OpenEyes for Nurses and Technicians

(User Manual)

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Colour Key: ***OpenEyes Form links***, ***OpenEyes navigation links***, *Notes*, ***Field names***

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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Documentation History

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Document Status

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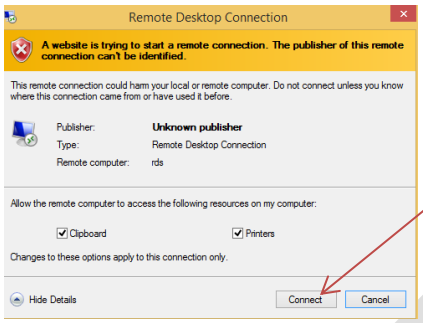
Logging on and Getting Started

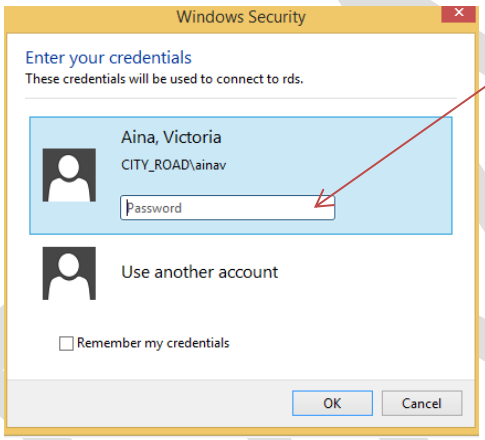
The OpenEyes login page is case sensitive.

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



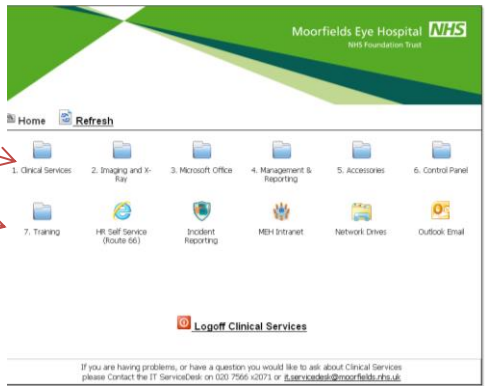
REMOTE DESKTOP POP UP BOX 1

- Within the 'Window 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

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.

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

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.

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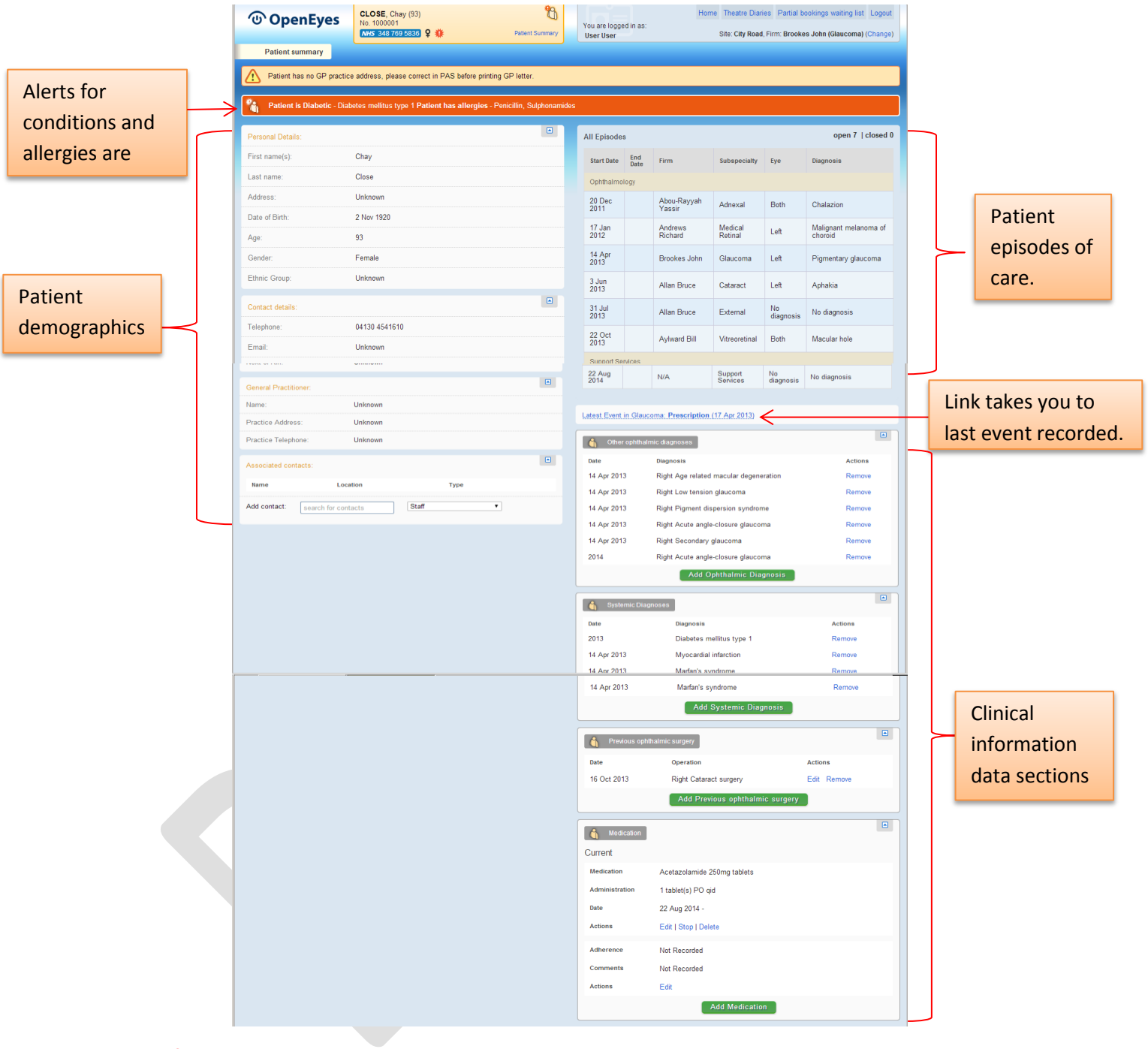


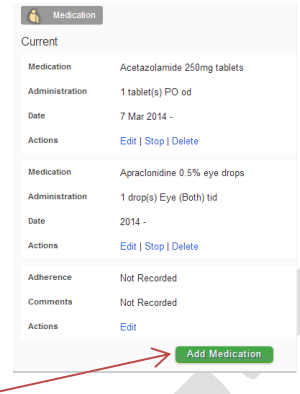
Note: After Medication section are CVI Status, Allergies, Family History and Social History sections. A number of the sections, relevant to Nursing / Technician staff are covered in this manual.

Minimum Legacy Data Set.

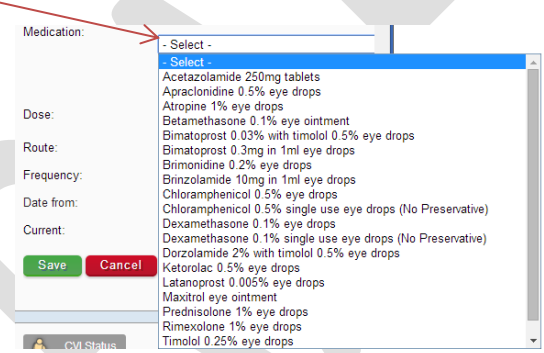
Inform delegates that it is expected that Nurses and Technicians enter the minimum legacy data sets into the relevant fields located on the summary page.

Medication

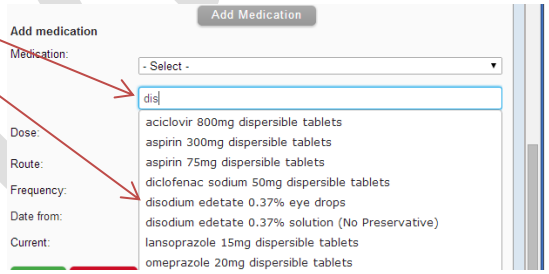
To add medications, do the following.



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.

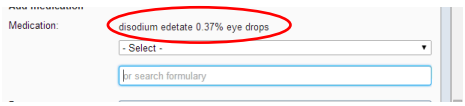


or, (b) selecting the search formulary dynamic box and start to type the name of the medication and pick from the options listed. The search uses SNOMED terminology.



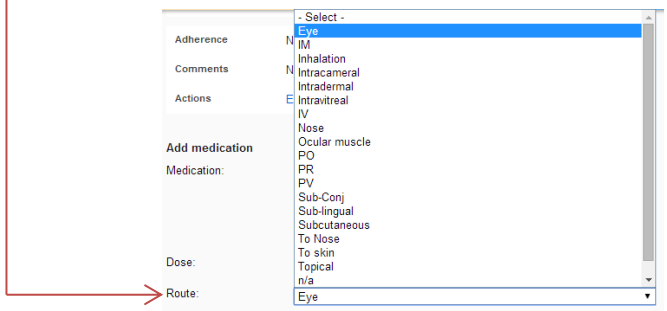
SNOMED is a systematically organised computer processable collection of medical terms providing codes, terms, synonyms and definitions used in clinical documentation and reporting.

