

What's New in



The latest version of PPM+ goes live on 4th of July 2018

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Custom Patient List Improvements

Applies to: LTHT Users

As well as being able to create a custom list of patients along with a ward and consultant details, you can now filter by the following types:

- Recent Admissions
- Patients Discharged
- NEWS Score

Custom View

Name

48hr D/C On My Ward

Category

Custom Patient Lists

Filters

Sharing

Choose filter type

Patients Discharged

▼

Select Patients Discharged

Patients discharged within 24 hours (1 day)

+

Patients discharged within 48 hours (2 days)

✓

Patients discharged within 72 hours (3 days)

+

Patients discharged within 96 hours (4 days)

+

Filter Criteria

Ward Number

TEST EPR ZZZ

Patients Discharged

Patients discharged within 48 hours (2 days)

Cancel

Delete

Save

Remember, you can create a new *Custom Patient List* from the *Actions* bar on the *Home* tab:

Home

Create Custom List x

Actions

←

Patient Lists

Browse List

>

Create Patient List

>

Custom Patient List

>

eDAN

>

Ward

>

Unplanned Patient List

>

Bed State

>

Share Custom Patient Lists with other Users

Applies to: LTHT Users

In addition to the new Custom Patient List filters, users are now able to share their custom lists with other colleagues and teams.

When creating or editing a Custom List, select the **Sharing** tab to search for a user:

Custom View

Name
My Patients and Ward

Category
Custom Patient Lists

Filters **Sharing**

Search Contact

Search: Smith

Select Contact

Smith, E	User +
Smith, S	User +
Smith, Y	User +
Smith, V	User +
Smith, R	User +
Smith, J	User +
Smith, B	User +

Share With

User

Smith, A	Read List <input checked="" type="checkbox"/>	Edit List <input checked="" type="checkbox"/>	Delete List <input checked="" type="checkbox"/>
----------	---	---	---

Cancel Delete Save

You can then allow users different levels of access (read/edit/delete).

If a list has been shared with you, it will appear in your *My Custom Patient Lists* marked with *(Shared)*:

My Custom Patient Lists

Filter...

Custom Patient List
Test Patient List
Testpatients and Ward (Shared)

My Details

Applies to: LTHT Users

To help support current and future developments such as Specialist Referrals, Tasks, Custom Patient Lists and referencing individuals in activities, you can now associate your account with your contact details within PPM+:

My Details Creation Wizard

Warning

Search

Details

Addresses

Search existing details

Please search for your details using surname or surname and forename, or national code e.g. GMC code before proceeding. Please note that you cannot search on an individuals username

j smith

SMITH, J		Nurse	+
SMITH, J	St James's University Hospital, Beckett Stre...	Admin	+
SMITH, J	St James's University Hospital, Beckett Stre...	Admin	+
SMITH, J		Nurse	+
SMITH, J		Nurse	+
SMITH, P	St James's University Hospital, Beckett Stre...	Consultant	+
SMITH, T	Chapel Allerton Hospital, Harehills Lane, Le...	Allied Health Professionals	+

Cancel

Prev

Next

Use the *My Details Creation Wizard* to add your details and addresses, which will appear the next time you log in and also can be accessed from the User Menu:

Your Name

Sign Out

- Intranet
- FAQs
- What's New
- Help
- Feedback
- My Details**
- Sign Out


You will be asked to check your details every six months to ensure we have the most up-to-date information.

IBD Clinical Assessment Improvements

Applies to: All Users

Based on clinical we have improved the IBD Clinical Assessment form:

The screenshot shows the 'IBD Clinical Assessment' form for patient 'TEST-TEST, Beryl (Ms)'. The patient's details include 'Born 01-Feb-1970 (48y)', 'Gender Male', and 'NHS No.'. The address is 'LS1' and the phone number is '0113'. The form is divided into two main sections: 'Admission' and 'Consent'. The 'Admission' section has a question: '* Has a hospital admission for IBD management occurred since the previous visit?' with 'No' and 'Yes' buttons. The 'Consent' section has four questions: '* Date consent last recorded' (with a date picker set to 2018-06-12), '* Informed consent for registry' (with 'No' and 'Yes' buttons), '* Informed consent for linkage' (with 'No' and 'Yes' buttons), and '* Informed consent for research' (with 'No' and 'Yes' buttons). There is also a question '* Consent to be contacted for future research' (with 'No' and 'Yes' buttons). The form has a 'Save and Continue' button at the bottom right and a 'Cancel' button at the bottom left. There is also an 'Unsaved changes' indicator and a 'Close' button at the bottom right.

