

# OpenEyes for Nurses and Technicians

## (User Manual)

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*In case of any query, please contact OPO team – Ext 4752*

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## Aims

This session is designed to introduce delegates to OpenEyes by presenting Healthcare professionals the technology to be able to document the clinical journey of patients under their care. The session aims to give the best practices on better patient care and management.

The Nurse/Technician will use mainly episode / events and patient summary screens within OpenEyes for recording visual acuities, IOP's, CVI status and medications.

## The following features are included in this course:

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DRAFT

## Documentation History

Date	Version number	Revision details	Written by	Approved by
25/11/2014	0.1	First draft of document	Kevin Wood	OpenEyes Programme Office

## Document Status

This is a controlled document.

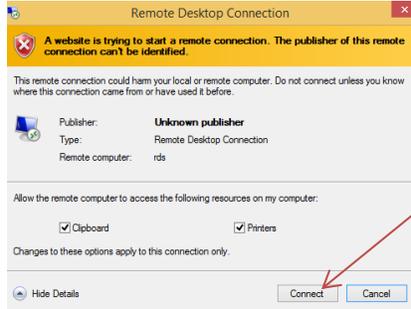
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## Logging on and Getting Started

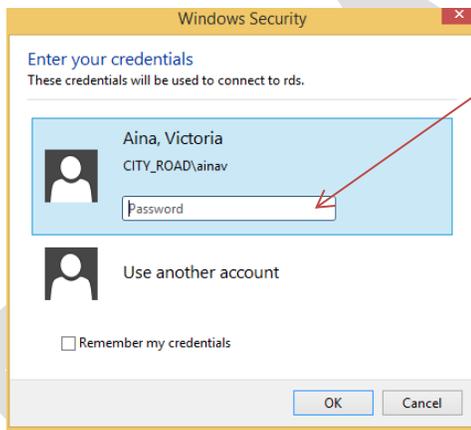
*The OpenEyes login page is case sensitive.*

- Select the clinical services link within the intranet.
- The remote desktop pop up box opens, select the grey connect button situated within the box.



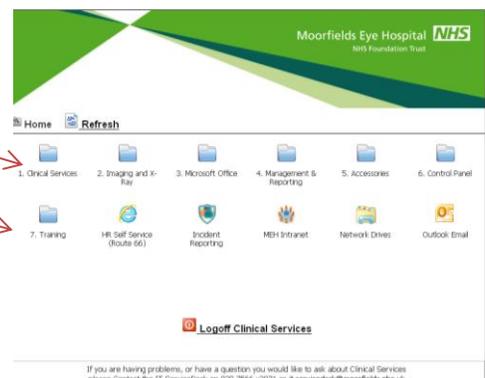
REMOTE DESKTOP POP UP BOX 1

- Within the 'Windows Security' pop up box, enter password.



WINDOWS SECURITY POP UP BOX 2

- Select Clinical services folder.
- For training, select the Training folder.





- Launch **Open Eyes** by selecting (double click) the **OpenEyes Training** Icon.
- Delegates will now have entered the OpenEyes page and be able to view the login page.
- Enter Username and Password then select the blue login button .

## Searching for a Patient

*Scan barcode on notes if scanners present*

1. Select site and/or firm from the pop up box then the green confirm button.



Select a new Site and/or Firm

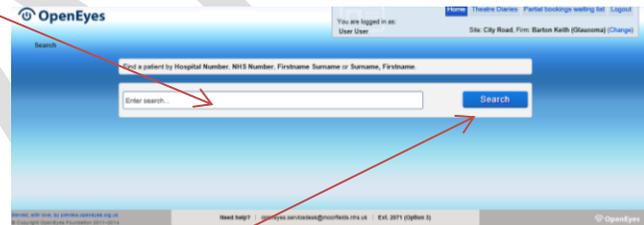
Site \* City Road

Firm \* Brookes John (Glaucoma)

Confirm

*Diagnosis, Templates and medication will be firm dependent.*

2. Search for the Patient allocated by the Trainer using the search criteria.
3. Example - Hospital Number: 1000001



OpenEyes

You are logged in as User User

Site: City Road, Firm: Barlow Health (Glaucoma) (Change)

Search

Find a patient by Hospital Number, NHS Number, Firstname Surname or Surname, Firstname

Enter search...

Search

4. Then select search to open the patient record.

## Overview of Patient Summary Page

*Demographic details may need to be altered; this action can currently be altered/updated in PAS.*

Alerts for conditions and allergies are

Patient demographics

Patient episodes of care.

Link takes you to last event recorded.

Clinical information data sections

**OpenEyes** CLOSE, Chay (93)  
No. 1000001  
NHS 348 769 5830

You are logged in as: User User  
Site: City Road, Firm: Brookes John (Glaucoma) (Change)

**Alerts**  
Patient has no GP practice address, please correct in PAS before printing GP letter  
Patient is Diabetic - Diabetes mellitus type 1 Patient has allergies - Penicillin, Sulphonamides

**Personal Details:**  
First name(s): Chay  
Last name: Close  
Address: Unknown  
Date of Birth: 2 Nov 1920  
Age: 93  
Gender: Female  
Ethnic Group: Unknown

**Contact details:**  
Telephone: 04130 4541610  
Email: Unknown

**General Practitioner:**  
Name: Unknown  
Practice Address: Unknown  
Practice Telephone: Unknown

**Associated contacts:**  
Add contact:

**All Episodes** open 7 | closed 0

Start Date	End Date	Firm	Subspecialty	Eye	Diagnosis
20 Dec 2011		Abou-Rayyah Yassir	Adnexal	Both	Chalazion
17 Jan 2012		Andrews Richard	Medical Retinal	Left	Malignant melanoma of choroid
14 Apr 2013		Brookes John	Glaucoma	Left	Pigmentary glaucoma
3 Jun 2013		Allan Bruce	Cataract	Left	Aphakia
31 Jul 2013		Allan Bruce	External	No diagnosis	No diagnosis
22 Oct 2013		Aylward Bill	Vitreoretinal	Both	Macular hole
22 Aug 2014		N/A	Support Services	No diagnosis	No diagnosis

**Latest Event in Glaucoma: Prescription (17 Apr 2013)**

**Other ophthalmic diagnoses**

Date	Diagnosis	Actions
14 Apr 2013	Right Age related macular degeneration	Remove
14 Apr 2013	Right Low tension glaucoma	Remove
14 Apr 2013	Right Pigment dispersion syndrome	Remove
14 Apr 2013	Right Acute angle-closure glaucoma	Remove
14 Apr 2013	Right Secondary glaucoma	Remove
2014	Right Acute angle-closure glaucoma	Remove

**Systemic Diagnoses**

Date	Diagnosis	Actions
2013	Diabetes mellitus type 1	Remove
14 Apr 2013	Myocardial infarction	Remove
14 Apr 2013	Marfan's syndrome	Remove
14 Apr 2013	Marfan's syndrome	Remove

**Previous ophthalmic surgery**

Date	Operation	Actions
16 Oct 2013	Right Cataract surgery	Edit Remove

**Medication**

**Current**

Medication	Acetazolamide 250mg tablets
Administration	1 tablet(s) PO qid
Date	22 Aug 2014 -
Actions	Edit   Stop   Delete
Adherence	Not Recorded
Comments	Not Recorded
Actions	Edit

**Note: After Medication section are CVI Status, Allergies, Family History and Social History sections. A number of the sections, relevant to Nursing / Technician staff are covered in this manual.**

### Minimum Legacy Data Set.

**Inform delegates that it is expected that Nurses and Technicians enter the minimum legacy data sets into the relevant fields located on the summary page.**

## Medication

To add medications, do the following.

Medication	
Medication	Acetazolamide 250mg tablets
Administration	1 tablet(s) PO od
Date	7 Mar 2014 -
Actions	<a href="#">Edit</a>   <a href="#">Stop</a>   <a href="#">Delete</a>
Medication	Apraclonidine 0.5% eye drops
Administration	1 drop(s) Eye (Both) tid
Date	2014 -
Actions	<a href="#">Edit</a>   <a href="#">Stop</a>   <a href="#">Delete</a>
Adherence	Not Recorded
Comments	Not Recorded
Actions	<a href="#">Edit</a>

[Add Medication](#)

1. Select **Add Medications** in the medications section of the patient summary screen.
2. Medications section expands to display Add medications question fields.
3. Medication can be added either by (a) selecting the appropriate **Medication** from the drop down menu.