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

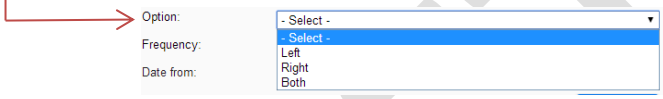


5. Ensure the **Dose** field is correct and amend if necessary.

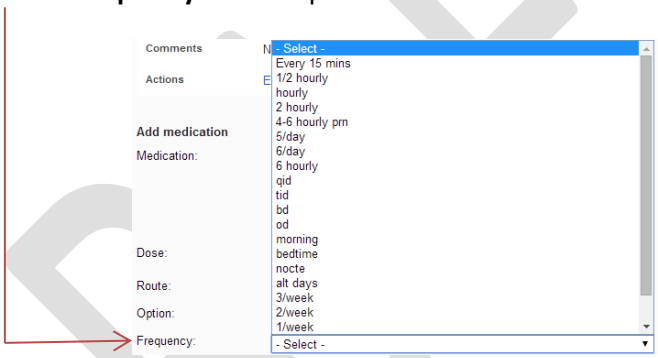
6. Ensure the **Route** is correct and select appropriate option from drop down list, if need to amend.



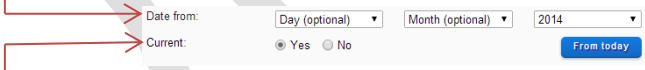
7. Select appropriate **Option** from drop down menu.



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



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

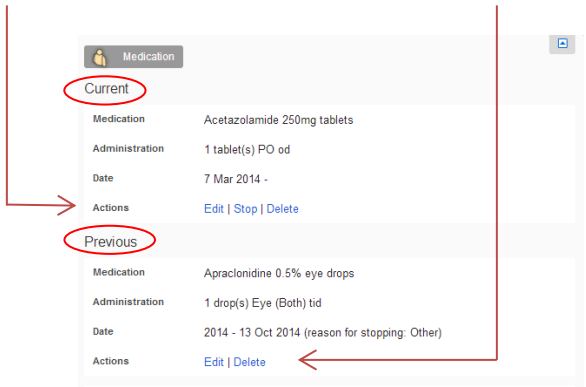


10. In **Current** field select whether the medication is current or not by selecting **Yes** or **No** radio button.
11. Select **Save** to record medication on patients record. Select **Cancel** if there is a need to start again.

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

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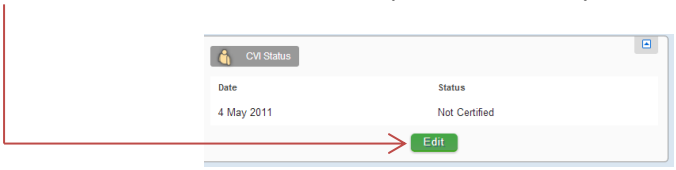
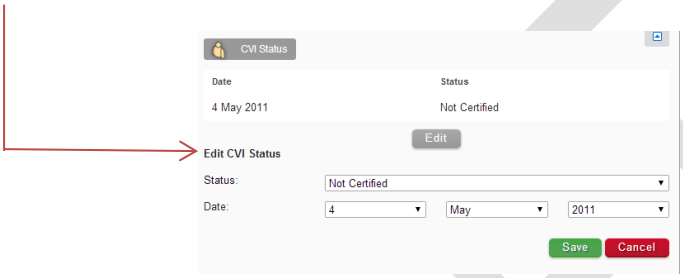
CVI Status

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

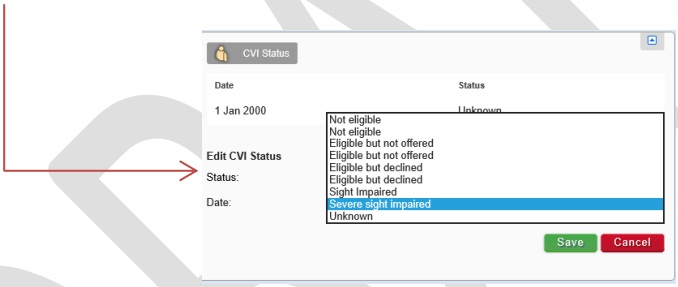
1. Select **Edit** in the CVI status section of the patient summary screen.



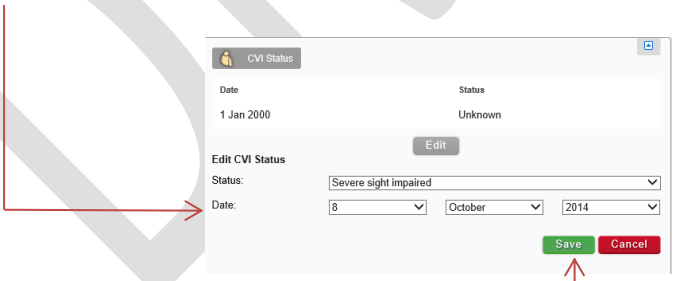
2. **Edit CVI Status** opens.



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



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

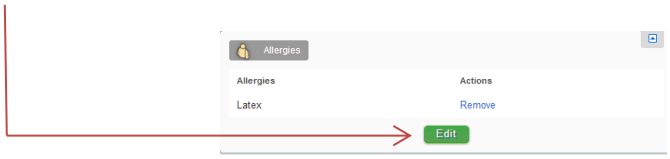


5. Select **Save**

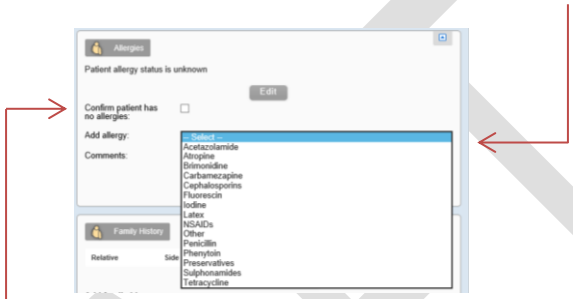
Allergies

Adding an allergy

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

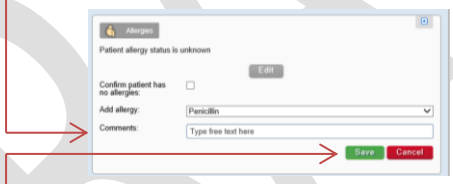


2. The allergies section expands. Select appropriate **Allergy**, from drop down menu.



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

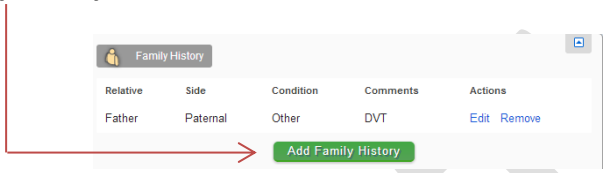
1. Go to the Allergies section of the patient summary screen.
2. Select **Remove**, located to the right of the allergy to be removed.
3. **Confirm remove allergy** warning message appears.

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

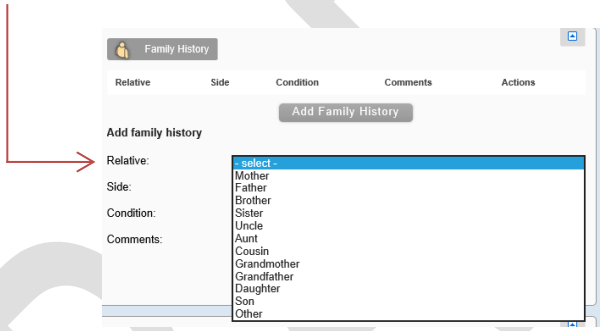
Family History

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

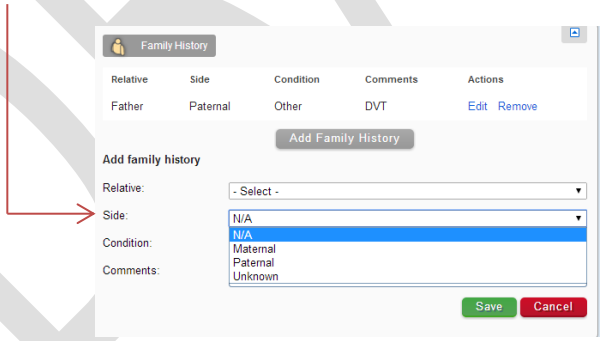
1. Go to the **Family History** section of the patient summary screen.
2. Select **Add Family History**.



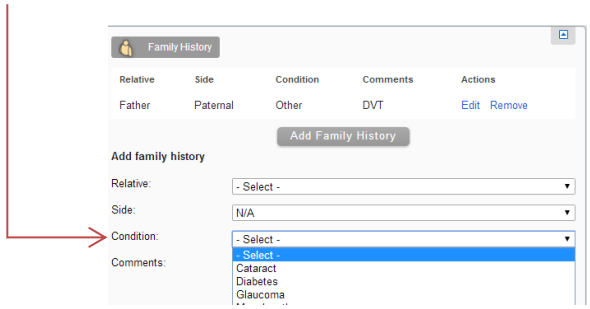
3. The **Family History** section expands to show fields for **Add family history**. Select appropriate **Relative** from drop down menu.