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.

ReSPECT and DNACPR Alerts

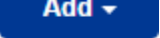

Applies to: All Users

If there is a ReSPECT form present in PPM+, a *Clinical Alert* will appear in the patient's Electronic Health Record.

Further, if there is a DNACPR decision within the ReSPECT form in PPM+, a *High Priority Alert* will also appear above like in the example below:

The screenshot displays the PPM+ interface for patient Beryl (Ms). The top header shows patient details: Born 01-Feb-1970 (48y), Gender Male, NHS No. [redacted]. Below this, the 'Hospital' and 'Mental Health' tabs are visible. The 'Mental Health' tab is active, showing a 'Summary' section with a list of events from 2018, including 'Patient Preference', 'Referral', 'Wait', and 'Nursing Note'. To the right, the 'Patient Clinical Alerts' section is highlighted with a red box. It contains two alerts: a 'High Priority Alert' for DNACPR dated 01-May-2018, and a 'Clinical Alert' for ReSPECT dated 01-May-2018. Both alerts describe the completion of a ReSPECT plan for emergency care.

Date	Name	Description
High Priority Alerts		
01-May-2018	DNACPR	A ReSPECT plan for emergency care, including a DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION decision, is in place. Please review the ReSPECT form and CPR decision, check for changes and, if valid and applicable, take this DNACPR status into account.
Clinical Alerts		
01-May-2018	ReSPECT	An ReSPECT plan for care in emergency situations has been completed. Please read and consider these recommendations in event of clinical deterioration.

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.


Specialist Wound Assessment

Applies to: All Users

We have introduced a *Specialist Wound Assessment* eForm into PPM+ for the Tissue Viability Service:

The screenshot shows the 'Specialist Wound Assessment' eForm interface. At the top, a blue header bar contains the form title and a close button. Below this, a purple bar displays patient information: 'TEST-TEST, Beryl (Ms)', 'Born 01-Feb-1970 (48y)', 'Gender Male', and 'NHS No.'. A white bar below shows 'Address LS1', 'Phone 0113', and 'PAS No.'. On the left, a sidebar lists four sections: 'General medical details' (checked), 'Indicators and general investigation' (selected), 'Wound examination and intervention', and 'Follow up plan'. The main content area is divided into sections for 'Height' and 'Weight'. The 'Height' section includes 'Measurement type' (Actual, Recalled, Estimated from ulna length, Unable to assess), 'Measurement units' (Metric, Imperial), and 'Current height (cm)' (183). The 'Weight' section includes 'Measurement type' (Actual, Estimated, Unable to assess), 'Measurement units' (Metric, Imperial), 'Current weight (Kg)' (86), and a question about factors affecting weight (No, Yes). A 'BMI' section at the bottom shows 'Calculated BMI 25.7' and 'Interpretation Overweight'. At the bottom of the form, there are 'Cancel', 'Unsaved changes', and 'Close' buttons.

Specialist Wound Assessment	
TEST-TEST, Beryl (Ms) Born 01-Feb-1970 (48y) Gender Male NHS No.	
Address LS1 Phone 0113 PAS No.	
<input checked="" type="checkbox"/> General medical details	
<input checked="" type="checkbox"/> Indicators and general investigation	
<input type="checkbox"/> Wound examination and intervention	
<input type="checkbox"/> Follow up plan	
Height	
* Measurement type	
<input checked="" type="button"/> Actual <input type="button"/> Recalled <input type="button"/> Estimated from ulna length <input type="button"/> Unable to assess	
* Measurement units	
<input checked="" type="button"/> Metric <input type="button"/> Imperial	
* Current height (cm)	
<input type="text" value="183"/>	
Weight	
* Measurement type	
<input checked="" type="button"/> Actual <input type="button"/> Estimated <input type="button"/> Unable to assess	
* Measurement units	
<input checked="" type="button"/> Metric <input type="button"/> Imperial	
* Current weight (Kg)	
<input type="text" value="86"/>	
* Are there any factors affecting the patient's weight e.g. Amputation, Ascites, Clinical Oedema?	
<input checked="" type="button"/> No <input type="button"/> Yes	
BMI	
Calculated BMI	
<input type="text" value="25.7"/>	
Interpretation	
Overweight	

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.

