



LOGGING IN AND OUT OF ADASTRA

What is Logging In and Out of Aداstra?

Logging in and out of Aداstra is the process whereby a secure username and password is entered, giving the user access to Aداstra. The username also controls which modules the user has available to them (for example a receptionist would not normally have access to 'Clinician' or 'Manager' modules).

Please note - A different process applies for logging in and out of Aداstra using a Smartcard. Please refer to helpsheet 'CFH-SMC' for more information on this.

Operational Use

This helpsheet has been split into five sections:

1. Starting Aداstra
2. Logging into Aداstra
3. Main Aداstra screen
4. Logging out of Aداstra
5. Shutting down Aداstra

1. Starting Aداstra

To start the Aداstra application, double click on the Aداstra desktop shortcut.



If there is no desktop shortcut, Aداstra may be being run over Citrix. If this is the case, double click on the Citrix desktop shortcut.

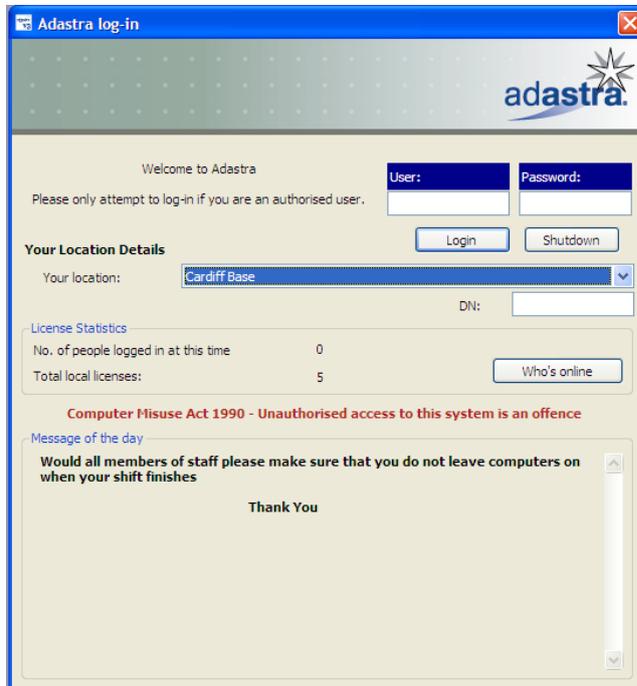


This will open a window that will show an Aداstra shortcut. Double click on the Aداstra shortcut.



2. Logging into Adastra

Once Adastra has been started, the Adastra login screen will open.



Either use the mouse to click into each field, or use the 'Tab' key on the keyboard to navigate around the screen.

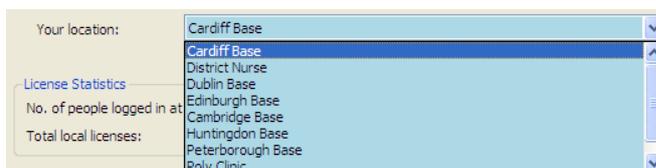
Type the user name into the 'User' field and the password into the 'Password' field.



In accordance with recent NHS Connecting for Health guidelines, the following amendments and additions have been made to passwords and user log in functionality from Adastra version 3.15.

- Passwords are case sensitive
- User accounts will become locked out if the password is entered incorrectly five times
- New passwords will need to be at least six characters long
- Passwords cannot be re-used within one year
- Passwords must contain at least one character that is not a letter
- Passwords will expire and must be changed every ninety days

Select the location that you are currently working at by clicking on the  button next to the 'Your Location' field. Available locations will be shown in a list.



Click on the relevant location from the list.

If there is a choice of rooms available, click on the  button, for the 'Room' drop down menu.

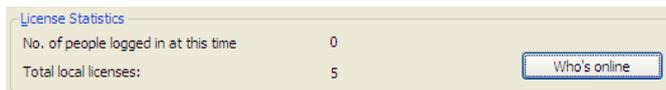


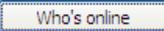
If an integrated telephone system is being used with Adastra, the telephone number for the current desk must be entered into the 'DN' field.

