

# What's New in



*The latest version of PPM+ goes live on 22nd March 2018*

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# eDAN Improvements

**Applies to:** All Users

We have improved the eDAN process within PPM+ which includes the following enhancements:

- Adherence to the Acute Kidney Injury (AKI) CQUIN by including details of AKI in the eDAN output automatically
- Allow Pharmacy staff to edit internal Pharmacy notes during Release Medication stage
- Remove *Launch eMeds to review allergies* action from Clinical Information Stage task list
- Keep the eDAN at the Pharmacy stage if a Pharmacist made a change to medications and finalised during the same session
- Retain a patient's compliance aid data for subsequent eDANs
- A new section for *Plan and Requested Actions* that provides greater clarity to the GP of next steps
- Addition of free text *Significant events/Discussions* whilst inpatient in the *Clinical Summary* Section
- Ability to include medication instructions for GP, i.e. whether to continue, stop or review
- Include information buttons to provide more lengthy explanatory text against relevant eForm items

# Unplanned Patient List Improvements

**Applies to:** All Users

We have improved the Unplanned Patient List to identify a patient's Destination Ward and Early Warning Score (EWS):

Unplanned Patient List

MCTEST-TESTERTON, Testy (Mrs)

Born 05-Mar-2002Gender FemaleNHS No.

DetailsAudit

Early Warning Score Type

☒ NEWS (National Early Warning Score)  
☐ PAWS (Paediatric Advanced Warning Score)

Early Warning Score  
1

Arrival to Hospital

14-Mar-2018

06:15

☐ Does a 4 hour target apply?

Assess Time

14-Mar-2018

06:30

TCI Decision Time

14-Mar-2018

06:40

☐ Is Trolley Wait?

Time Into Bed

Specialty

CancelSave

Remember, you can access the Unplanned Patient List from the *Home* tab > *Browse List* > *Virtual Lists* > *Trust Wide Patients Virtual List*.

## eObs Improvements

**Applies to:** All Users

Based on clinical feedback we have improved the ability to document Flow Rate to include decimal points:


\* Flow rate (L/min)

1.25

# Auto-Save eForms

**Applies to:** All Users

We have introduced an auto-save function for eForms as users have identified some issues around lost work on larger eForms, where the user is distracted from completing the eForm and data is lost.

Remember, your auto-saved documents will be displayed in the top *In Progress (Drafts)* section along with your username, when you click on  and then *Clinical Document*.

Add Document

Filter

Show AllSort Alphabetically Ascending

In Progress (Drafts)

Cardiac Rehabilitation	02-Jun-2017 10:02	bouffles	<a href="#">Documents</a>
Free Text Annotation	07-Aug-2017 16:17	forbesg	<a href="#">Documents</a>
Holistic Needs Assessment	18-Aug-2017 10:12	bouffles	<a href="#">Documents</a>
Initial Medical Assessment	14-Mar-2016 15:08	moors	<a href="#">Documents</a>

Add New Document

CNS Consultation	<a href="#">Documents</a>
Cardiac Rehabilitation	<a href="#">Documents</a>
Central Venous Catheter	<a href="#">Procedures</a>
Community Intermediate Care Bed Medical Progress Notes	<a href="#">Documents</a>
Free Text Annotation	<a href="#">Documents</a>
HIV Clinic note	<a href="#">Documents</a>
Heart Failure Out-Reach Review	<a href="#">Documents</a>
Heart Failure Proforma	<a href="#">Documents</a>

Cancel

# Patient Search Improvements

**Applies to:** All Users

We have improved the search functionality to enable users to search on other patient IDs such as

- PAS number
- NHS number
- Surname
- DOB

Where more than one record is found, these will be presented for selection.

Further, users can search by any partial matching record e.g. 24/07/2017 and 24th July 2017, name dependencies and matches found.

These changes will be reflected in PPM+ roughly a week after the update.

## Children's Social Care Tab

**Applies to:** All Users

Previous work has been delivered through the Leeds Care Record (LCR) to display an Adult Social Care Summary for patients who have a social care plan from Leeds City Council. LCR are now working towards sharing the equivalent information for children known to Children's Social Care.