Sepsis Screening Tool

Applies to: All Users

We have introduced a *Sepsis Screening Tool* to aid fast detection of deteriorating patients:

Sepsis Screening Tool

TESTTEAM, One (Miss)

Born 03-Feb-1984 (34y)Gender FemaleNHS No. 947

Address LS1Phone 0113PAS No.

Sepsis Screening Tool

Screen any adult patient with a new total NEWS > 5 or 3 in one parameter or new suspected infection. If suspected neutropenia, use Neutropenic Sepsis Pathway

* Could this be an infection? (Symptoms may include: cough, sore throat, shortness of breath, chest pain, headache, abdominal pain, diarrhoea/vomitting, urinary frequency/pain, fevers/sweating, unsteady/falls, confusion)

☒ Yes

☐ Unsure

☐ No

Assess for High Risk Criteria

* Tick if applicable

☒ None of the below

☐ Respiratory rate > 25 bpm

☐ Oxygen to keep SATS > 92% or > 88% in COPD

☐ Systolic BP < 90mmHg

☐ Pulse > 130 BPM

☐ New altered mental state

☐ NEWS = 7

☐ Not passed urine in the last 18 hours or < 0.5ml/hr if catheterised

☐ Purpuric/non blanching rash

Assess for Moderate Risk Criteria

* Tick if applicable

☐ None of the below


☒ Respiratory rate > 20bpm

Cancel

Unsaved changes

Save Draft

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.

Children's Nurse Allergy Clinic Notes

Applies to: All Users

We have introduced a *Children's Nurse Allergy Clinic Notes* eForm for use in outpatient consultation:

Childrens Nurse Allergy Clinic Notes

TESTPATIENT, (Master)Born 08-Apr-2008 (10y 2m)Gender MaleNHS No.

Address LS1PAS No. 001

Children's Height and Weight

Person/s accompanying child to clinic

Jane Testpatient - Mum

* Allergens introduced/now tolerating

Allergens introduced

Reaction details

Details of reaction

Details

Other health issues

* Allergens currently avoiding

Allergens avoiding

* Recent allergic reactions

☒ Yes
☐ No

* Any other health issues or professionals involved

☒ Yes
☐ No

Children's Nurse Allergy Clinic Notes

CMPA

* CMPA

Milk substitute

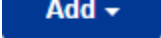

Rice Milk

Cancel

Unsaved changes

Save Draft

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.

Nutritional Screening Tool - Adult

Applies to: All Users

An electronic version of the frequently completed Nutritional Screening Tool has been introduced to help identify adults who are malnourished, at risk of malnutrition (undernutrition) or obese:

Nutritional Screening Tool - Adult

TEST-TEST, Beryl (Ms)

Born 01-Feb-1970 (48y)Gender MaleNHS No.

Address LS1Phone 0113PAS No.

Author

Author
robinsst

Date
21-Jun-2018

Time
10:08:54

Please Note

All patients must have a height and weight recorded within the first 24 hours of admission.
If current height and weight data is not present in the fields below, it can be entered here, or a separate Adult Height and Weight e-form can be completed.

Height

* Measurement type

ActualRecalledEstimated from ulna lengthUnable to assess

* Measurement units

MetricImperial

* Current height (cm)

183

Weight

* Measurement type

ActualEstimatedUnable to assess

* Measurement units



MetricImperial

* Current weight (Kg)

88

* Are there any factors affecting the patient's weight e.g. Amputation

CancelUnsaved changesSubmit

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.

PPMplus Whats New v18.3.0e.docx

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Last updated: 29/06/2018

Yorkshire Lung Cancer Screening Programme

Applies to: Pilot Users

To assist in the Yorkshire Lung Cancer Screening Programme we have introduced two new eForms. Namely, the *YLIST - Lung Screening CT Request Form* and the *Yorkshire Lung Cancer Screening Programme - Telephone Triage*:

YLIST - Lung Screening CT Request Form

TEST-TEST, Beryl (Ms) Born 01-Feb-1970 (48y) Gender Male NHS No. Address LS1 Phone 0113 PAS No.