Medication:

Dose:

Route:

Frequency:

Date from:

Current:

[Save](#) [Cancel](#)

- Select -
- Acetazolamide 250mg tablets
- Apraclonidine 0.5% eye drops
- Atropine 1% eye drops
- Betamethasone 0.1% eye ointment
- Bimatoprost 0.03% with timolol 0.5% eye drops
- Bimatoprost 0.3mg in 1ml eye drops
- Brimonidina 0.2% eye drops
- Brimonidina 10mg in 1ml eye drops
- Chloramphenicol 0.5% eye drops
- Chloramphenicol 0.5% single use eye drops (No Preservative)
- Dexamethasone 0.1% eye drops
- Dexamethasone 0.1% single use eye drops (No Preservative)
- Dorzolamide 2% with timolol 0.5% eye drops
- Ketorolac 0.5% eye drops
- Latanoprost 0.005% eye drops
- Maxitrol eye ointment
- Prednisolone 1% eye drops
- Rimexolone 1% eye drops
- Timolol 0.25% eye drops

or, (b) selecting the search formulary dynamic box and start to type the name of the medication and pick from the options listed. **The search uses SNOMED terminology.**

[Add Medication](#)

Add medication

Medication:

Dose:

Route:

Frequency:

Date from:

Current:

- disodium edetate 0.37% eye drops
- disodium edetate 0.37% solution (No Preservative)
- lansoprazole 15mg dispersible tablets
- omeprazole 20mg dispersible tablets

**SNOMED is a systematically organised computer processable collection of medical terms providing codes, terms, synonyms and definitions used in clinical documentation and reporting.**

4. The selected medication name will then appear to right of **Medication** title.

Medication:

5. Ensure the **Dose** field is correct and amend if necessary.

6. Ensure the **Route** is correct and select appropriate option from drop down list, if need to amend.

A screenshot of a medication form. The 'Route' field is selected, and a dropdown menu is open showing various options. A red arrow points from the instruction to the 'Route' field. The dropdown menu lists the following options: Eye, IM, Inhalation, Intracameral, Intradermal, Intravitreal, IV, Nose, Ocular muscle, PO, PR, PV, Sub-Conj, Sub-lingual, Subcutaneous, To Nose, To skin, Topical, and n/a.

7. Select appropriate **Option** from drop down menu.

A screenshot of a medication form. The 'Option' field is selected, and a dropdown menu is open showing options: Left, Right, and Both. A red arrow points from the instruction to the 'Option' field.

8. Select appropriate **Frequency** from drop down menu.

A screenshot of a medication form. The 'Frequency' field is selected, and a dropdown menu is open showing various frequency options. A red arrow points from the instruction to the 'Frequency' field. The dropdown menu lists the following options: Every 15 mins, 1/2 hourly, hourly, 2 hourly, 4-6 hourly pm, 5/day, 6/day, 6 hourly, qid, tid, bd, od, morning, bedtime, nocte, alt days, 3/week, 2/week, 1/week, and - Select -.

9. In **Date from** field, select date medications started. Day and Month are optional but year is not. Use **From today** button if medications start same day as being recorded.

A screenshot of the 'Date from' field. It contains three dropdown menus: 'Day (optional)', 'Month (optional)', and '2014'. Below the dropdowns are radio buttons for 'Yes' and 'No', with 'Yes' selected. A blue 'From today' button is located to the right. A red arrow points from the instruction to the 'Date from' field.

10. In **Current** field select whether the medication is current or not by selecting **Yes** or **No** radio button.

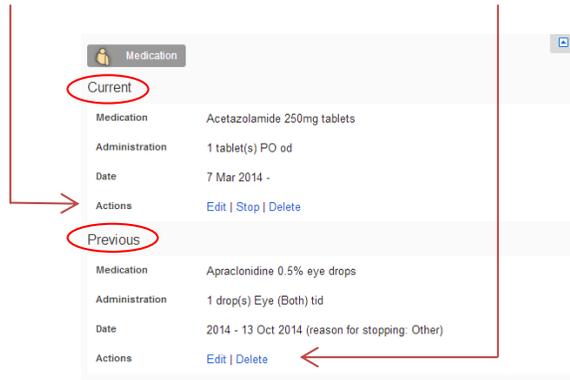
11. Select **Save** to record medication on patients record. Select **Cancel** if there is a need to start again.

Two buttons: a green 'Save' button and a red 'Cancel' button.

12. If there's further medication to record, repeat the same process for each one.

## Edit, Stop or Delete Medications

Each medication is listed under, either Current or Previous. The current medications will have actions to Edit, Stop or Delete. Previous medications will have actions to Edit and Delete.



## Edit Medications

1. Selecting **Edit** will enable the user to amend details of the selected medication. Select **Save** when finished editing.

## Stop Medications

1. Select **Stop** will open the Stop Medication at the base of the Medications section. Select **Date stopped** using the drop down menu's.



2. Select appropriate **Reason for stopping** from drop down menu.
3. Select **Stop** and the medication will move from Current medication to Previous medication.
4. If the medication has been incorrectly stopped, select Edit for that medication. In the **Current** field select Yes radio button.
5. The medication is now listed under the Current medication.

## Delete Medications

If an error is made and the wrong medication is entered and saved, the entry can be deleted.

1. Select **Delete** for the medication to be removed. Confirm delete medication message appears.



2. Select **Remove medication**.
3. Medication will be removed from patients record.

**NOTE: Only use delete to remove medication entered in error. Do not use for medication stopped**

## CVI Status

*CVI status may not be populated by Nurses at some satellite sites.*

1. Select **Edit** in the CVI status section of the patient summary screen.



A screenshot of the 'CVI Status' section in a patient summary screen. It shows a table with two columns: 'Date' and 'Status'. The 'Date' column contains '4 May 2011' and the 'Status' column contains 'Not Certified'. Below the table is a green 'Edit' button. A red arrow points from the 'Edit' button in the first step to this 'Edit' button.

2. **Edit CVI Status** opens.



A screenshot of the 'Edit CVI Status' form. It shows a table with 'Date' (4 May 2011) and 'Status' (Not Certified). Below the table is an 'Edit' button. The form below the table has 'Status:' with a dropdown menu set to 'Not Certified' and 'Date:' with three dropdown menus set to '4', 'May', and '2011'. There are 'Save' and 'Cancel' buttons at the bottom. A red arrow points from the 'Edit CVI Status' text in the second step to the 'Edit' button.

3. Select appropriate **Status** from drop down menu.



A screenshot of the 'Edit CVI Status' form with the 'Status' dropdown menu open. The table shows 'Date' as '1 Jan 2000' and 'Status' as 'Unknown'. The dropdown menu lists several options: 'Not eligible', 'Not eligible', 'Eligible but not offered', 'Eligible but not offered', 'Eligible but declined', 'Eligible but declined', 'Sight Impaired', 'Severe sight impaired', and 'Unknown'. The 'Severe sight impaired' option is highlighted in blue. A red arrow points from the 'Status' text in the third step to the dropdown menu.

4. Select **Date** fields to confirm date CVI status recorded.



A screenshot of the 'Edit CVI Status' form with the date fields selected. The table shows 'Date' as '1 Jan 2000' and 'Status' as 'Unknown'. The form below the table has 'Status:' with a dropdown menu set to 'Severe sight impaired' and 'Date:' with three dropdown menus set to '8', 'October', and '2014'. There are 'Save' and 'Cancel' buttons at the bottom. A red arrow points from the 'Date' text in the fourth step to the date dropdown menus.

5. Select **Save**



A screenshot of the 'Edit CVI Status' form with the 'Save' button highlighted. The table shows 'Date' as '1 Jan 2000' and 'Status' as 'Unknown'. The form below the table has 'Status:' with a dropdown menu set to 'Severe sight impaired' and 'Date:' with three dropdown menus set to '8', 'October', and '2014'. There are 'Save' and 'Cancel' buttons at the bottom. A red arrow points from the 'Save' text in the fifth step to the 'Save' button.

## Allergies

### Adding an allergy

1. Select **Edit** in the Allergies section of the patient summary screen.

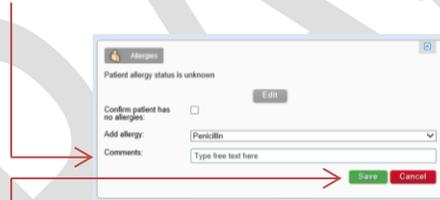


2. The allergies section expands. Select appropriate **Allergy**, from drop down menu.



**NOTE: If patient has no allergies, select Confirm patient has no allergies.**

3. Select the **Comments** field to add additional information by free text.

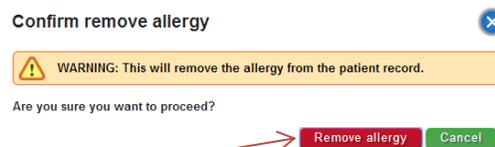


4. Select **Save**. The selected allergy and comment are displayed.



### Removing an allergy

1. Go to the Allergies section of the patient summary screen.
2. Select **Remove**, located to the right of the allergy to be removed.
3. **Confirm remove allergy** warning message appears.