DN:

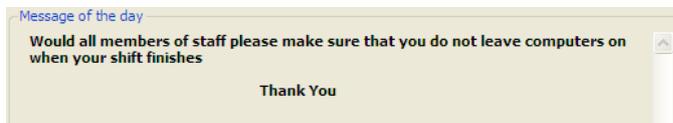
The 'License Statistics' area of the login screen shows the total amount of users that are currently logged into Adastra and the total amount of licenses available.

Please note - The amount of users logged into Adastra cannot exceed the total number of licenses.



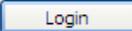
To view which users are online, click on the  button.

The 'Message of the day' is a feature that can be edited to show any message required.



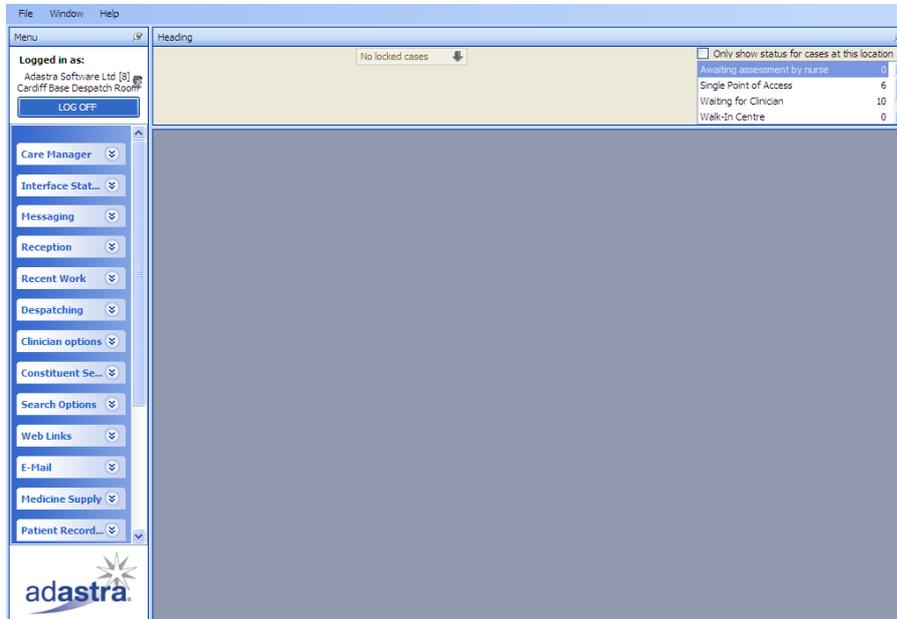
The message can be location specific, so depending on which location is selected the message may differ.

Please refer to helpsheet OP-MSG for more information on how to use the 'Message of the Day Editor'.

Once the username and password have been entered, location, room and phone number (if appropriate) have been selected, click the  button to login to Adastra.

3. Main Adastra Screen

Once logged into Adastra the following screen will appear:



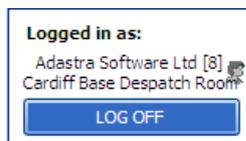
The three areas of the screen described in this helpsheet are:

1. Logged in as
2. Menu options
3. Case status box

Logged in as

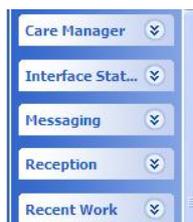
This shows the user name and the machine number of the user currently logged in.

Also shown is the location and room, (if a room has been attached to the location).



Menu Options

The left hand column of the screen will display the menu options/modules available at the current location, appropriate to the user's rights.



Product Information

On-line clinician

Overview

Central to Aadastra v3 is the clinical consultation recording module, On-line Clinician (OLC). A powerful and highly versatile tool for clinicians of all specialisms, OLC works in step with the logical progression of an urgent encounter from initial presentation and case selection through assessment and/or telephone advice stages to examination, treatment, clinical coding and prescribing and follow-up actions.