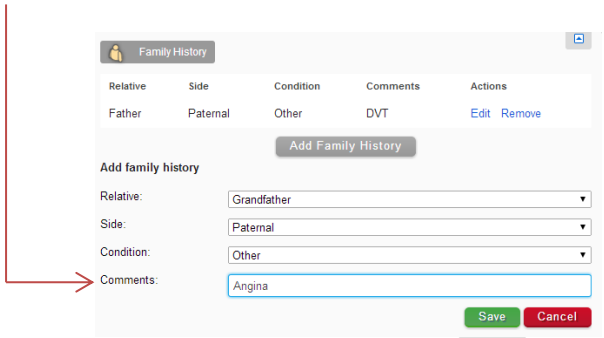
4. Select appropriate **Side** from drop down menu.



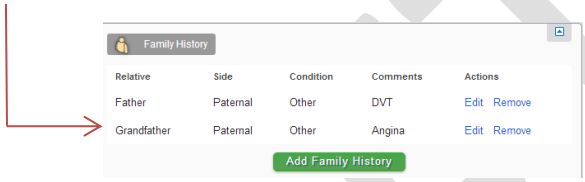
5. Select appropriate **Condition** from drop down menu.



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)

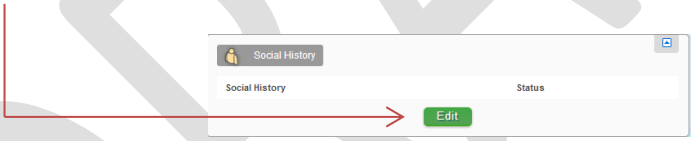


7. Select **Save**. Condition is now showing, along with comment, in **Family History**.

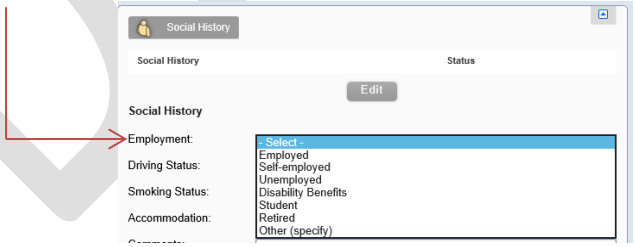


Social History

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



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



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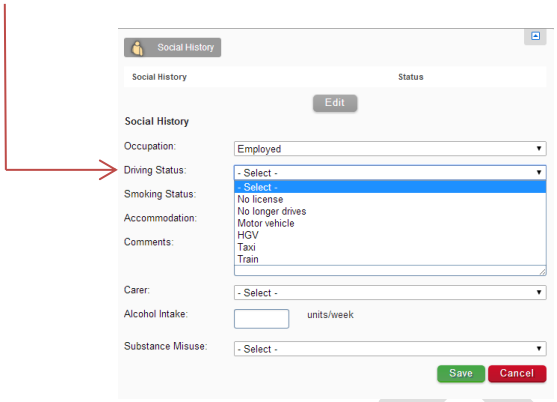
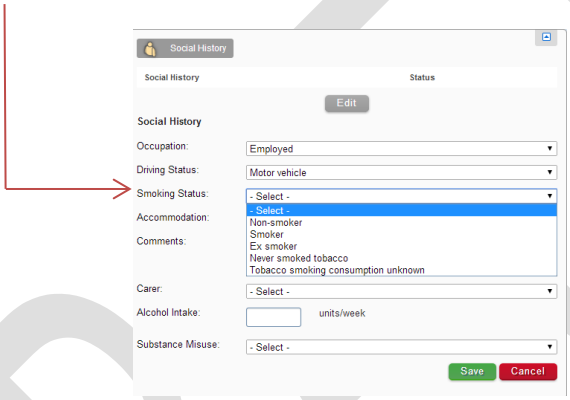
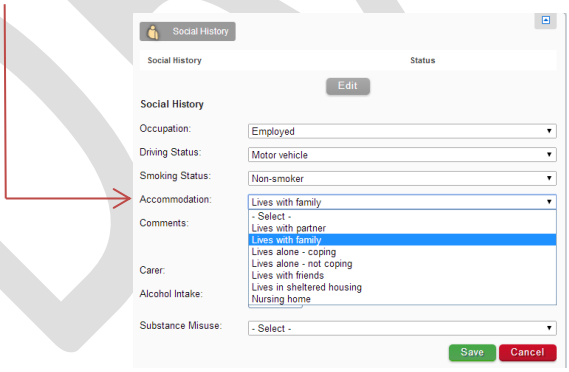
4. Select appropriate **Driving Status** from drop down menu.



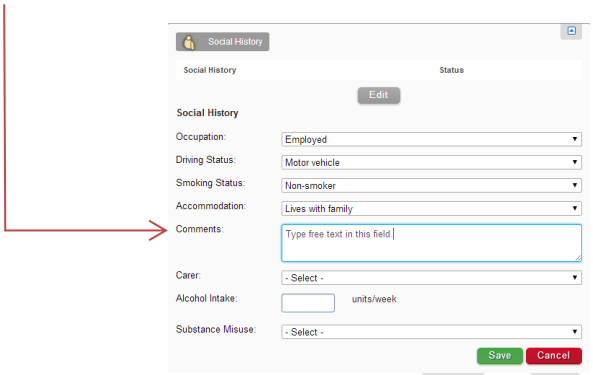
5. Select appropriate **Smoking Status** from drop down menu.



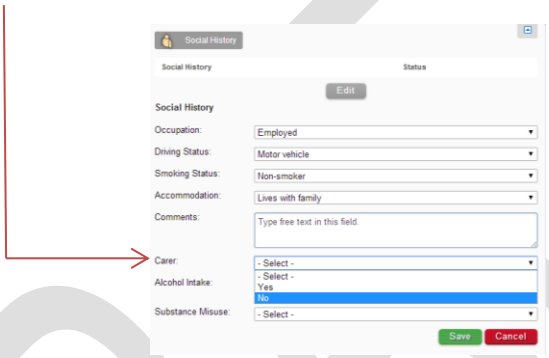
6. Select appropriate **Accommodation** from drop down menu.



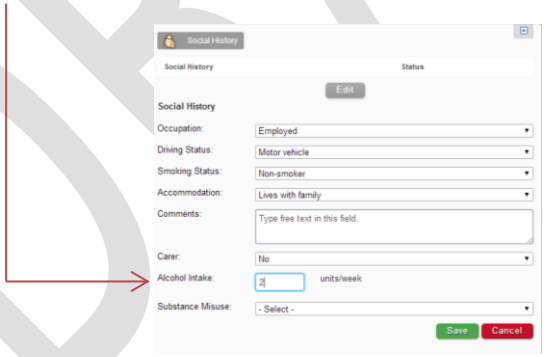
7. Select **Comments** field to add additional information using free text.



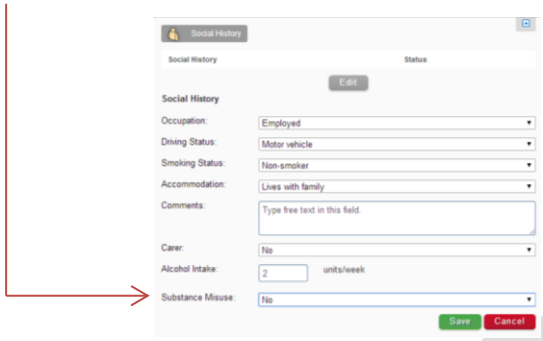
8. Select appropriate **Carer** from drop down menu.



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

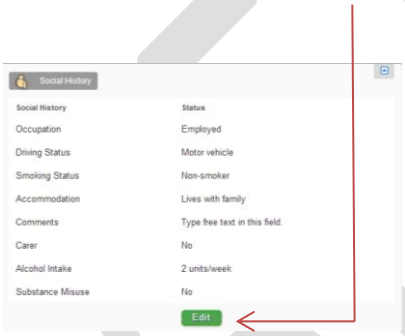


10. Select appropriate **Substance Misuse** from drop down menu



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.



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.

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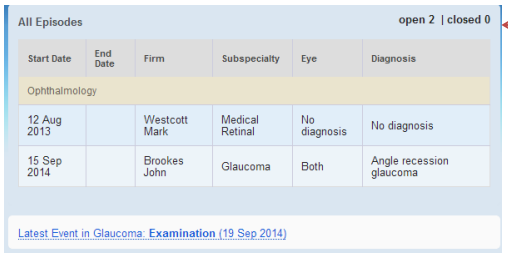
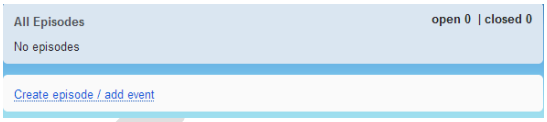
Access to patient episodes is via the Patient Summary screen.

Example - Patient with two episodes.



Example - Patient with no episodes.

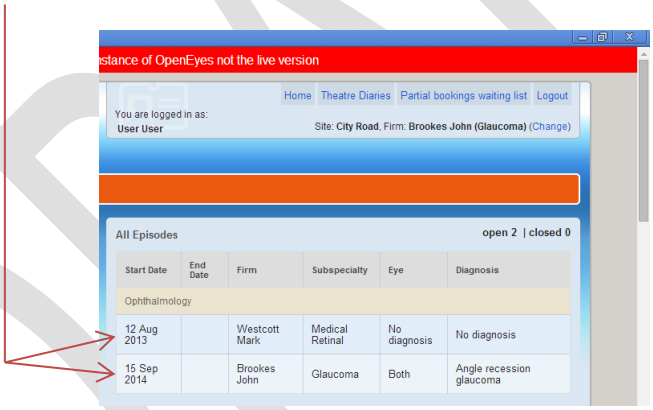


Open episode = indicates on-going clinical care and is current. E.g. has a start date but no end date

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.