4. Select **Remove allergy** (or select **Cancel** if you do not wish to remove allergy.)
5. The allergy will now be removed.

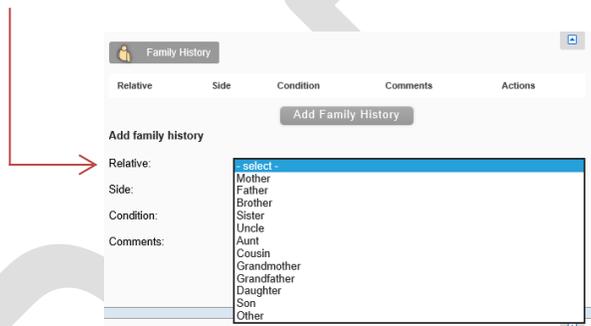
## Family History

*This section is used to record past instances of conditions that have occurred within the patients family.*

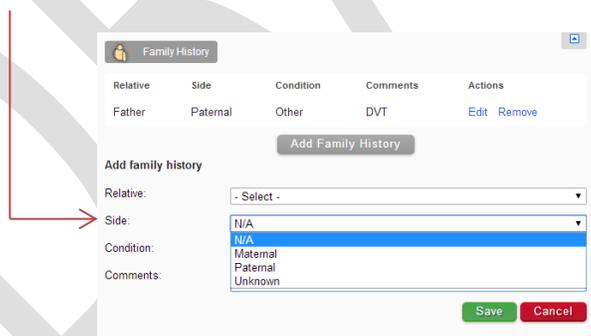
1. Go to the **Family History** section of the patient summary screen.
2. Select **Add Family History**.



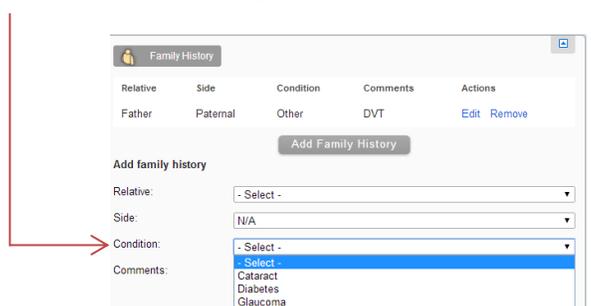
3. The **Family History** section expands to show fields for **Add family history**. Select appropriate **Relative** from drop down menu.



4. Select appropriate **Side** from drop down menu.



5. Select appropriate **Condition** from drop down menu.



6. Select the **Comments** field to add additional information by free text. (i.e. If **Other** were selected in the **Condition** field, comments can be free text to identify which other condition)

Family History

Relative	Side	Condition	Comments	Actions
Father	Paternal	Other	DVT	Edit Remove

Add Family History

Add family history

Relative: Grandfather

Side: Paternal

Condition: Other

Comments: Angina

Save Cancel

7. Select **Save**. Condition is now showing, along with comment, in **Family History**.

Family History

Relative	Side	Condition	Comments	Actions
Father	Paternal	Other	DVT	Edit Remove
Grandfather	Paternal	Other	Angina	Edit Remove

Add Family History

## Social History

1. Go to the **Social History** section of the patient summary screen.
2. Select **Edit**

Social History

Status

Edit

3. The **Social History** section expands to show fields to populate. Select appropriate **Employment** from drop down menu.

Social History

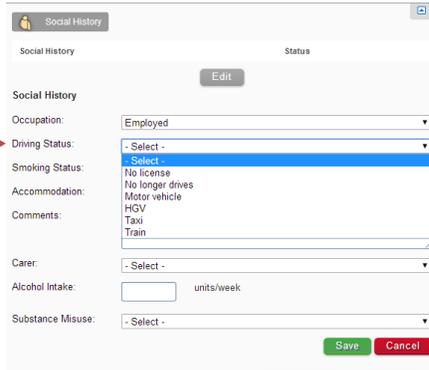
Status

Edit

Social History

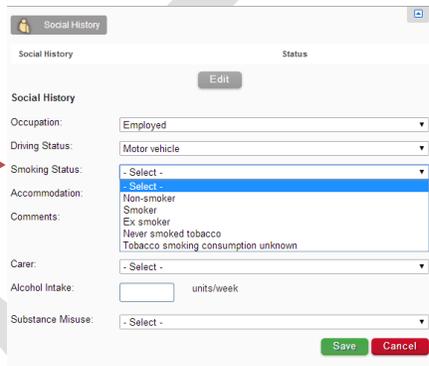
Employment: Select -  
Employed  
Self-employed  
Unemployed  
Disability Benefits  
Student  
Retired  
Other (specify)

4. Select appropriate **Driving Status** from drop down menu.



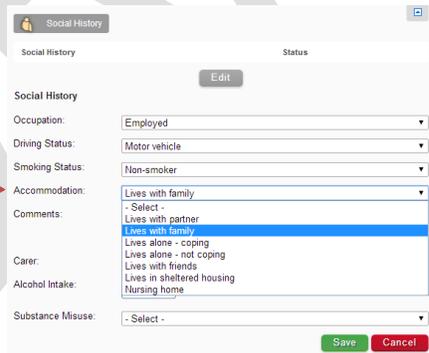
A screenshot of a 'Social History' form. The 'Driving Status' dropdown menu is open, showing options: '- Select -', 'No license', 'No longer drives', 'Motor vehicle', 'HGV', 'Taxi', and 'Train'. A red arrow points from the instruction above to the 'Driving Status' label. The form also includes fields for Occupation (Employed), Smoking Status, Accommodation, Comments, Carer, Alcohol Intake, and Substance Misuse. 'Save' and 'Cancel' buttons are at the bottom right.

5. Select appropriate **Smoking Status** from drop down menu.



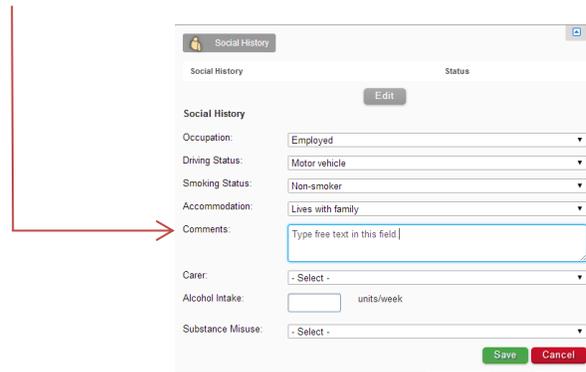
A screenshot of a 'Social History' form. The 'Smoking Status' dropdown menu is open, showing options: '- Select -', 'Non-smoker', 'Smoker', 'Ex smoker', 'Never smoked tobacco', and 'Tobacco smoking consumption unknown'. A red arrow points from the instruction above to the 'Smoking Status' label. The form also includes fields for Occupation (Employed), Driving Status (Motor vehicle), Accommodation, Comments, Carer, Alcohol Intake, and Substance Misuse. 'Save' and 'Cancel' buttons are at the bottom right.

6. Select appropriate **Accommodation** from drop down menu.



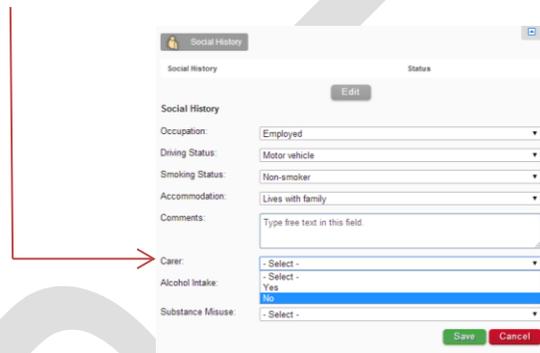
A screenshot of a 'Social History' form. The 'Accommodation' dropdown menu is open, showing options: 'Lives with family', '- Select -', 'Lives with partner', 'Lives with family', 'Lives alone - coping', 'Lives alone - not coping', 'Lives with friends', 'Lives in sheltered housing', and 'Nursing home'. A red arrow points from the instruction above to the 'Accommodation' label. The form also includes fields for Occupation (Employed), Driving Status (Motor vehicle), Smoking Status (Non-smoker), Comments, Carer, Alcohol Intake, and Substance Misuse. 'Save' and 'Cancel' buttons are at the bottom right.