By presenting a structured and sequential pathway through the response to each patient encounter, OLC is straightforward to learn and easy to use. This is especially important given that in the present-day operational setting, many clinicians will work only occasional out-of-hours sessions and they cannot be expected to need an IT tutorial ahead of each duty.

General

OLC provides a comprehensive and highly versatile system for managing the clinical consultation process in both the telephone and face-to-face settings. Key features include these:

- Initial summary screen covering demographics, case origin and reported condition
- Lookup of previous encounters for the same patient within the current case
- Highlighted cautionary information for patients with special needs
- A medical history summary identifying allergies and ongoing medication therapies
- Integral assessment information accompanying cases referred by NHS Direct or NHS24 (or other connected services)
- Presentation of summary information drawn from national care record systems
- Embedded third party clinical decision support software
- Sequential presentation of history, examination, diagnosis and treatment, with examination fields and outcome coded to support interoperation with core clinical record systems
- Prescribing, underpinned by multiple formulary support and dispensing/stock control capability

Quick and easy demographic view

The system is designed to enable clinicians to select each case online from case lists which will have been filtered to be specific to location and/or clinical specialism. In this illustration the clinician is dealing with patients with appointments to attend at the local PCC, and other patients anywhere in the wide-area scheme awaiting initial assessment or telephone advice.

Case #	Performance...	Case Type	Entry Time	Priority	Case Contact ...	Fullname	Sex	Age	Special N...	Last Cont
10117		Advice	14-Aug-05 16:50...	Emergency	01223 741321	Raymond Hutton	Male	30 years	(Notes)	
10047		Advice	25-Aug-05 18:37...	Immediate	01323 553367	Frances Beresford	Female	-16 days		
10094		Advice	08-Mar-07 11:58:00	Urgent	01233 455455	Colin Green	Male	61 years		
10040		Advice	25-Aug-05 18:55...	Payphone	01223 741321	Raymond Hutton	Male	30 years	(Notes)	
10042		Advice	25-Aug-05 18:37...	Routine	01323 319319	Anne Williamson	Female	66 years		
10044		Advice	25-Aug-05 18:37...	Routine	01323 332233	Hanna Colbert	Female	20 years		
10046		Advice	25-Aug-05 18:37...	Routine	01323 122332	Jade Dongerel	Female	27 years		
10096		Advice	08-Mar-07 12:52:55	Routine	01233 722700	Alex Yeates	Male	48 years		

Once a case is selected it will present as shown at the head of the next page. Note the series of tabs spread horizontally along the top of the screen. Each represents a separate screen of information or options supporting the management of the encounter.

This initial screen offers a simple summary of demographics, contact information, case origin and presenting problem. The dropdown box (top-right) alerts the clinician to any pattern of recent contacts which can then be examined in more detail via the 'Previous Encounters' tab. The edit command, if configured, will launch a Demographics Editor to allow the user to make simple corrections to errors of demographic detail.

One-click access to a list of all patient contact attempts for the case is available via the telephone feature highlighted orange, which changes to this colour to signal that earlier contact attempts have already been made. Clicking the feature lists and updates all such contact attempts, which are also copied across automatically to the 'Event List' (another of the tabs across the top of the page).

Using the CTI feature, clinicians can dial any of the telephone numbers shown on the demographics screen at the click of a button. The patient's demographic details may also be edited at this point in the consultation where necessary and subject to user rights.

On-line clinician [Raymond Hutton]

Patient Details | Medical history | Event List | Previous Encounters | Special Notes | Emergency Care Summary | Current Consultation

10117 | Raymond Hutton | Male | 03-May-76 | 30 years | English | 0 last week

Active date: 14-Aug-05 16:50:47 | Entry date: 14-Aug-05 16:50:32

Contact
 Home: 01223 741321 | Dial
 Mobile: | Dial
 Cur. loc: | Dial
 Other: | Dial

Status
 Advice | Waiting for Clinician
 Before assessment: **Emergency**

CHI Number
 |

Registration Details
 Registered Cambridge
 Adair, Kenneth Park Lane Surgery

Current Location
 11 Gilbert Road
 Cambridge
 Postcode: CB4 3NX | Map Reference: TL:451 598
 Directions | Map

Case Summary
 Symptoms:
 Comments:
 These cases for this patient open at time of receive: Advice #10040 at 25-Aug-05 18:56:46
 No performance counters registered against this case

Record 8 of 8

Special notes alert

Where a cautionary note is recorded for a specific patient or a particular feature of their demographic details, the clinician is alerted immediately the case is selected. The clinician is then able to review the notes, which present in a separate tab as in this example.