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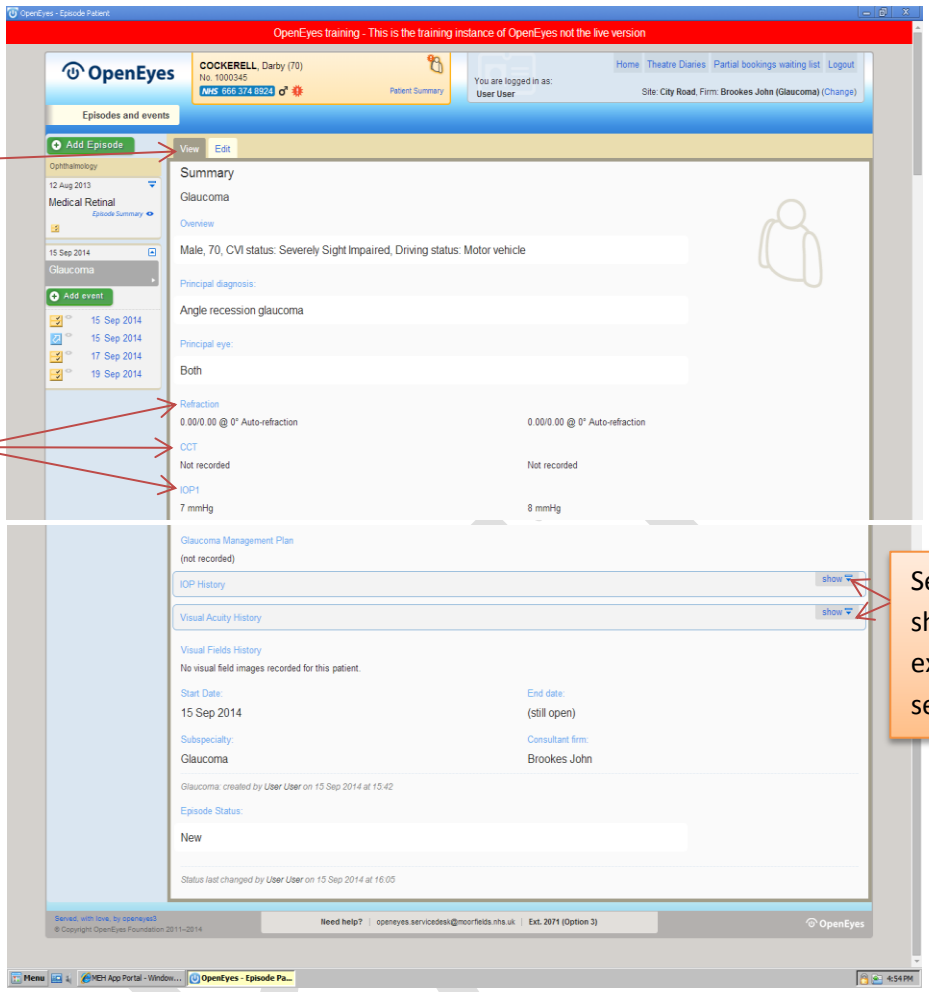
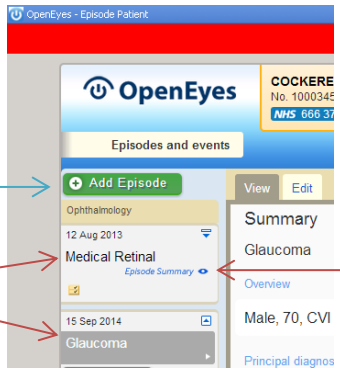
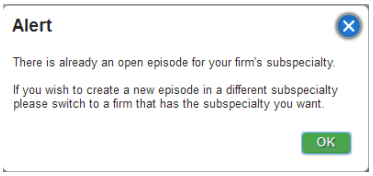


3. Top left side of the patient's episode summary screen you can view the patients episodes. In the example, below, the patient has both Glaucoma and Medical Retinal episodes.
4. To change view from one episode summary to another, select *Episode Summary* of chosen episode.



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



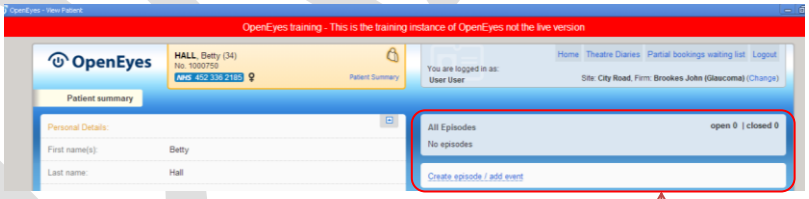
6. Select OK to clear message.

Creating an Episode

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

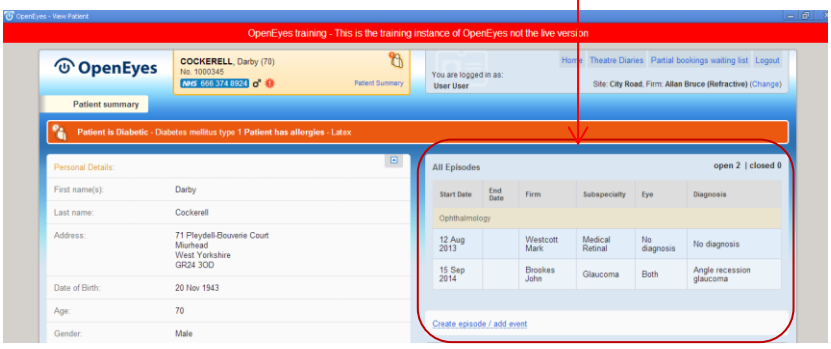
2. Search for the Patient allocated by the Trainer using the search criteria.
3. Example - Hospital Number: 1000001

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.



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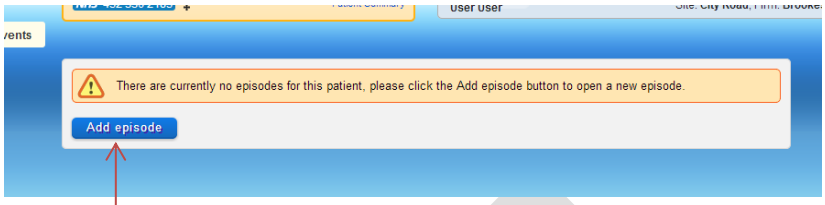
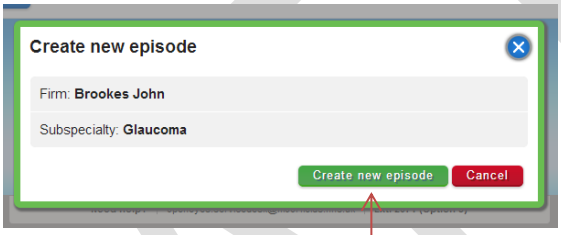
6. When you select **Create episode**, the next screen you see will depend on whether the patient has, or does not have, episodes on Openeyes.
7. Select **Create episode** on a patient with no episodes.
8. Message opens confirming that there are no episodes.