7. Select **Comments** field to add additional information using free text.



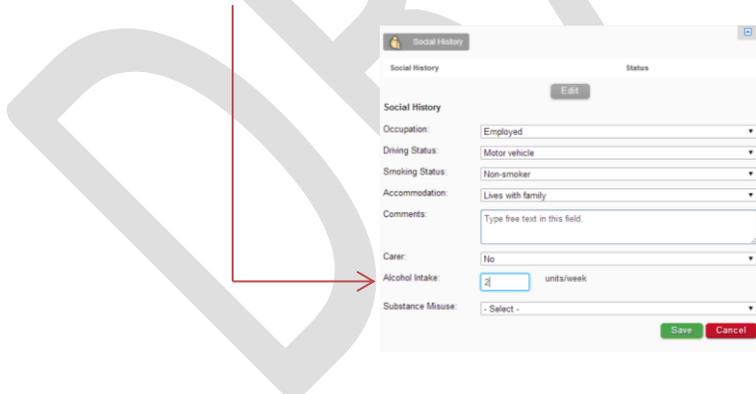
A screenshot of a web form titled "Social History". The form contains several fields: Occupation (Employed), Driving Status (Motor vehicle), Smoking Status (Non-smoker), Accommodation (Lives with family), Comments (a text input field with a placeholder "Type free text in this field"), Carer (- Select -), Alcohol Intake (units/week), and Substance Misuse (- Select -). A red arrow points to the Comments field. At the bottom right, there are "Save" and "Cancel" buttons.

8. Select appropriate **Carer** from drop down menu.



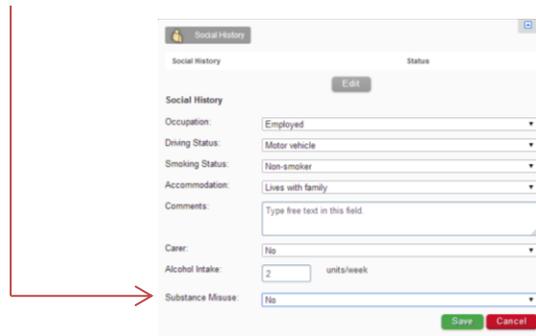
A screenshot of the "Social History" form. The "Carer" dropdown menu is open, showing options: "- Select -", "- Select -", "Yes", and "No". A red arrow points to the "No" option. The other fields in the form are the same as in the previous screenshot. "Save" and "Cancel" buttons are at the bottom right.

9. Select **Alcohol Intake** field and free text the number of units consumed weekly.



A screenshot of the "Social History" form. The "Alcohol Intake" field is highlighted with a red arrow. The field contains the number "2" followed by "units/week". The other fields in the form are the same as in the previous screenshots. "Save" and "Cancel" buttons are at the bottom right.

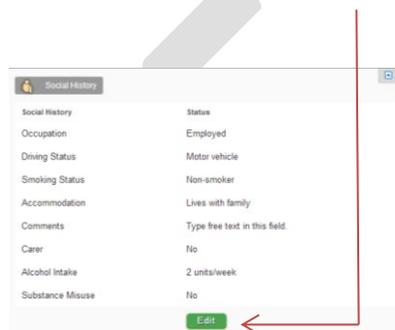
10. Select appropriate **Substance Misuse** from drop down menu



A screenshot of a 'Social History' form. The form contains several dropdown menus: Occupation (Employed), Driving Status (Motor vehicle), Smoking Status (Non-smoker), Accommodation (Lives with family), Carer (No), Alcohol Intake (2 units/week), and Substance Misuse (No). A red arrow points to the Substance Misuse dropdown menu. At the bottom right, there are 'Save' and 'Cancel' buttons.

11. Click **Save**. Social history information saved and presented as shown below.

*Should any social history information need amending, select Edit, amend the relevant field as described above and select Save.*



A screenshot of the 'Social History' form, identical to the one above, but with a red arrow pointing to the 'Edit' button at the bottom center.

*Having completed details on the Patient Summary screen, nursing staff will now need to access the appropriate episode for their patient. This is so they can record visual acuities and IOP's.*

## Episodes and Events

Definition of:

**Episode** – An episode is a collection of events relating to the care of a patient under a consultant / firm and representing a complete picture of the clinical management of a single condition. For example, a patient treated for a right cataract would have an episode containing a referral letter, examination, biometry, operation note, prescription and discharge letter.

**Event** – An event is a distinct clinical occurrence, which may happen to a patient during the course of their care. The range of events includes referral letters, clinical examinations, pre-assessments, operations and letters to GP's.

Access to patient episodes is via the Patient Summary screen.

### Example - Patient with two episodes.

All Episodes						open 2   closed 0
Start Date	End Date	Firm	Subspecialty	Eye	Diagnosis	
Ophthalmology						
12 Aug 2013		Westcott Mark	Medical Retinal	No diagnosis	No diagnosis	
15 Sep 2014		Brookes John	Glaucoma	Both	Angle recession glaucoma	

Latest Event in Glaucoma: Examination (19 Sep 2014)

### Example - Patient with no episodes.

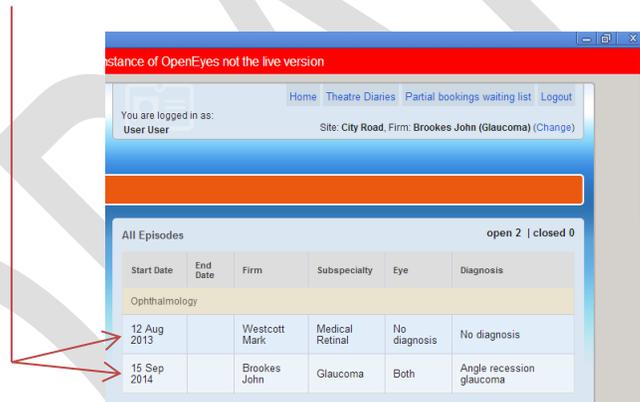
All Episodes						open 0   closed 0
No episodes						
<a href="#">Create episode / add event</a>						

**Open episode = indicates on-going clinical care and is current. E.g. has a start date but no end date**

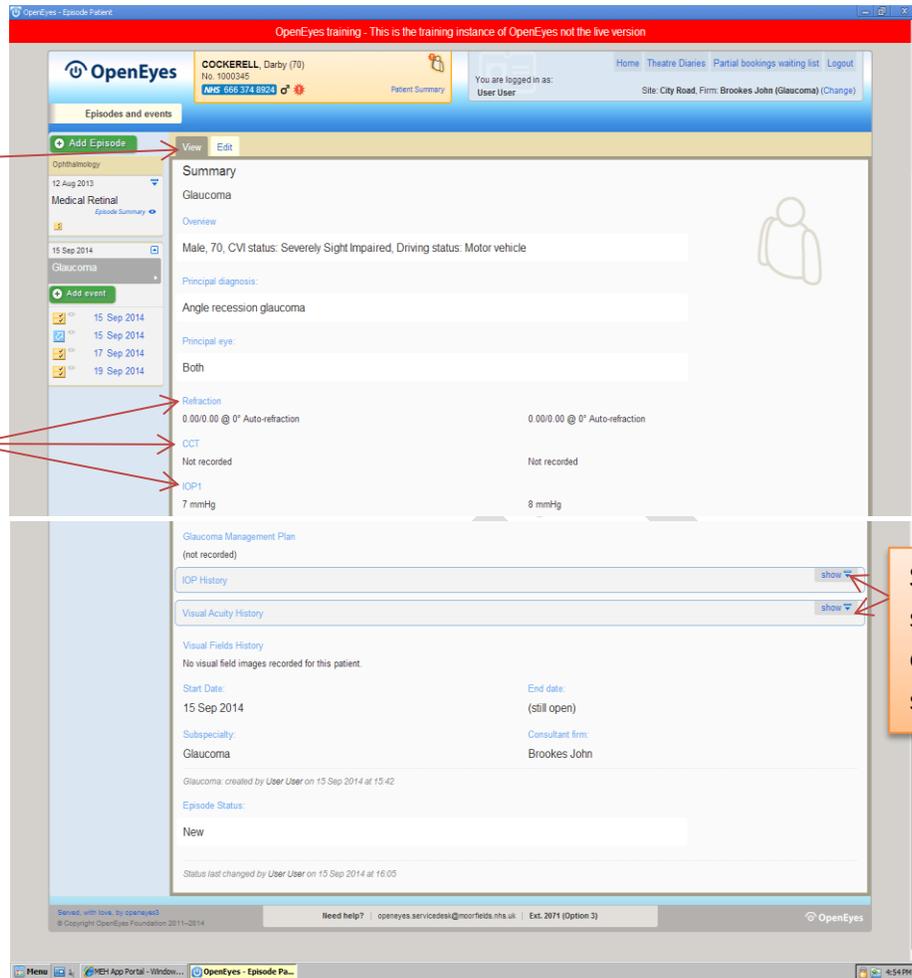
**Closed episode = has a start and end date and represents a period of clinical care under a Consultant that has finished.**

## Opening an Episode

1. Select Episode from the Patient Summary screen. **Ensure correct episode is selected.**



2. The Episodes and events Summary screen will open.

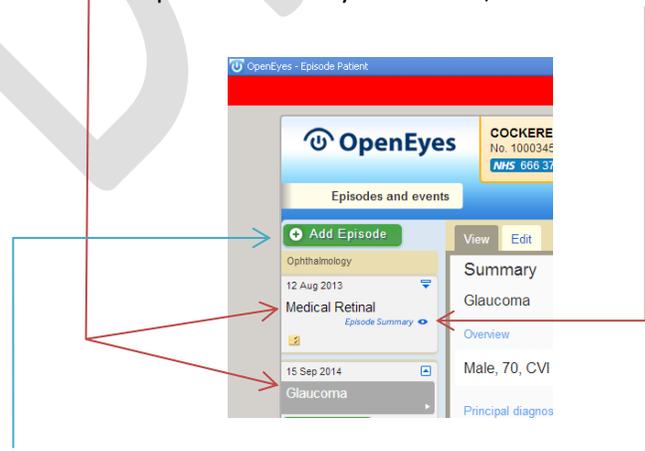


Summary opens with View tab selected.