Special and cautionary notes are key to the support of special care plans for the vulnerable or terminally ill, and (subject as always to user rights) are primed on the system either by the customer or by the patient's own GP or surgery using the Adastra WebView application in an internet browser over a suitable secure connection.

On-line clinician [Raymond Hutton]

Patient Details | Medical history | Event List | Previous Encounters | Special Notes | Current Consultation

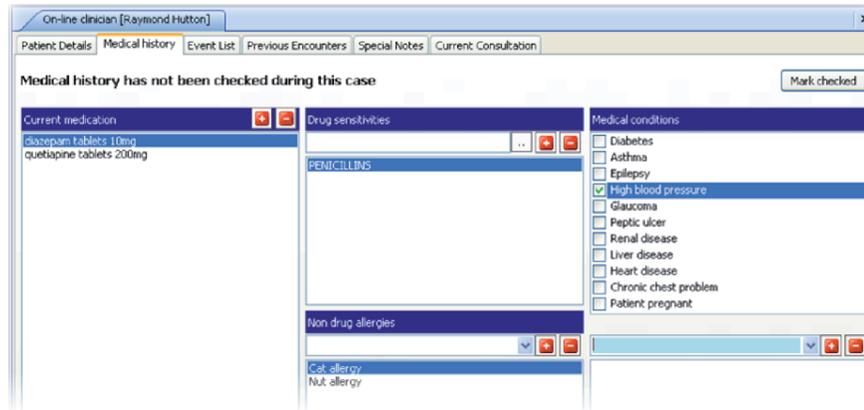
Review Date: 24/04/2007 | Note Type: Patient | Edit date: 06/03/2007 | Last edited by: Simon Sharp

Known psychiatric patient known to suffer from depression.

Previous medical history

The 'Medical History' screen presents a patient's current medication, drug sensitivities, non-drug allergies and medical conditions, and may be updated by the clinician during a live episode.

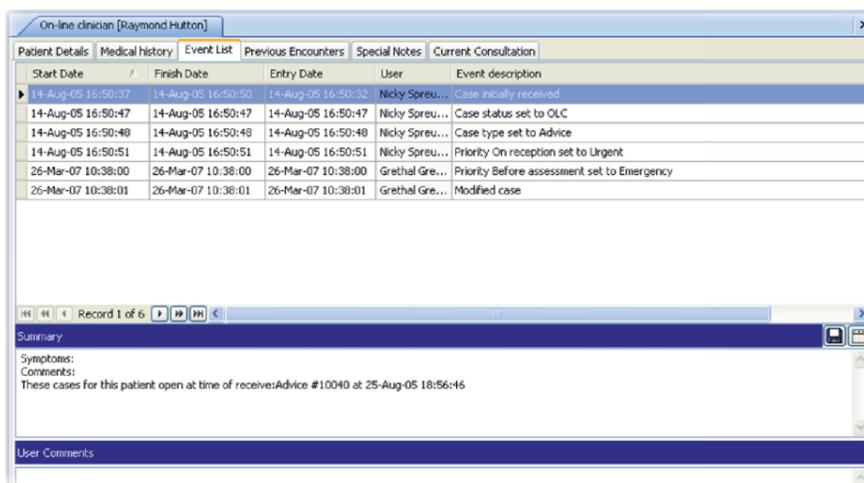
This information is stored against the patient rather than the case and is therefore available throughout the system wherever a tabbed screen is used. For current medication and drug sensitivities, any information entered is validated against the Multilex Drug Database - as also used to underpin the prescribing, dispensing, formulary and stock control functions within the program. Non-drug allergies and general medical conditions are selected from underlying pick lists. Clinicians and others with appropriate user rights may also record a free-text entry against the patient.