This release delivers the first stage of information sharing from Children's Social Care by showing a Children's Social Care tab. This tab alerts users to the fact that the Council is working with the patient and clicking this tab gives contact information within the Council. This initial stage will be followed by sharing an agreed Children's Social Care dataset and by expanding the cohort of children for whom this information will be shared.

Please note that for some patients both the Adult and Children's Social Care information may apply.

**TEST, Beryl** Born Gender NHS No.

Address Leeds Phone (Home) 0113 GP GP (Dr) PAS No. Allergies: see GP tab or eMeds

**Hospital** **Mental Health** **Children's Social Care** **Results**

**Actions**

- View Patient Details
- View Audit Log
- Clinical Record Types
- All
- Alerts
- Allergies

For further information about this child, please call Children and Family Services on 0113 3760336.

# Stool Record Chart

## Applies to: Pilot Users

We have introduced a Stool Record Chart to be used Trustwide by children and adult wards to monitor a patient's bowel movements.

One form will be created for each patient's admission:

**Stool Record Chart**

TEST, Beryl (Ms) Born 17-Oct-1990 (27y) Gender Female NHS No. 999

Address LS1 Phone 0113 PAS No.

**Stool Record Chart** [Hide Image](#)

Please record ALL bowel movements.  
Enter any measurable amounts on the patients fluid balance chart.  
Report ANY significant changes to senior medical/nursing staff and ensure these are documented.

**Bristol Stool Chart**

- Type 1: Separate hard lumps, like nuts (difficult to pass)
- Type 2: Sausage-shaped but lumpy
- Type 3: Like a sausage but with cracks on its surface
- Type 4: Like a sausage or snake, smooth and soft
- Type 5: Soft blobs with clear-cut edges passed easily
- Type 6: Fluffy pieces with ragged edges, a mushy stool
- Type 7: Water, no solid pieces

**Stool Chart**

Author: robinsst  
Ward: 15-Mar-2018

\*Date taken: 2018-03-15  
\*Time taken: 16:11:00  
Format HH:mm:ss

\*Type: Type 1  
\*Colour: Brown

\*Amount: Medium  
\*Mucus / Blood: None  
\*Specimen: Not sent

Comment: Stool Chart comment

[Cancel](#) [Submit](#) Unsaved changes

This also includes a tabular view for reviewing previous records:

Stool Record Chart: Table					
<a href="#">Expand</a>	<a href="#">Add New Assessment</a>	<a href="#">Refresh View</a>			
Show All	<	06-Mar-2018	02-Mar-2018	27-Feb-2018	26-Feb-2018
Page 1 of 4		13:52	13:48	13:21	13:28
Ward		40 (LGI)	40 (LGI)	40 (LGI)	40 (LGI)
Type		Type 2	Type 1	Type 2	Type 1
Colour		Green	Black	Brown	Brown
Amount		Large	Medium	Small	Small
Mucus / Blood		Blood & Mucus	Blood	Blood & Mucus	Blood
Specimen		Sent	Sent	Not applicable	Not sent
Comment		ew		fdfsd	
Created By		BROAD, Andrew J (Dr)	BROAD, Andrew J (Dr)	BROAD, Andrew J (Dr)	BROAD, Andrew J (Dr)

Remember, you can add clinical documents to a patient's record through the [Add](#) button in the Single Patient View or the [Add](#) in the *Action* column on the Ward Patient List.

# Falls Prevention Care Plan

**Applies to:** Pilot Users

Nurses complete Falls Assessments on relevant patients. These improvements now replicate the full paper care plan by incorporating the initial assessment and the daily evaluation.

This also includes a tabular view for reviewing previous daily evaluations:

Falls Prevention Care Plan:...


Expand

Add New Assessment

Refresh View

Some information may be omitted from this view. Please open the individual assessment for full details.