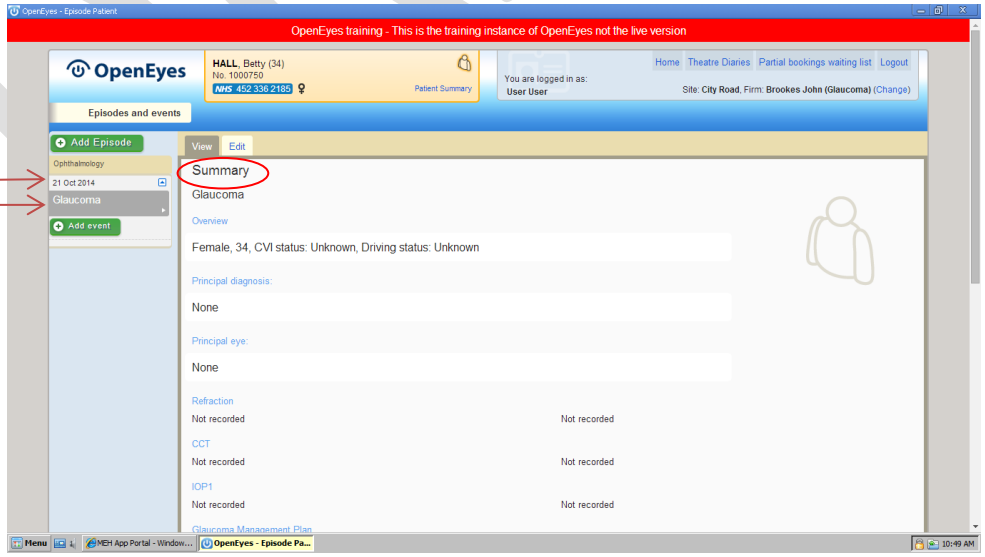


9. Select Add episode.
10. Create new episode message opens. This is based on Firm/sub-specialty selected.



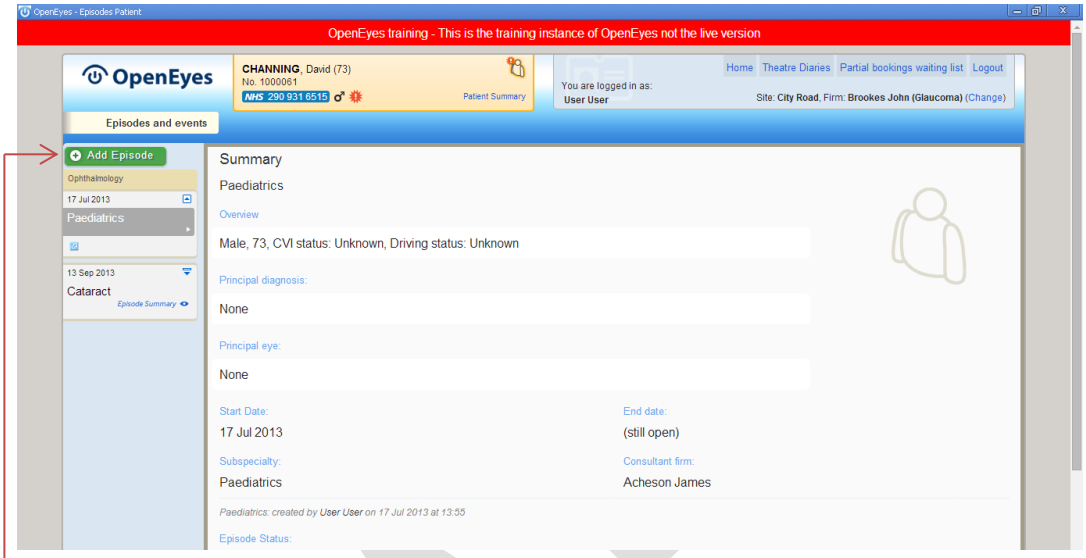
11. Select Create new episode.

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.

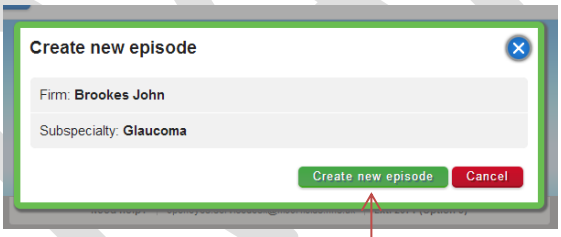


13. Now we will look at creating an episode for a patient with previous/current episodes.

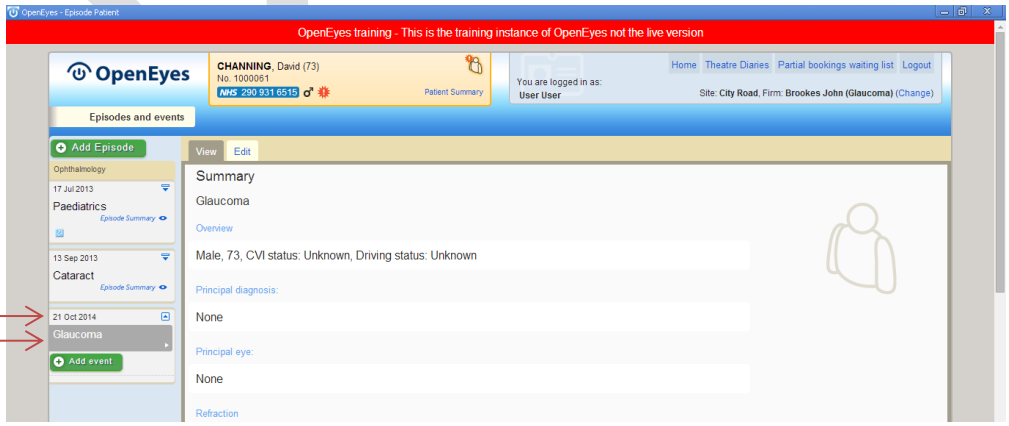
14. Select Firm/sub-specialty of Glaucoma.
15. Search for a patient with episodes, but does not have a Glaucoma episode.
16. Again, from the Patient Summary screen, select **Create episode**. An episode summary screen opens displaying a current episode. The example below displays Paediatrics.



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



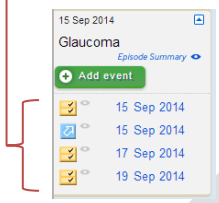
19. Select **Create new episode**.
20. Episode Summary screen will open. Note to the left hand side of screen sub-specialty of episode created is viewable, as is the date created.



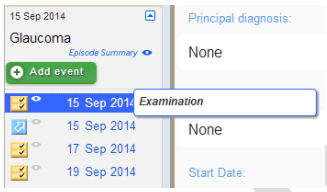
21. With the episode created, events can be added.

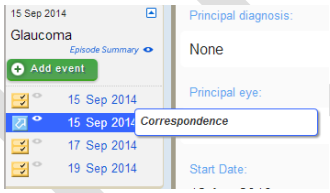
Viewing Events

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

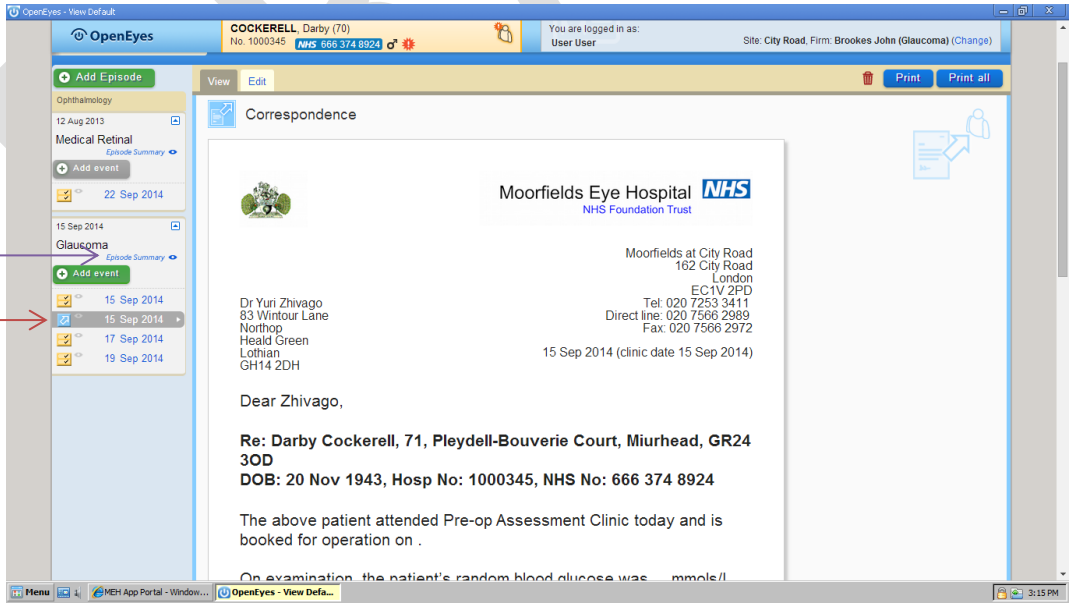


2. For each type of event, a different icon is used, along with the date the event was undertaken.
3. By placing the mouse over an icon, a pop-up will tell you the type of event. See examples below.



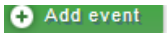


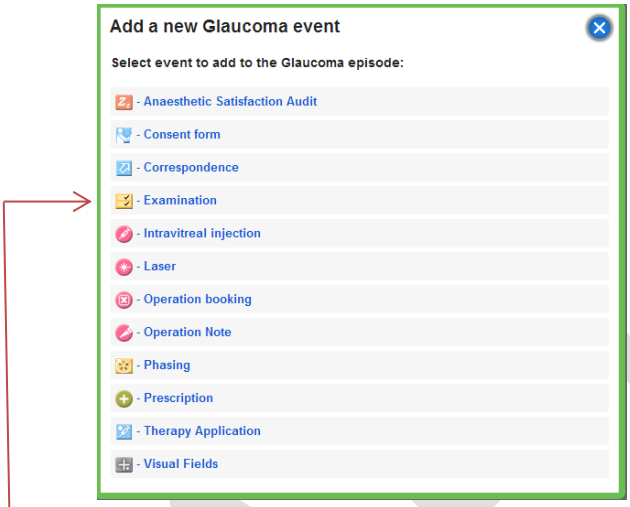
4. Select the event you wish to view and it will display on screen. In the example below, correspondence has been selected.



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.

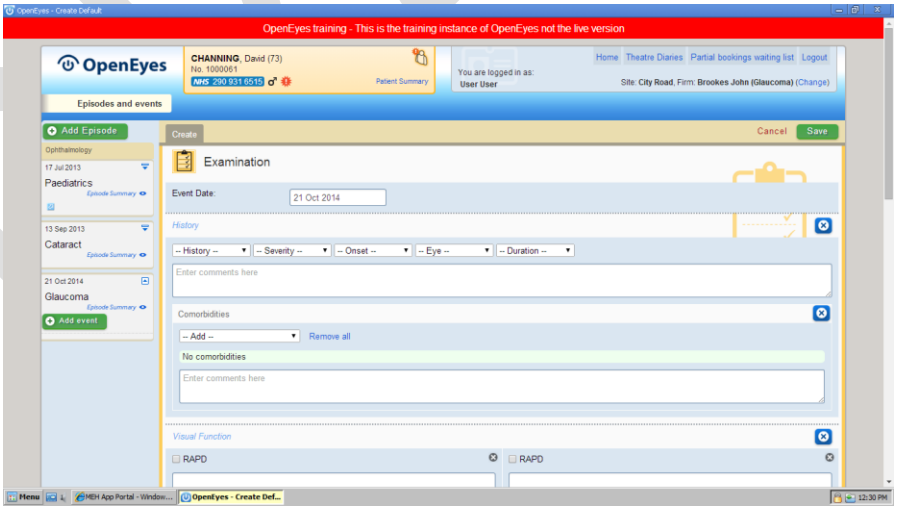
Adding an Event

1. Select  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).

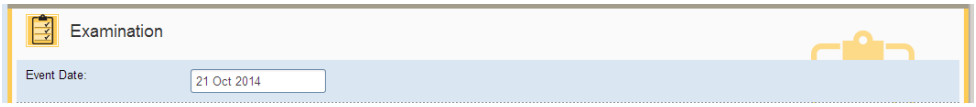
4. Examination event screen opens.