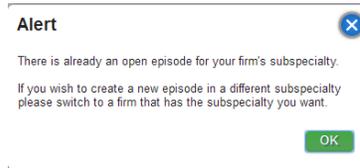
Headings are in blue text.

Selecting show will expand that section.

3. Top left side of the patient's episode summary screen you can view the patients episodes. In the example, below, the patient has both Glaucoma and Medical Retinal episodes.
4. To change view from one episode summary to another, select **Episode Summary** of chosen episode.



5. If you select **Add Episode** whilst you have an episode open, you will get the following message.



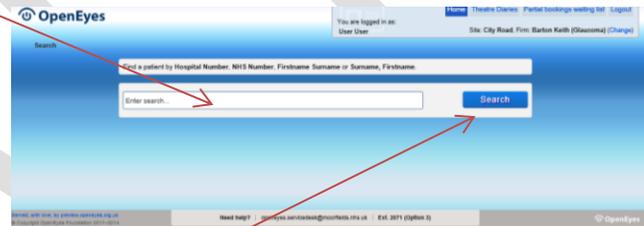
6. Select **OK** to clear message.

## Creating an Episode

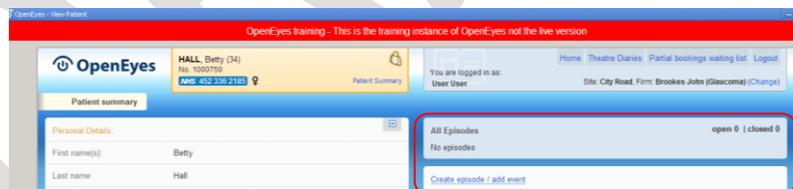
1. Select site and/or firm from the pop up box then the green confirm button.



2. Search for the Patient allocated by the Trainer using the search criteria.
3. Example - Hospital Number: 1000001

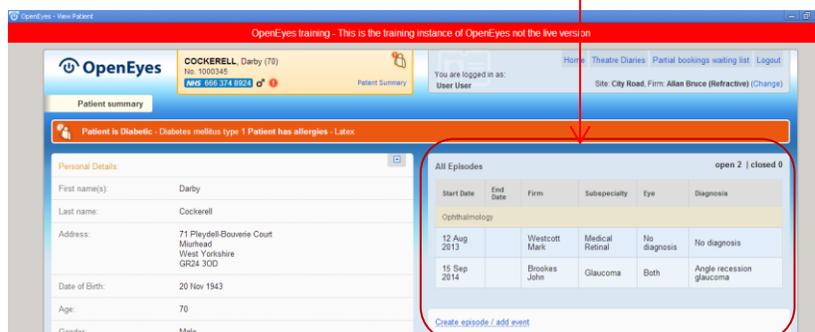


4. Then select search to open the patient record.
5. Patients Summary screen opens. Episode section determines whether patient has any prior episodes on OpenEyes. (two examples shown below)



**Above:** Patient who has had no episodes recorded on OpenEyes.

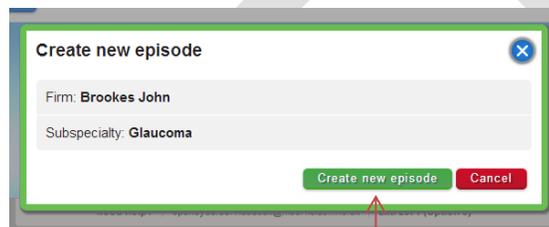
**Below:** Patient who has episodes recorded on OpenEyes.



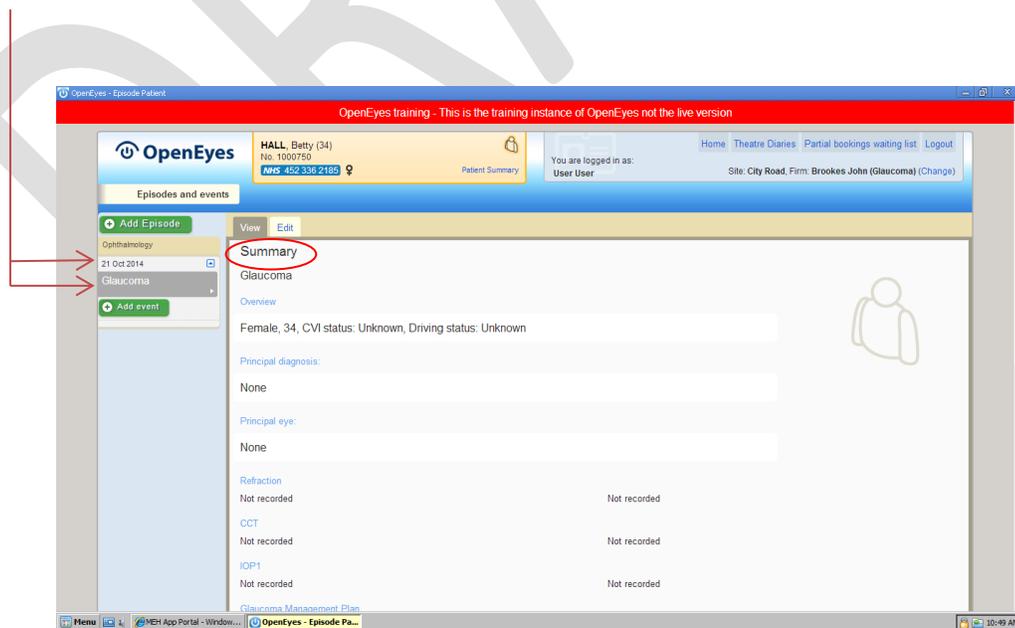
6. When you select **Create episode**, the next screen you see will depend on whether the patient has, or does not have, episodes on Openeyes.
7. Select **Create episode** on a patient with no episodes.
8. Message opens confirming that there are no episodes.



9. Select Add episode.
10. Create new episode message opens. This is based on Firm/sub-specialty selected.

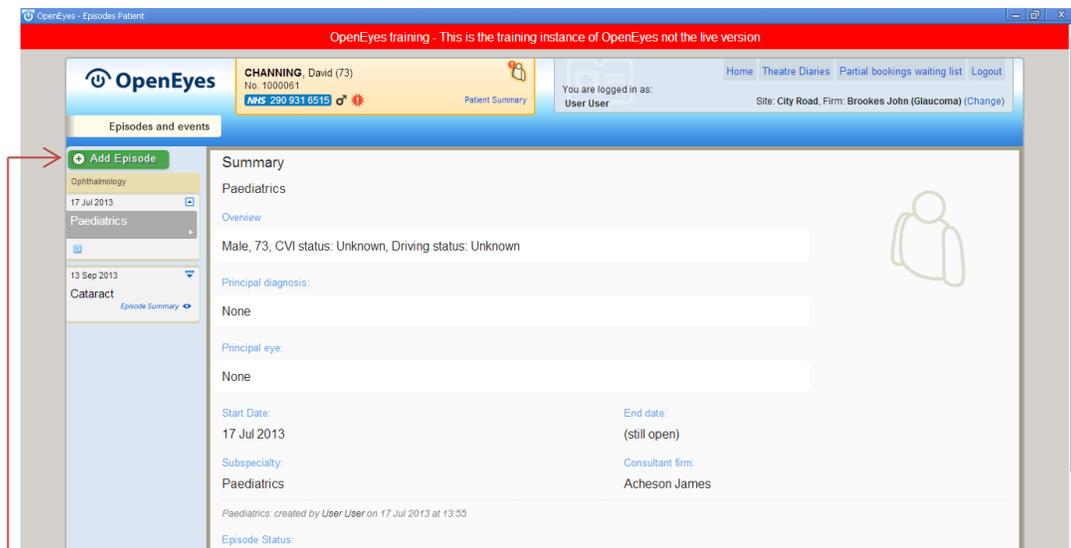


11. Select Create new episode.
12. Episode Summary screen will open. Note to the left hand side of screen sub-specialty of episode created is viewable, as is the date created.