Show All	15-Mar-2018	14-Mar-2018	
Page 1 of 1	15:14	12:16	
Walking Aids	Yes	Yes	
Walking Aids: Variation and Action Taken			
Assistance with Toilet	Yes	No	
Assistance with Toilet: Variation and Action Taken	1234		
Appropriate Place on Ward	No	Yes	
Appropriate Place on Ward: Variation and Action Taken	1234		
Location on Ward			
Bed Setting	Yes	Yes	
Bed Setting: Variation and Action Taken			
Footwear Secure Fit	Yes	Yes	
Footwear Secure Fit: Variation and Action Taken			
Glasses Worn	Yes	Yes	
Glasses Worn: Variation and Action Taken			
Call Explained	Yes	Yes	
Call Explained: Variation and Action Taken			
Bedside Light	Yes	Yes	

Remember, you can add clinical documents to a patient's record through the **Add** button in the Single Patient View or the  in the *Action* column on the Ward Patient List.

# Nursing Specialist Assessment (Short-Stay)

**Applies to:** Pilot Users

The Nursing Specialist Assessment (NSA) is a key element of standard nursing practice and record keeping. The changes in this update relate to the Short-Stay version only:

Short-stay Nursing Specialist Assessment (NSA)

TEST, Beryl (Ms)

Born 17-Oct-1990 (27y)Gender FemaleNHS No. 999

Address LS1Phone 0113PAS No.

Author

AuthorrobinsstDate14-Mar-2018Time13:01:01

Admission Details

Current ConsultantJohn (Mr)Current Ward NumberZZZExpected Date of Discharge

Short Stay

Complete on admission to identify care needs and re-assess if condition changes. Commence care plans according to risks identified. A full nursing specialist assessment should be completed if patient stay exceeds 48 hours or if risks exceed in 3 of the domains.

\* Assessment Type

AdmissionPost-procedureRe-assessment

\* Mobility

IndependentNeeds AssistanceRecent Fall

Mobility - Consider the following Care Plans

Moving and HandlingFalls Risk AssessmentVTE

\* Infection Risk

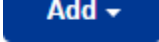

No risks identifiedPotential risk

\* Hygiene

Cancel

Unsaved changes

Submit

Remember, you can add clinical documents to a patient's record through the  button in the Single Patient View or the  in the *Action* column on the Ward Patient List.



# Pressure Ulcer Risk Assessment (Purpose T)

**Applies to:** Pilot Users

We have introduced a Pressure Ulcer Risk Assessment (Purpose T) eForm to help improve the delivery of care:

Pressure Ulcer Risk Assessment (Purpose T)

TEST, Beryl (Ms)

Born 17-Oct-1990 (27y)

Gender Female

NHS No. 999

Address LS1

Phone 0113

PAS No.

Author

Author

robinsst

Date

14-Mar-2018

Time

13:10:14

Screening

\* Mobility Status - tick all applicable

☐ Walks independently with or without walking aids

☒ Needs the help of another person to walk or move

☐ Spends all or majority of time in bed or chair

☒ Remains in the same position for long periods

Full Assessment

\* Frequency of position changes

Doesn't move

Moves occasionally

Moves frequently

\* Extent of independent movement

Slight position changes

Major position changes

\* Sensory perception and response

☒ No problem

☐ Patient is unable to feel and / or respond appropriately to discomfort from pressure

\* Moisture due to perspiration, urine, faeces or exudate

Cancel

Unsaved changes

Submit

Remember, you can add clinical documents to a patient's record through the **Add** button in the Single Patient View or the **▼** in the *Action* column on the Ward Patient List.

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# Contact Us

Please contact the Informatics Service Desk at x26655 or [informaticsservicedesk.lth@nhs.net](mailto:informaticsservicedesk.lth@nhs.net) to:

- Reset your password
- Report a problem you are having within PPM+ functionality
- Report a data quality problem within PPM+
- Request new user accounts for PPM+
- Disable PPM+ accounts for any leavers from your department

Please contact the PPM+ EPR team at [leedsth-tr.EPR@nhs.net](mailto:leedsth-tr.EPR@nhs.net) if you have any development ideas or comments on your experience of using the EPR.

If you would like to make a request for change to PPM+, please contact us at: [leedsth-tr.EPR@nhs.net](mailto:leedsth-tr.EPR@nhs.net) with a completed [request for change \(RFC\) form available here](#)

Please contact the IT Training Department at [ITTraining.LTHT@nhs.net](mailto:ITTraining.LTHT@nhs.net) if you require further training on PPM+ or any other Clinical System.

PPM+ Help Site: <http://www.ppmsupport.leedsth.nhs.uk/>