YLIST - Lung Screening CT Request Form

* CRIS ID number 1234 * CRIS accession number 1234 * Family history of lung cancer? (if not known, put no) No Yes

* Scan timing T0+3months If other - give details * Fulfills USPSTF criteria No Yes

* PLCO lung cancer risk 1 * Fulfills PLCO criteria No Yes * LLP lung cancer risk 1

* Fulfills LLP criteria No Yes * Eligible for LDCT scan No Yes

* Date of planned Lung Health Check 2018-06-22 * Time of planned Lung Health Check 12:00:00

22-Jun-2018 Format HH:mm:ss

Author

Author robinssst Date 21-Jun-2018 Time 10:13:05

Cancel Unsaved changes Submit

Yorkshire Lung Cancer Screening Programme - Telephone Triage

TEST-TEST, Beryl (Ms) Born 01-Feb-1970 (48y) Gender Male NHS No. Address LS1 Phone 0113 PAS No.

Call Details

* Date of phone call 2018-06-22 * Time of phone call 12:00:00 * Name of administrative team taking phone call Stuart

22-Jun-2018 Format HH:mm:ss

When was the last time you smoked a cigarette?

* When was the last time you smoked a cigarette? Today In the last week In the last month In the last year Over a year ago I have never smoked

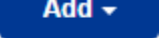

Telephone Triage

GP coded diagnosis of COPD * Previous respiratory diagnosis ☒ None ☐ COPD ☐ Emphysema ☐ Bronchitis ☐ TB ☐ Pneumonia

* Personal history of previous cancer? No Yes * Family history of lung cancer? (if not known, put no) No Yes

* Job or activity with asbestos exposure? No Yes * If ever smoked cigarettes, age when started? 17


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.



Frailty Alert



Applies to: All Users

Following an assessment with the GP, a patient may then be recorded with a moderate or severe frailty alert, which will then be shown in the Electronic Health Record under the *Clinical Alerts* section:



TESTTEAM, One (Miss) Current Location **TEST EPR ZZZ** Born **03-Feb-1984 (34y)** Gender **Female** NHS No. 



Address Phone (Home) **0113** GP **SMITH,** PAS No.  Allergies: see GP tab or eMeds 

Hospital  **Results** 

Actions  Filter Events... Show Booked and Delivered 

Clinical Record Types

- TESTTEAM, One (Miss)
- All
- Alerts (1)
- Allergies
- eMeds Allergies 
- Audits/Tracking (2)
- Clinical Documents (220+)
- Dictation (EPRO) 


Summary  **Add** 



2018



- 21-Jun-2018 [Alerts](#) Patient is moderately frail
- 11-Jun-2018 [Nursing Note](#)
- 11-Jun-2018 [Medical Assess](#) Vascular Outpatients Specialist W...
- 11-Jun-2018 [Summary](#) Adult Height and Weight
- 11-Jun-2018 [Medical Assess](#) Tissue Viability Specialist Wound...
- 08-Jun-2018 [AHP Assess](#) AHP Consultation Dietetics: JadavJ
- 01-Jun-2018 [Nursing Assess](#) SSI - Hip replacement: SYKES, Mi...
- 31-May-2018 [Medical Assess](#) Specialist Wound Assessment: SY...



Patient Clinical Alerts

Date	Name	Description
Clinical Alerts		
21-Jun-2018	Patient is moderately frail	Frailty Alert - this patient has been assessed via their GP record as being moderately frail . If appropriate, please discuss with the patient the underlying reasons for their score as part of your diagnosis This score has been derived from the patient's GP record and comprises of up to 36 deficits across over 2000 read codes. A high score indicates increasing frailty and greater risk of adverse outcomes


TEST-TEST, Beryl (Ms) Born **01-Feb-1970 (48y)** Gender **Male** NHS No. 