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

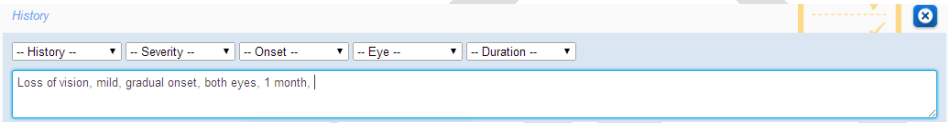
EVENT DATE

5. 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.



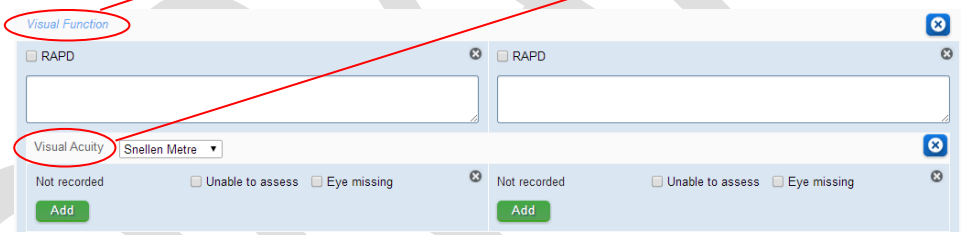
HISTORY

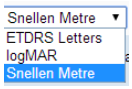
6. Within the History section are drop down menus to select appropriate options. When you select an option from the menus, the selection drops into the comments field. There is also the ability to free text in additional information.



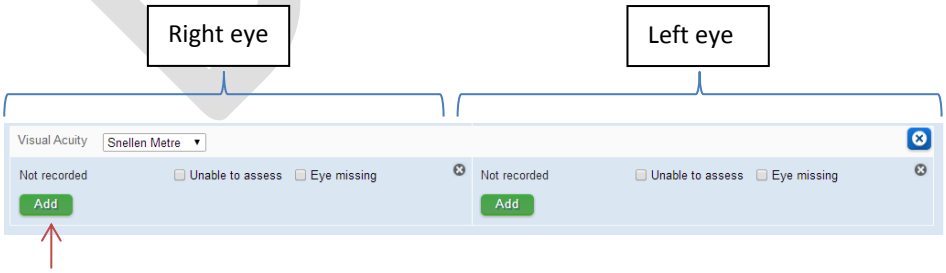
VISUAL ACUITY

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



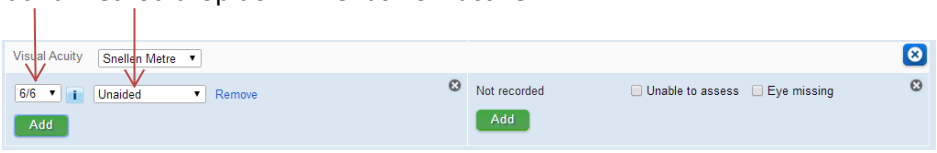


7. Select drop down menu, to right of Visual Acuity, to select appropriate option.
8. Remember: left and right eyes are recorded separately.



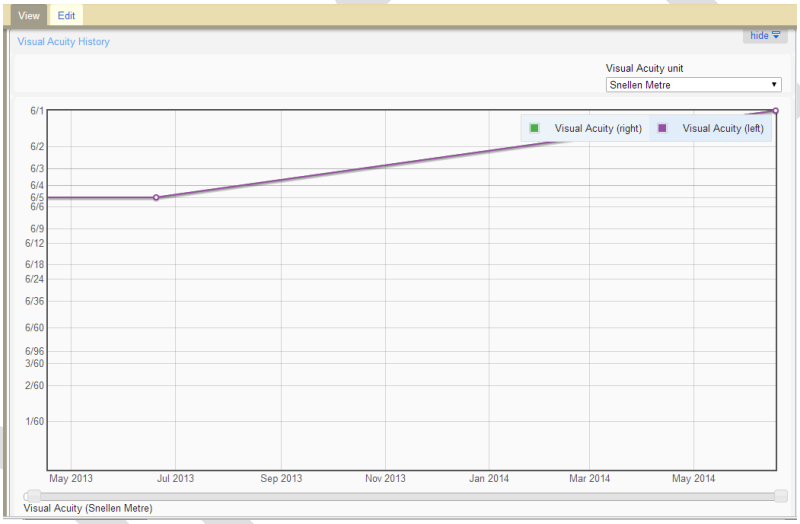
9. Select **Add** for right eye.

10. Result and method drop down menus now active.



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)

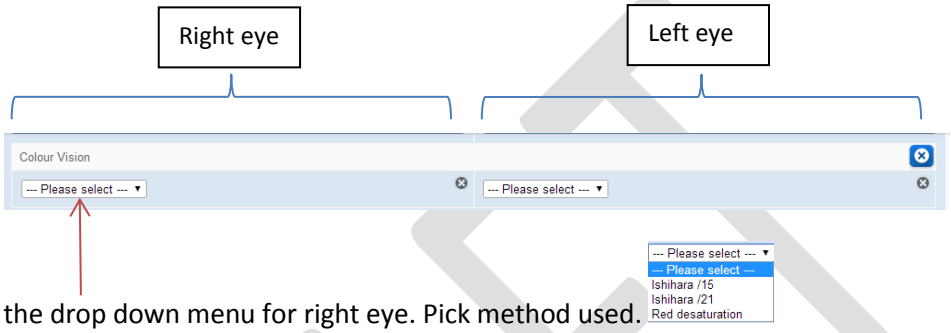
There will be graph of VA results viewable on a patients Episode Summary, under Visual Acuity History, when there have been a number of occurrences.



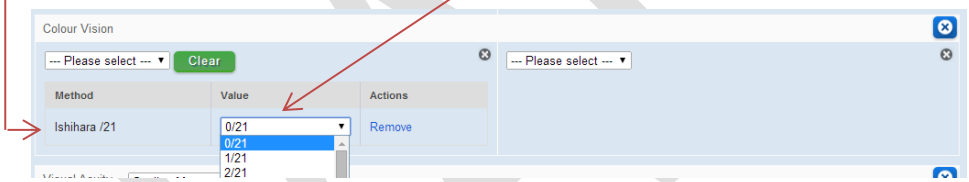
COLOUR VISION

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.

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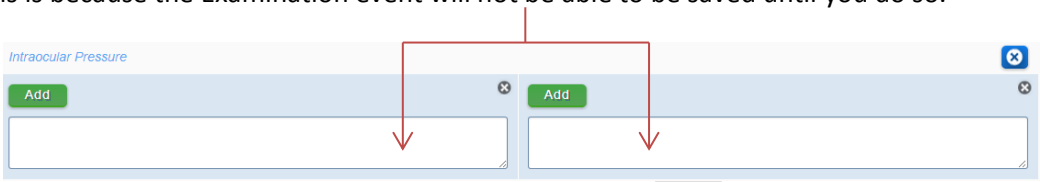
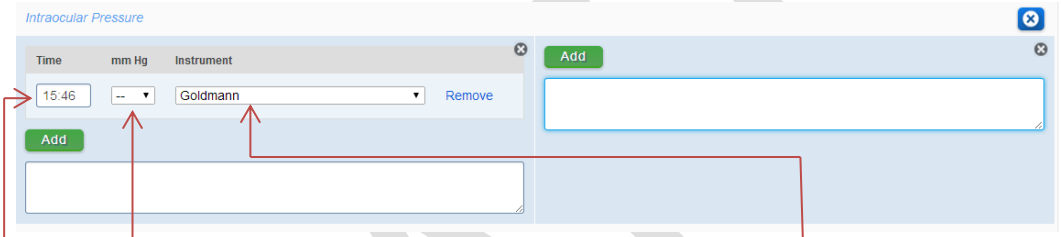
INTRAOCULAR PRESSURE

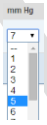
19. Find the section, Intraocular Pressure. If there are no readings add text in the comments fields. This is because the Examination event will not be able to be saved until you do so.

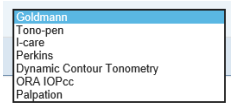


20. If there is Intraocular pressure to record, select Add for the left / right eye as required.
21. The Intraocular section expands to show Time / mm Hg / Instrument fields.