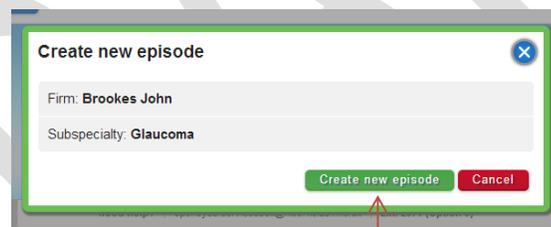


13. Now we will look at creating an episode for a patient with previous/current episodes.

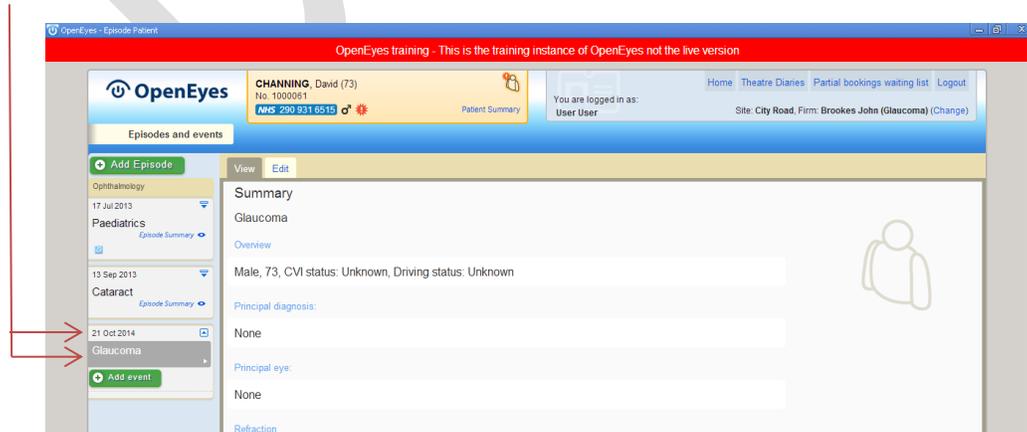
14. Select Firm/sub-specialty of Glaucoma.
15. Search for a patient with episodes, but does not have a Glaucoma episode.
16. Again, from the Patient Summary screen, select **Create episode**. An episode summary screen opens displaying a current episode. The example below displays Paediatrics.



17. Select **Add episode**.
18. Create new episode message opens. This is based on Firm/sub-specialty selected.



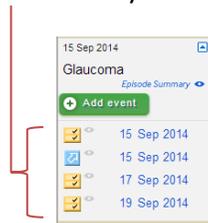
19. Select **Create new episode**.
20. Episode Summary screen will open. Note to the left hand side of screen sub-specialty of episode created is viewable, as is the date created.



21. With the episode created, events can be added.

## Viewing Events

1. Top left side of the patient's episode summary screen you can view the patients events.

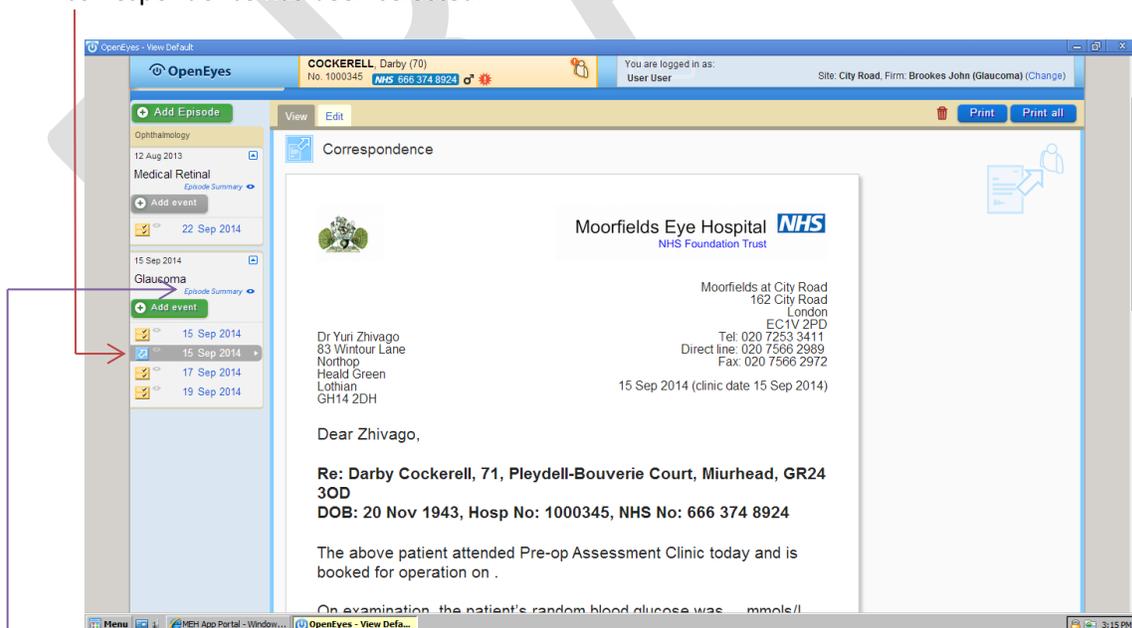


2. For each type of event, a different icon is used, along with the date the event was undertaken.

3. By placing the mouse over an icon, a pop-up will tell you the type of event. See examples below.



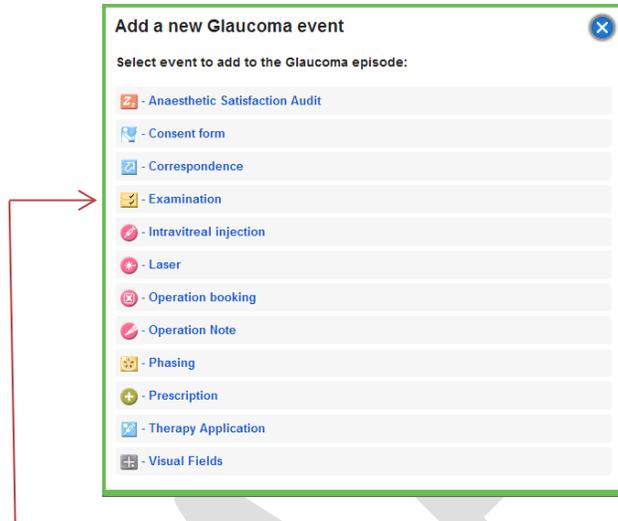
4. Select the event you wish to view and it will display on screen. In the example below, correspondence has been selected.



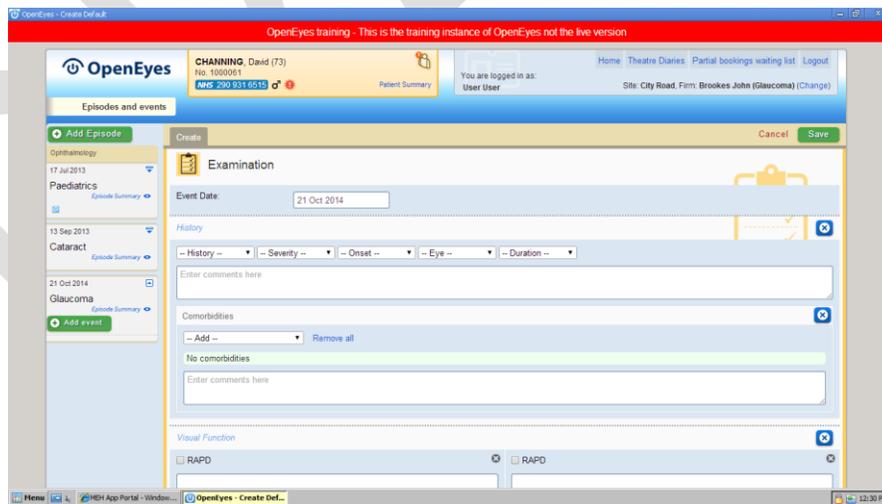
5. To view another event you just select again from the events list, otherwise, if you wish to return to the Episode Summary select [Episode Summary](#) for the appropriate sub-specialty.

## Adding an Event

1. Select **+ Add event** upper left of screen.
2. **Add a new Glaucoma event** options list appears in a pop up screen. Note the different icons against each event.



