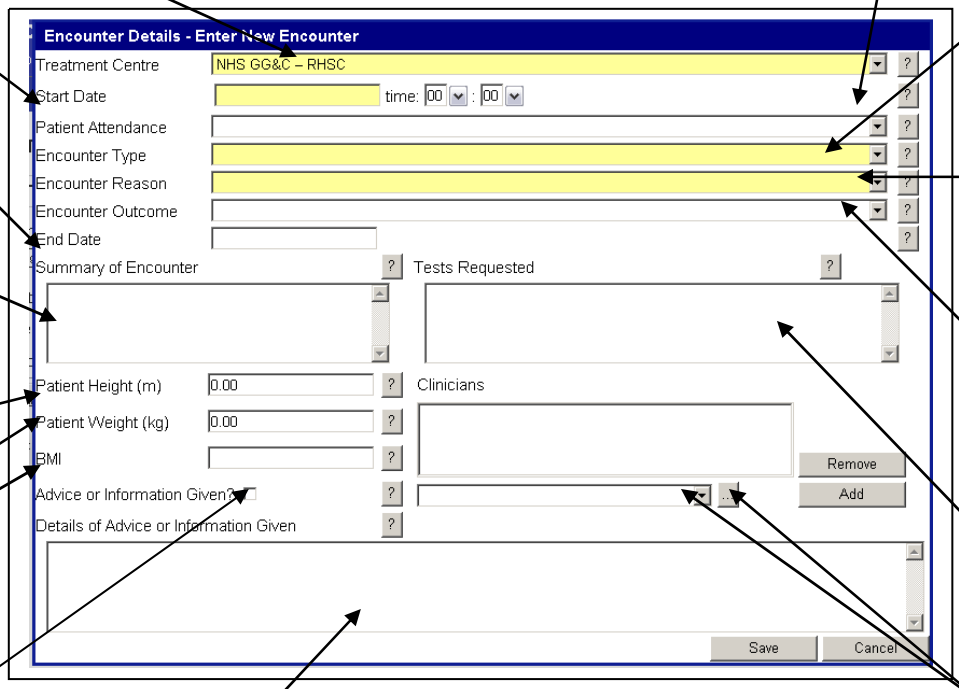
Encounter Type
Select the type of encounter from the dropdown list.

End date
Enter end date of encounter. For most encounter types this will be the same as the start date.

Encounter Reason
Select the reason for the encounter from the dropdown list.

Summary of Encounter
Freetext box to record additional information about the encounter if desired.

Encounter Outcome
Select from the dropdown menu all types of epilepsy information given to the patient at this encounter. Further boxes will display when selection is made.



Patient Height
Enter patient height in metres if known.

Patient Weight
Enter patient weight in kg if known.

BMI
Patient's BMI will calculate automatically if a height and weight have been entered.

Tests Requested
Not in use.

Clinicians
Select the clinicians present at the encounter from the dropdown list and click add. To select a clinician from a different centre use button on the right hand side.

Advice or Information Given?
Not in use.

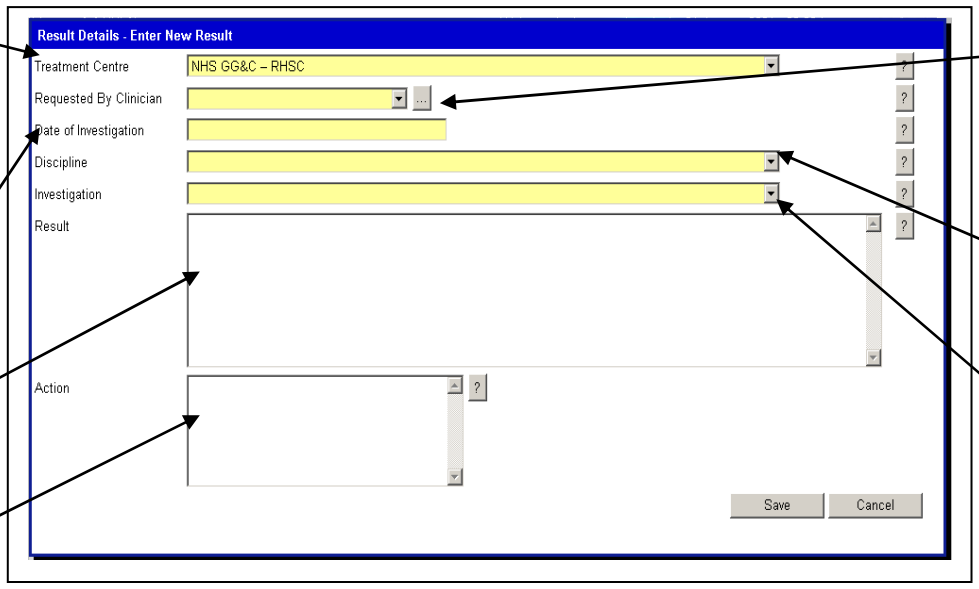
Details of Advice or Information Given
Not in use. Please ensure details of all information given is recorded in Encounter Outcome.

Results

Treatment Centre
If the investigation is being requested by a different treatment centre to your base you will need to select the appropriate centre from the dropdown list.