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

Hospital  **Results** 

Actions  Filter Events... Show Booked and Delivered 

Clinical Record Types

- TEST-TEST, Beryl (Ms)
- All
- Alerts (4)
- Allergies
- eMeds Allergies 
- Audits/Tracking (5)
- Clinical Documents (279+)

Summary  **Add** 

2018

- 26-Jun-2018 [Alerts](#) Patient is severely frail
- 21-Jun-2018 [Patient Prefe...](#)
- 19-Jun-2018 [Referral](#)
- 19-Jun-2018 [Referral](#)
- 19-Jun-2018 [Wait](#)
- 19-Jun-2018 [Referral](#)

Patient Clinical Alerts

Date	Name	Description
Clinical Alerts		
26-Jun-2018	Patient is severely frail	Frailty Alert - this patient has been assessed via their GP record as being severely frail . If appropriate, please discuss with the patient the underlying reasons for their score as part of your diagnosis This score has been derived from the patient's GP record and comprises of up to 36 deficits across over 2000 read codes. A high score indicates increasing frailty and greater risk of adverse outcomes

Initial Assessment Improvements

Applies to: All Users

We have improved the Initial Assessment eForm so that *Differential Diagnosis* section updates in the PDF:

Initial Assessment [X]

TEST-TEST, Beryl (Ms) Born **01-Feb-1970 (48y)** Gender **Male** NHS No. []

Address **LS1** Phone **0113** PAS No. []

☒ History of Current Episode
☒ Previous History
☒ Examination
☒ **Clinical Management**

Differential Diagnosis

B I U S [List Icon]


Differential Diagnosis information here.
Differential Diagnosis information here.
Differential Diagnosis information here.
Differential Diagnosis information here.

This Diagnosis / Problem list will form the basis of the ward Clinical Summary column wherever possible

Plan

[Text Area]

[<] [Save] [Unsaved changes] [Close] [Cancel]

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.

Scanned Case Notes

Applies to: LTHT Users

Further enabling staff to provide appropriate care to patients, you are now able to see historic scanned documentation via the *Scanned Case Notes* link in the Actions bar on the left:

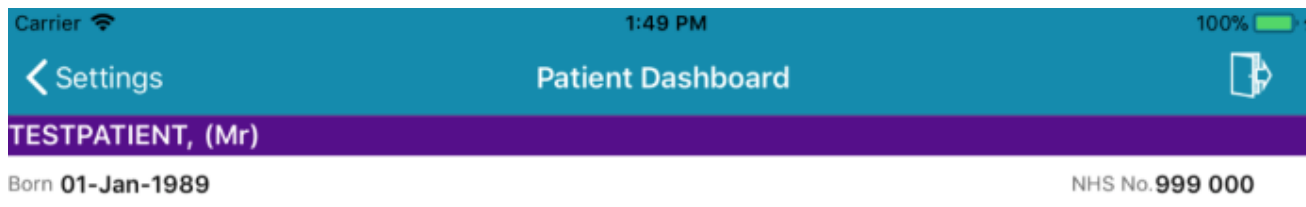
The screenshot displays the LTHT system interface. On the left, a navigation sidebar includes sections like 'Hospital', 'General Practice', 'Actions', 'Clinical Record Types', and 'External Systems'. The 'Scanned Case Notes' link is highlighted under 'Clinical Record Types'. The main content area is divided into three panels. The top panel shows a 'Filter Events...' search bar and a 'Show Booked and Delivered' dropdown. Below this is a table of case notes with columns for date and title. The middle panel shows a detailed view of a case note, with a '1' indicating the top section and a '2' indicating the bottom section. The right panel shows a 'Results' section with a search bar and a list of results.

Case notes	Add
16-Oct-2008 Scanned Cas...	
10-Oct-2008 Scanned Cas...	
15-Aug-2008 Scanned Cas...	
31-Jul-2008 Scanned Cas...	
17-Jul-2008 Scanned Cas...	
18-Jun-2008 Scanned Cas...	
28-May-2008 Scanned Cas...	
01-May-2008 Scanned Cas...	
22-Apr-2008 Scanned Cas...	
17-Apr-2008 Scanned Cas...	
19-Mar-2008 Scanned Cas...	
21-Feb-2008 Scanned Cas...	
15-Feb-2008 Scanned Cas...	
01-Jan-2008 Scanned Cas...	
25-Oct-2007 Scanned Cas...	
25-Oct-2007 Scanned Cas...	
22-Oct-2007 Scanned Cas...	
24-Aug-2007 Scanned Cas...	
14-Jun-2004 Scanned Cas...	
19-Dec-2003 Scanned Cas...	