22. The time field defaults to current time. Select to amend if required.
23. Select mm Hg field to record a value.

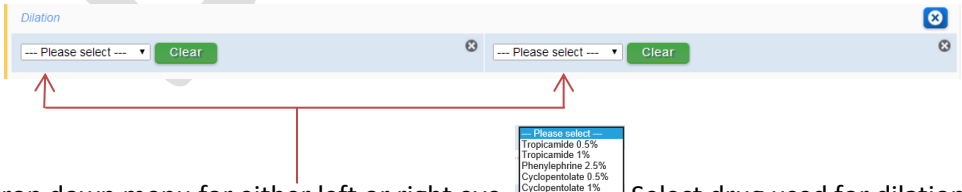




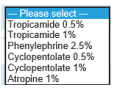
24. Select Instrument field to record instrument used.
25. Repeat steps 20 to 24 above for other eye.

DILATION

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



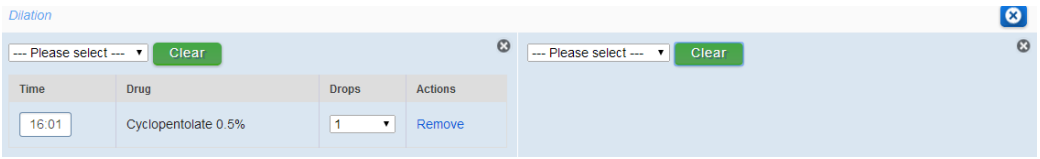
27. Select drop down menu for either left or right eye.



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.

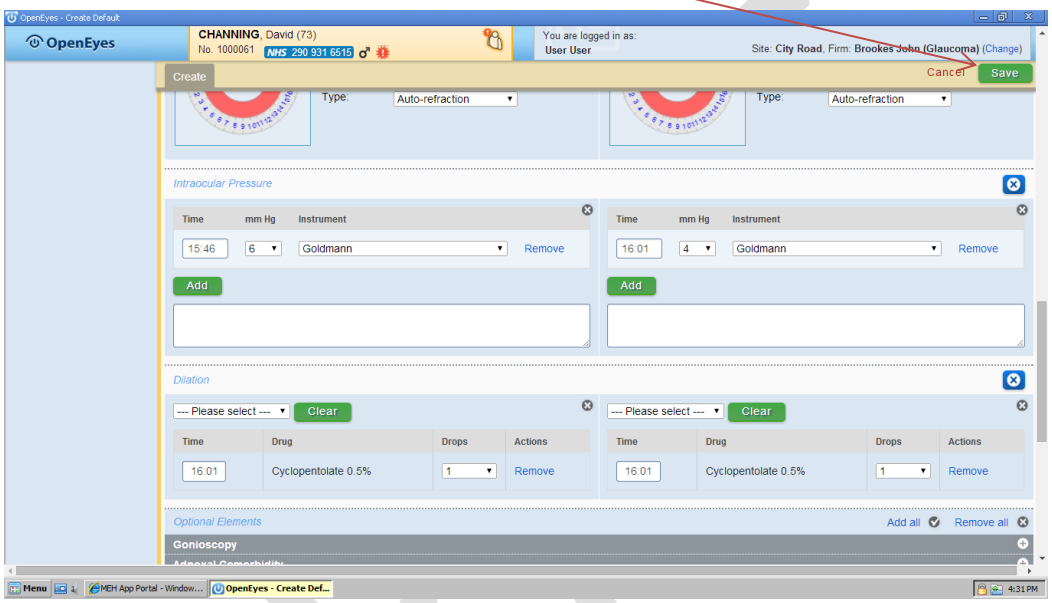
DRAFT



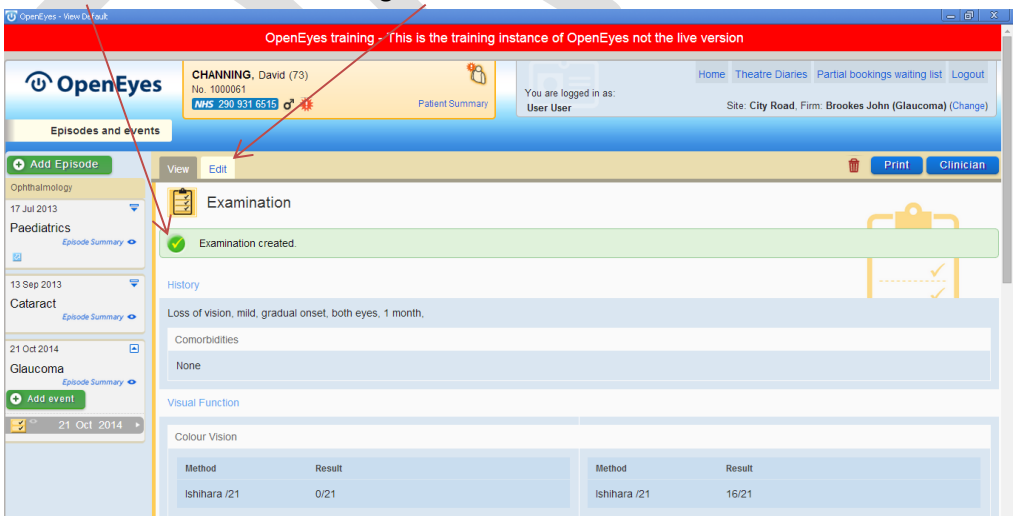
29. Repeat steps 27 and 28 for other eye.

SAVING EVENT

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

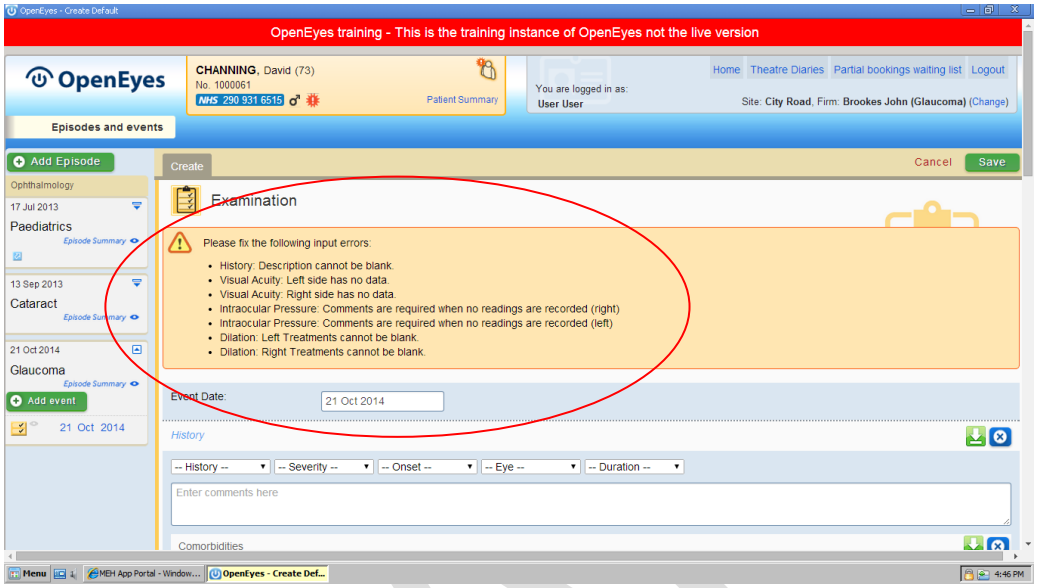


31. Once saved a view only screen of the Examination Event appears with confirmation of Examination created. The Edit tab is used to go back in to make amendments.

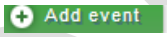


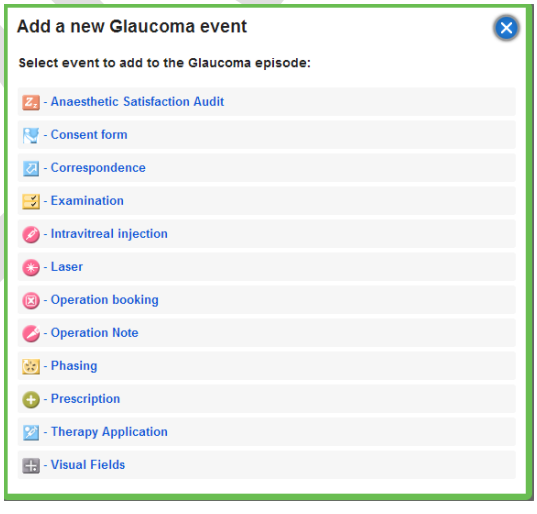
NOTE: If mandated fields are not completed, the Examination event cannot be saved. It would be necessary to address the errors identified, so that the document can be saved.

An example is shown below.