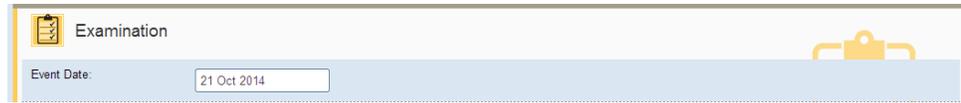
3. Select the event required (In this instance **Examination** will be selected).
4. Examination event screen opens.



*With the Examination event open Nurses and Techs can record Visual Acuity and IOP's*

## EVENT DATE

- The Event Date is at the top of the Examination screen and defaults to the current days date. Only change date if you are entering an examination retrospectively. Selecting the date field would offer you a calendar to choose the required date.

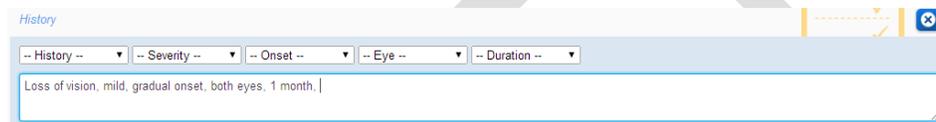


Examination

Event Date: 21 Oct 2014

## HISTORY

- Within the History section are drop down menus to select appropriate options. When you select an option from the menus, the selection drops into the comments field. There is also the ability to free text in additional information.



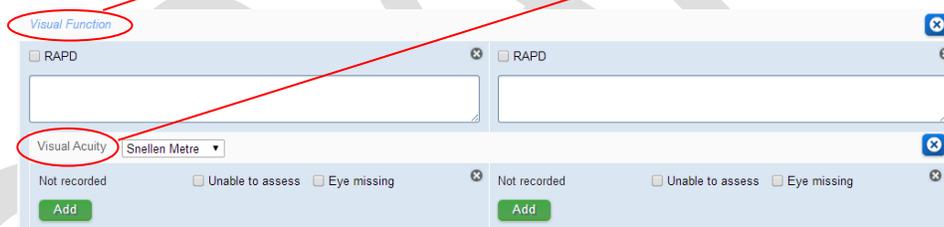
History

-- History -- -- Severity -- -- Onset -- -- Eye -- -- Duration --

Loss of vision, mild, gradual onset, both eyes, 1 month, |

## VISUAL ACUITY

- Find the section **Visual Function**. Within this section is **Visual Acuity**.



Visual Function

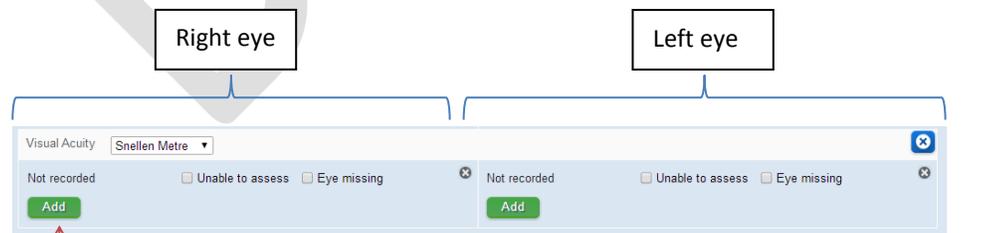
RAPD  RAPD

Visual Acuity Snellen Metre

Not recorded  Unable to assess  Eye missing Not recorded  Unable to assess  Eye missing

Add Add

- Select drop down menu, to right of Visual Acuity, to select appropriate option.
- Remember: left and right eyes are recorded separately.



Right eye Left eye

Visual Acuity Snellen Metre

Not recorded  Unable to assess  Eye missing Not recorded  Unable to assess  Eye missing

Add Add

Snellen Metre  
ETDRS Letters  
logMAR  
Snellen Metre

- Select **Add** for right eye.

10. Result and method drop down menus now active.

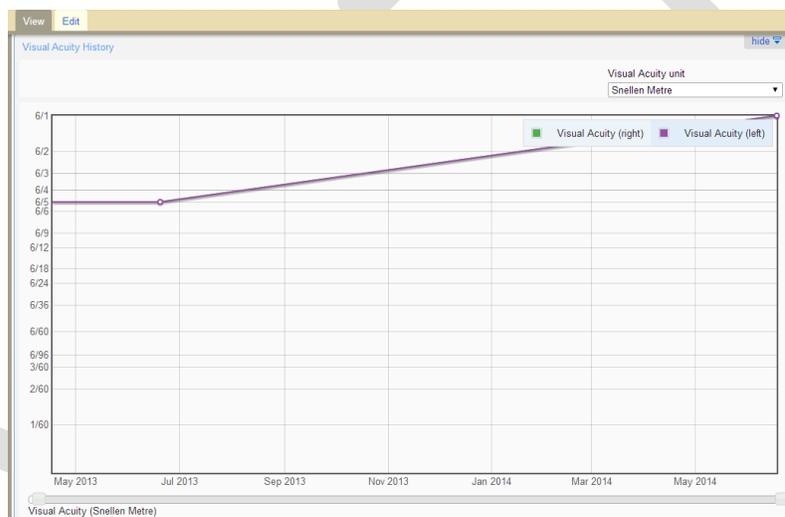
Visual Acuity: 6/6 | Snellen Metre | Unaided | Remove | Not recorded | Add | Unable to assess | Eye missing

11. Select the appropriate options from both result and method menus.

12. Repeat same process for Left eye using steps 8 and 9 above.

13. Select Save (top right corner of screen)

There will be graph of VA results viewable on a patients Episode Summary, under Visual Acuity History, when there have been a number of occurrences.



## COLOUR VISION

14. **Colour Vision** section may appear as shown below. Select  to expand section.

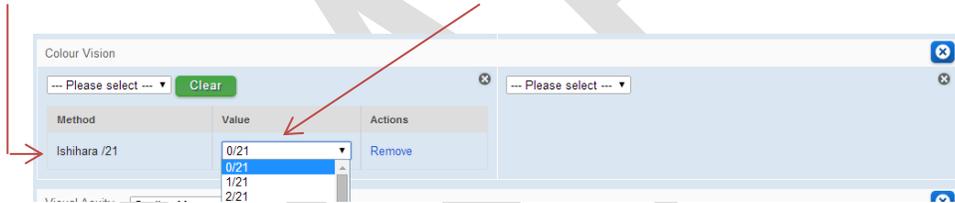


15. **Colour Vision** section opens.



16. Select the drop down menu for right eye. Pick method used.

17. The selection is placed under Method. Select Value from drop down menu.



18. Repeat process steps 16 and 17 above for left eye.

## INTRAOCULAR PRESSURE

19. Find the section, Intraocular Pressure. If there are no readings add text in the comments fields. This is because the Examination event will not be able to be saved until you do so.

20. If there is Intraocular pressure to record, select **Add** for the left / right eye as required.  
 21. The Intraocular section expands to show Time / mm Hg / Instrument fields.

22. The time field defaults to current time. Select to amend if required.

23. Select mm Hg field to record a value.

24. Select Instrument field to record instrument used.  
 25. Repeat steps 20 to 24 above for other eye.

## DILATION

26. Find the section, **Dilation**.

27. Select drop down menu for either left or right eye. Select drug used for dilation.

28. Dilation section expands with selection in Drug column along with current time and number of drops. These fields can be amended accordingly.

Dilation

--- Please select --- Clear

Time	Drug	Drops	Actions
16.01	Cyclopentolate 0.5%	1	Remove

29. Repeat steps 27 and 28 for other eye.

## SAVING EVENT

30. Select **Save**. (top right corner of screen)

OpenEyes - Create Default

CHANNING, David (73)  
No. 1000061 NHS 290 931 6515

You are logged in as: User User  
Site: City Road, Firm: Brookes John (Glaucoma) (Change)

Create Cancel **Save**

Type: Auto-refraction

Intraocular Pressure

Time	mm Hg	Instrument	Remove
15.46	6	Goldmann	Remove
16.01	4	Goldmann	Remove

Dilation

Time	Drug	Drops	Actions
16.01	Cyclopentolate 0.5%	1	Remove

Optional Elements  
Gonioscopy Add all Remove all

31. Once saved a view only screen of the Examination Event appears with confirmation of Examination created. The Edit tab is used to go back in to make amendments.

OpenEyes training - This is the training instance of OpenEyes not the live version

OpenEyes CHANNING, David (73)  
No. 1000061 NHS 290 931 6515 Patient Summary

You are logged in as: User User  
Site: City Road, Firm: Brookes John (Glaucoma) (Change)

Episodes and events

**View** Edit Print Clinician

Examination

Examination created.

History

Loss of vision, mild, gradual onset, both eyes, 1 month.