PPM+ Mobile - eObs Integration

Applies to: LTHT Users

eObs has now been integrated into the PPM+ Mobile app. Once you've scanned the patient's wristband, as well as being able to access the patient record and add an eForm, you can now input eObs:



Patient Record



Update Location

Bed14, Ward J



Free Text

Free Text Annotation



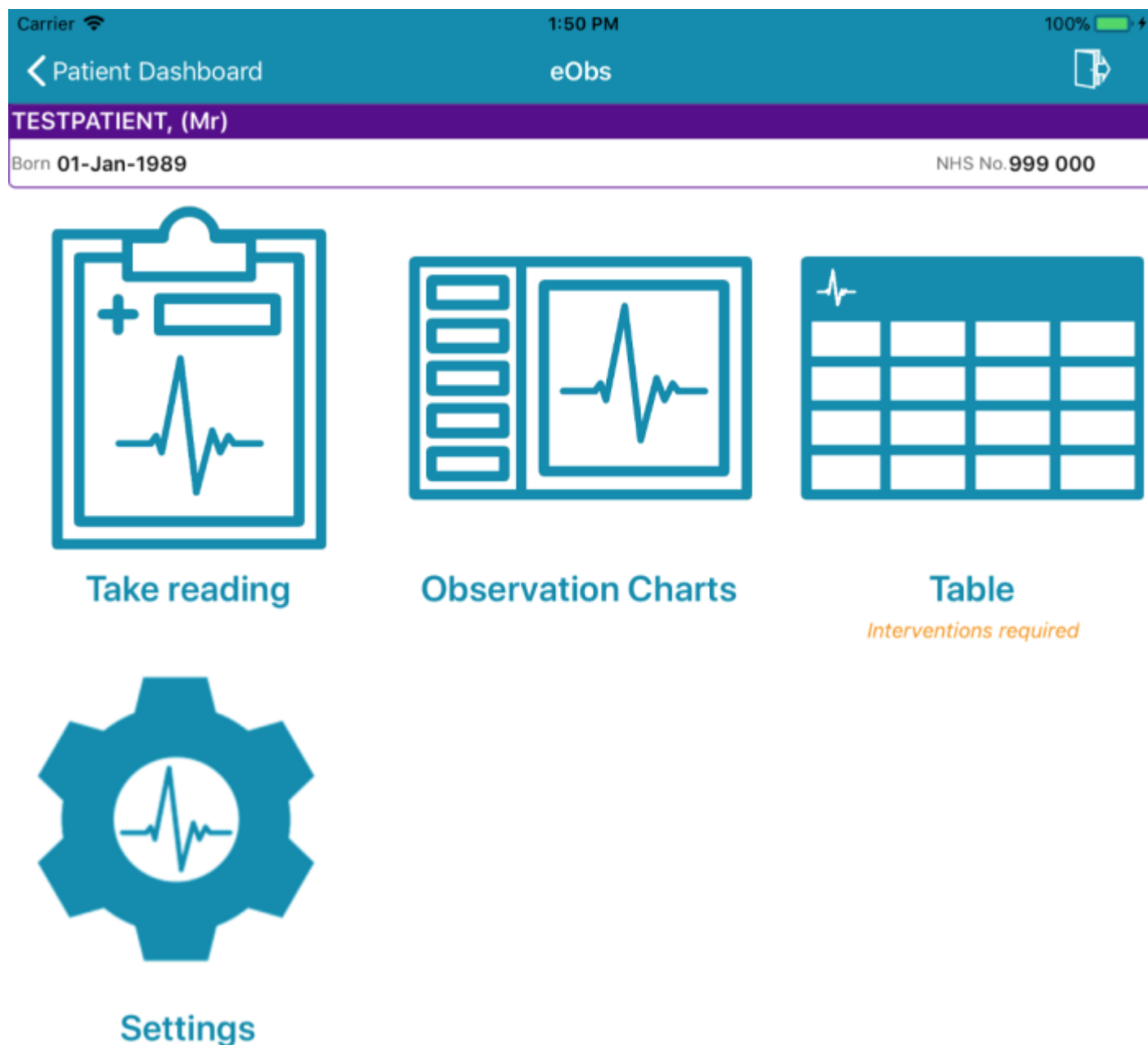
eObs



eForms



From here you will be able to access all your eObs functionality, with a ward list view to be introduced in the future:



NB: in the example above the patient has a NEWS of 1 or above and therefore alerting you that interventions are required.