Requested By Clinician
Select clinician from the dropdown list. To select a clinician from a different centre use button on the right hand side.

Date of Investigation



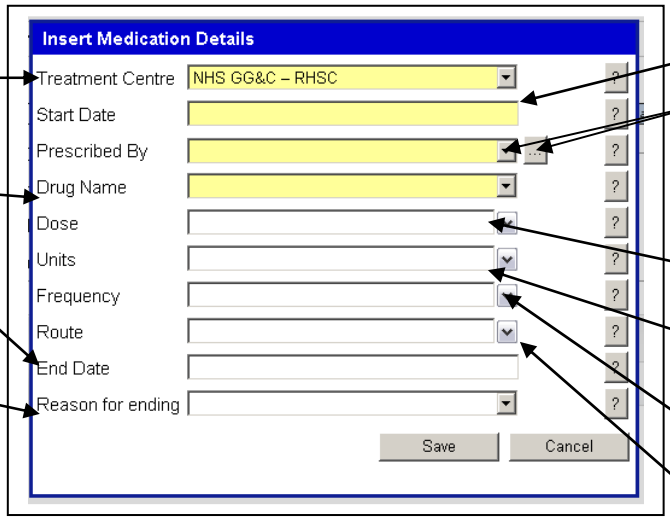
Discipline
Select the discipline from the dropdown list.

Result
Freetext box to add additional details if desired.

Investigation
Select the investigation from the dropdown menu. The list will relate to the discipline you have selected.

Action
Freetext box to add additional details if desired.

Medications



Treatment Centre
If medication is being prescribed by a different centre to your base, you will need to select appropriate centre from the dropdown list.

Drug Name
Select drug name from the dropdown list.

End Date
Enter date patient is to stop taking the medication.

Reason for ending
Select reason patient is to stop taking medication from dropdown list.

Start date
Medication start date.

Prescribed by
Select clinician from the dropdown list. To select a clinician from a different centre use button on the right hand side.

Dose
Type in dose in numbers.

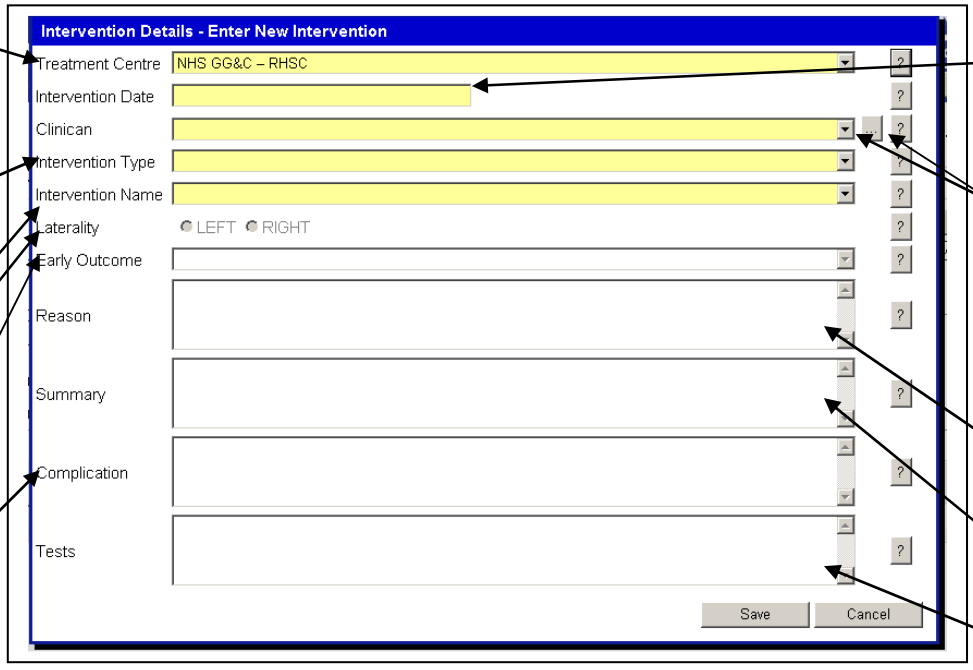
Units
Type in units of measurement.

Frequency
Select frequency from the dropdown list.

Route
Select route from dropdown list.

Additional medications can be added to the list by contacting Karyn (Karyn.robertson@nhs.net, 80704) or James (james.thom@ggc.scot.nhs.uk, 81850).

Interventions



Treatment Centre
If intervention is being requested by a different centre to your base, you will need to select appropriate centre from the dropdown list.

Intervention Type
Select intervention type from the dropdown menu.

Intervention Name
Select intervention name from the dropdown menu.

Laterality
Select where appropriate.

Early outcome
Not in use.

Complication
Additional text can be added here if desired.

Intervention Date
Enter the date the intervention was requested.

Clinician
Select the clinician requesting the intervention from the dropdown menu. To select a clinician from a different centre use button on the right hand side.

Reason
Additional text can be added here if desired.

Summary
Additional text can be added here if desired.

Tests
Additional text can be added here if desired.

Family History

This screen is not yet in use.

Core Dataset

This screen is not yet in use.