Comorbidities

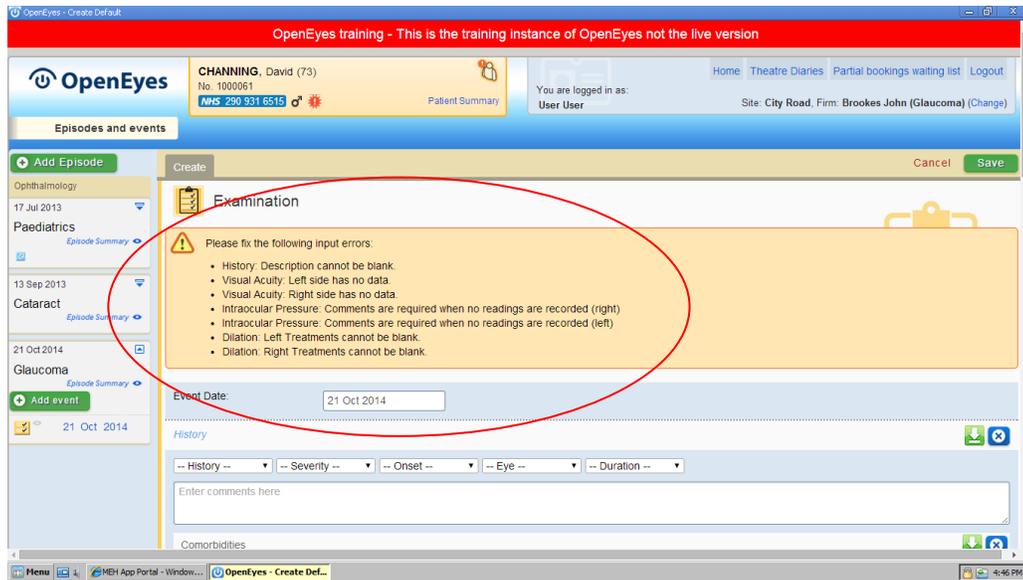
None

Visual Function

Method	Result	Method	Result
Ishihara /21	0/21	Ishihara /21	16/21

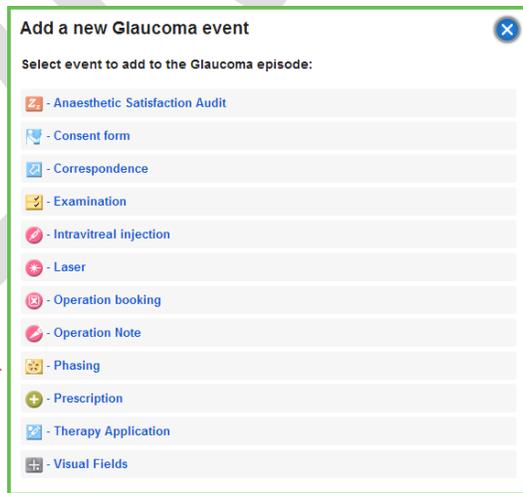
**NOTE: If mandated fields are not completed, the Examination event cannot be saved. It would be necessary to address the errors identified, so that the document can be saved.**

**An example is shown below.**



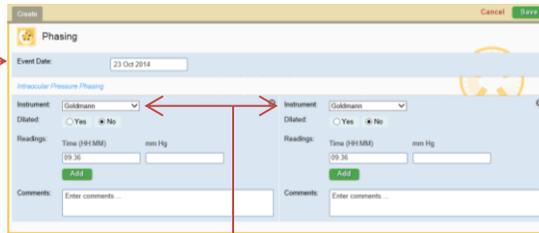
## PHASING

1. Select **+ Add event** upper left of screen.
2. **Add a new Glaucoma event** options list appears in a pop up screen.



3. Select **Phasing** event.

4. The Phasing screen opens.



5. Check **Event Date** is correct.

6. Select **Instrument** field to record instrument used.

7. Select appropriate **Dilated** radio button, **Yes** or **NO**.

8. **Time** defaults to current time but can be edited.

9. The pressure value is added to the **mmHG** field.

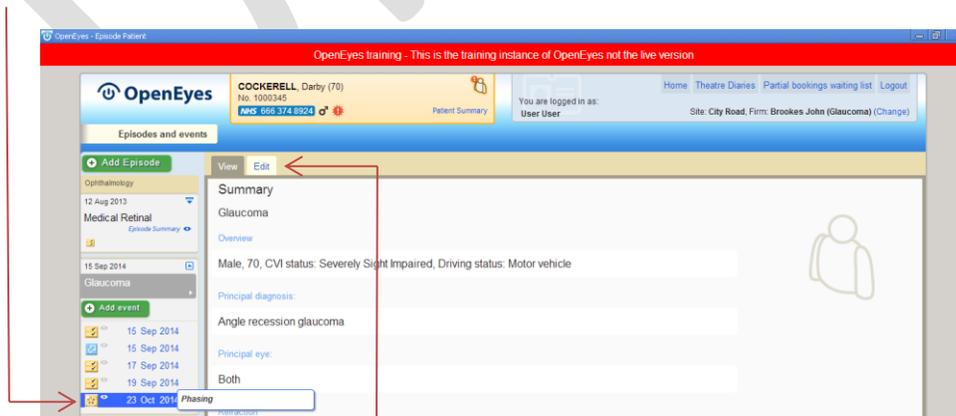
10. Select **Comments** in free text field.

11. Select **Save**. Phasing created confirmation appears.



**To record Phasing after a period of time on the same day**

12. Open the current Phasing event. This will be in the legacy events on left of episode summary screen.



13. Select **Edit** to add a new measurement.

14. Phasing event opens.

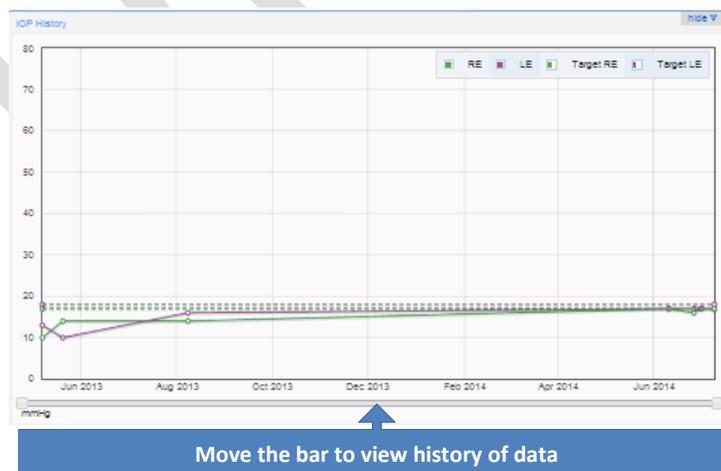
15. Select **Add** for appropriate eye.

16. A second set of **Time** and **mmHg** fields open to record new measurements.

17. Repeat point 15 and 16 above for other eye.

18. Follow same process for each occurrence on same day.

19. There will be graph of IOP results viewable on a patients Episode Summary, under IOP History, when there have been a number of occurrences.



## VISUAL FIELDS

### Visual Fields from Legacy Event

1. To the left of the Episodes and Events summary screen select the green **'Add event'** button, and select the **'Visual Field'** Event.
2. The **'Visual Field'** legacy event screen opens.
3. Select the appropriate option from the **'Right Eye'/'Left Eye'** drop down menu.

**Only select options both eyes if historical image is required for both eyes.**

Visual Fields

Event Date: 22 Oct 2014

Image

Right Eye: 27 Jun 2007 10:18:50

Left Eye: 24 Jul 2007 11:49:16

Strategy: SITA-Standard

Test Name: S S-24-2 Thr

Condition

Fixation Monitor: Blind Spot  
Fixation Target: Central  
Fixation Losses: 0/25  
False POS Errors: 0/15  
False NEG Errors: 1/14  
Test Duration: 15:40  
Fovea: 22 dB

Stimulus: III, White  
Background: 31.5 ASB  
Strategy: Full Threshold

Pupil Diameter: 4.0 mm  
Visual Acuity: 6/24  
RX: +3.00 DS DC X

GHT  
Outside normal limits  
VFI 72%

4. To view the full image, select the **'view full image'** hyperlink.
5. The **'image'** will open in a separate screen.
6. Select the appropriate option from the **'ability'** drop down menu.
7. Select the appropriate option from the **'Glasses'** drop down menu.
8. Record any relevant comments in the **'Comments'** box below.

Condition

Ability:

Glasses:  Yes  No

Comments

Comments:

Result

Result Assessment:

9. Select the appropriate option from the **'Results Assessment'** drop down menu.
10. Select the green **'Save'** button on the top right hand side of the examination form to save information entered.

## Logging Off

1. Select [Logout](#) from the tab located top right hand corner of the screen. *This can be seen from any screen within OpenEyes.*