PPM+ Mobile - Improved Login

Applies to: LTHT Users

PPM+ Mobile users will now have an improved signing in experience with the new login screen:

iPad 

10:28

  84% 

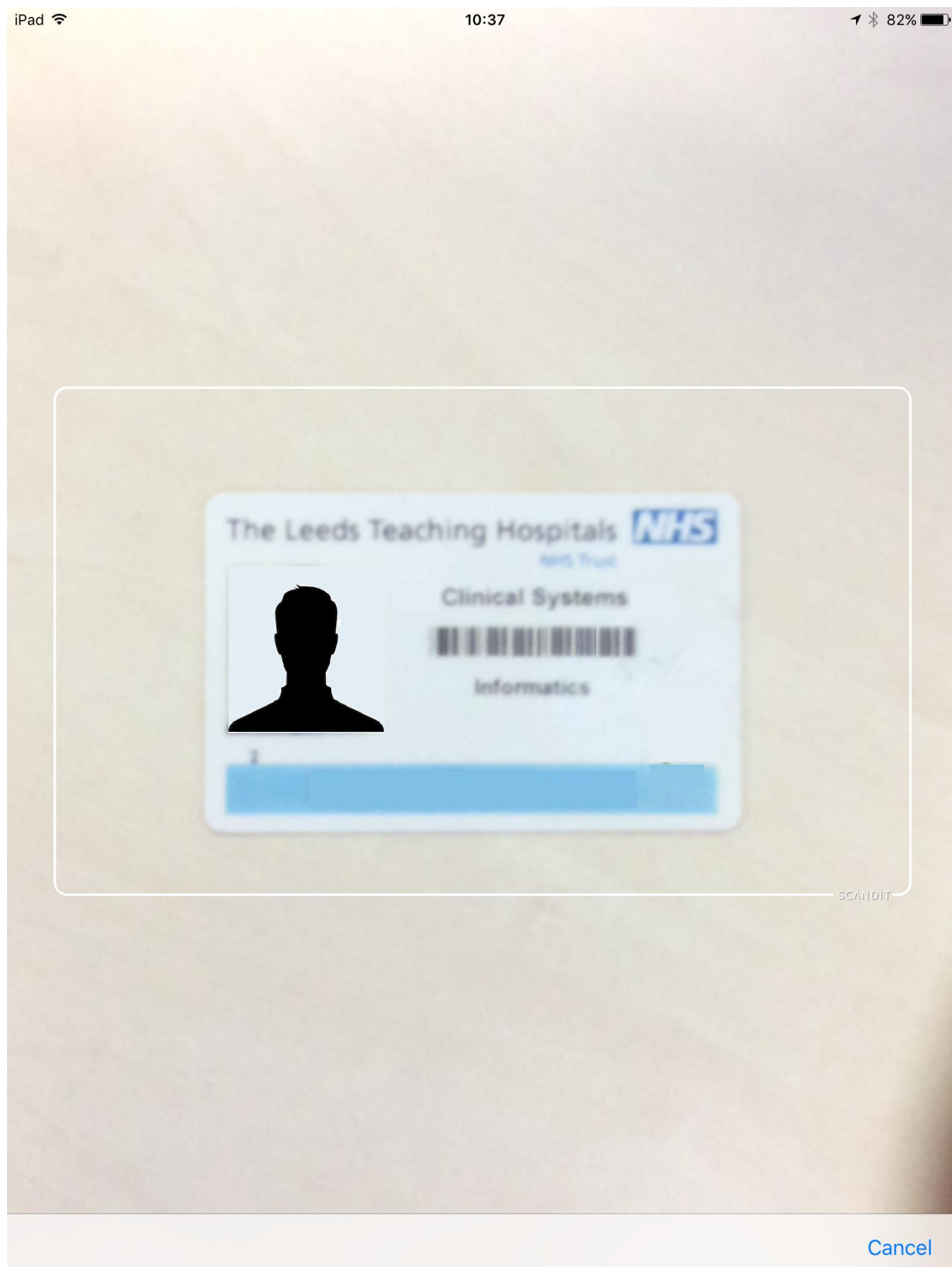


Please enter your PPM+ credentials

Login

Login Options

Further, if you tap on *Login Options* you will be able to associate your photographic LTHT Staff ID badge with your login details and a PIN. This will enable you going forward to login with just your ID and a PIN:



Contact Us

Please contact the Informatics Service Desk at x26655 or 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 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 with a completed [request for change \(RFC\) form available here](#)

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

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