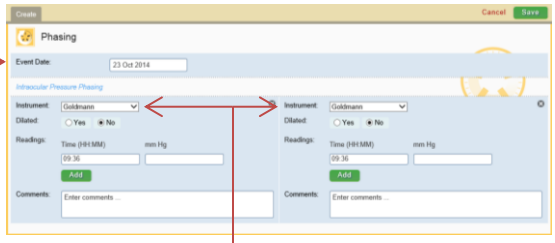
PHASING

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

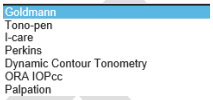


3. Select **Phasing** event.

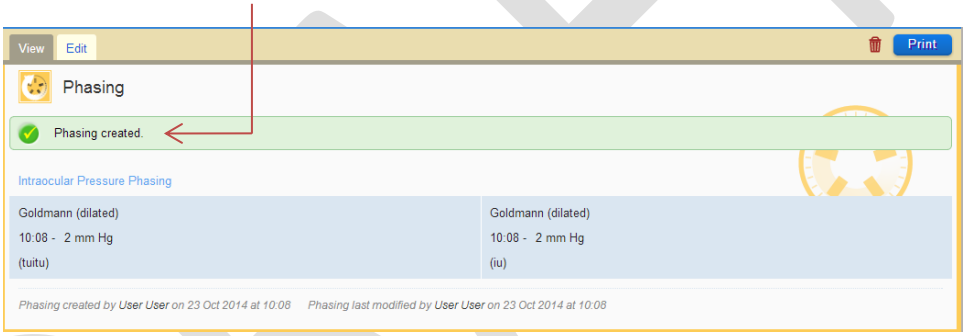
4. The Phasing screen opens.



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

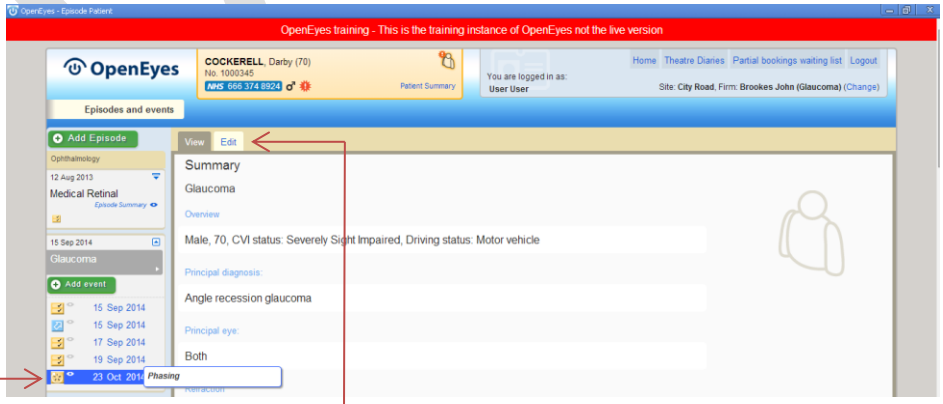


6. Select **Instrument** field to record instrument used.
7. Select appropriate **Dilated** radio button, **Yes** or **NO**.
8. **Time** defaults to current time but can be edited.
9. The pressure value is added to the **mmHG** field.
10. Select **Comments** in free text field.
11. Select **Save.** Phasing created confirmation appears.

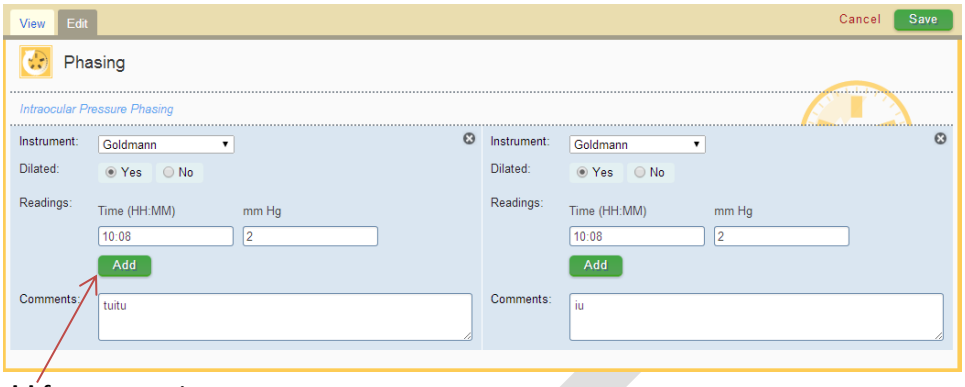


To record Phasing after a period of time on the same day

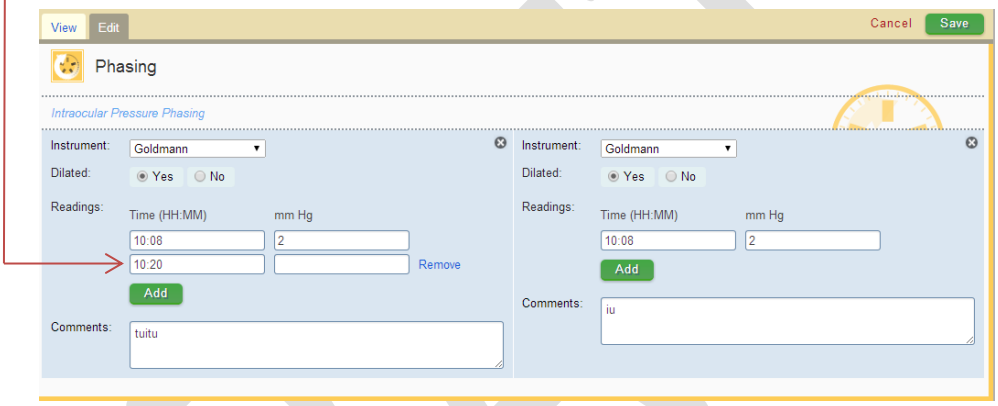
12. Open the current Phasing event. This will be in the legacy events on left of episode summary screen.



13. Select **Edit** to add a new measurement.
14. Phasing event opens.

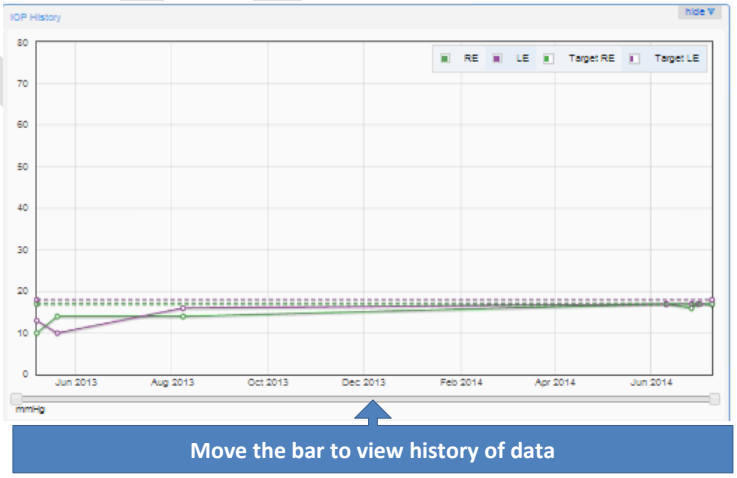


15. Select **Add** for appropriate eye.
16. A second set of **Time** and **mmHg** fields open to record new measurements.



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.

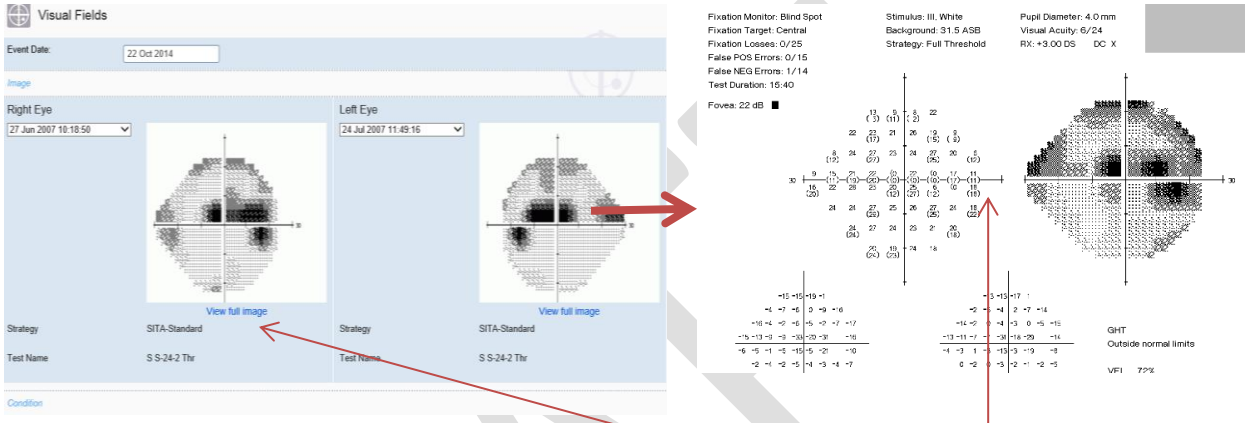


VISUAL FIELDS

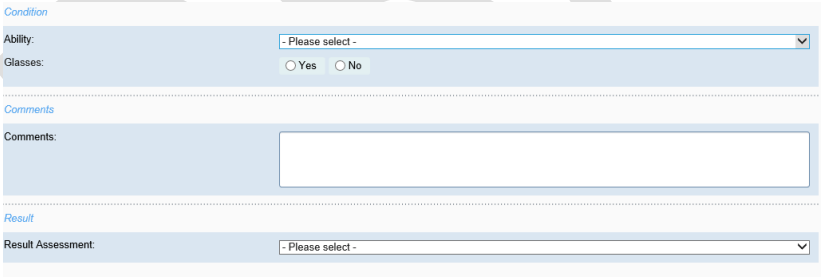
Visual Fields from Legacy Event

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.



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.



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 from the tab located top right hand corner of the screen. ***This can be seen from any screen within OpenEyes.***

DRAFT