The immediate clinical benefits to recording all of this information are self-evident, but also add an invaluable safeguard at prescribing level where the system will automatically warn if a selected prescribed drug sparks any allergy alert or other contra-indications.

Event list

The event list catalogues in sequence the progress of the case to date, and represents a key component of the audit trail. The event list (and the separate contemporaneous audit trail covering all activity on the system) are crucial to the preservation of data integrity, and will maintain a full record of all actions on a case record including live or post-event editing actions.



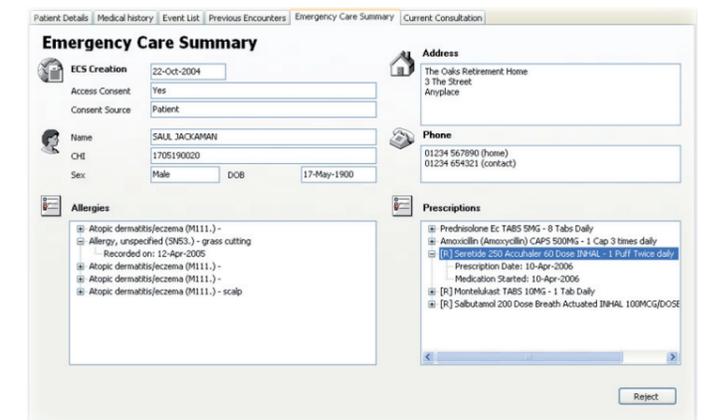
Previous encounters

The 'Previous Encounters' tab presents all past encounters for the patient. The system will already have flagged at inception if there has been an encounter in the immediate past - most users have their systems set to alert if there has been an episode in the last 3-4 days. These and other more distant encounters can then be straightforwardly reviewed within the 'Previous Encounters' screen. Users may select either a summary list of all previous encounters or a clinical summary, the latter being of more use and interest to clinicians. All information in this screen refers to closed records and is presented as view-only.



GP Summary Care Record/ Emergency Care Summary

The Emergency Care Summary in Scotland is now accessible by tabbed lookup from within the Adastra case record as illustrated below. Similar capability is presently being piloted in Wales. For services in England, Advanced Health & Care is actively involved in the GP Summary Care Record project.



Presentation of NHS Direct/NHS24 information

Where cases are assimilated into an Adastra database on electronic referral from NHS Direct or NHS24, the NHS Direct (or NHS24) tab will expose the supporting clinical detail which accompanies the case record as it is transferred. Again this is read-only data.

Previous consultations

Whereas the Previous Encounters tab brings up detail of past encounters, the 'Previous Consultation' tab presents any preceding action by another clinician for this current encounter.

Other tabs may also be available depending on the specific system events that the case has been through. For PCC appointments, the Previous Consultation tab might typically show the comments of the clinician who made the initial clinical assessment by telephone before the patient was invited to attend. Again this is read-only information.

Current consultation

The final tab in the OLC sequence allows clinicians to record the consultation details. The screen is designed to mimic the normal clinical sequence, with a range of specific fields for recording examination findings. The system makes use of dropdown boxes for rapid data entry, and these lists self-order themselves to recognise the selections made most often. An English medical spellchecker runs in the background to prompt the correction of misspelt medical terms. Each textbox scrolls without limitation, although user services can elect to place their own limit on field text capacity if they wish to discourage overelaborate entry of detail.

This screen in particular is necessarily detailed, hence Advanced Health & Care recommends a minimum screen resolution of 1024x768 for all Adastra terminals.

The screenshot shows the 'On-line clinician [Peter Galloway]' interface. It includes tabs for Patient Details, Event List, and Current Consultation. The 'Current Consultation' tab is active, showing fields for Clinician Name (Azizi, Tariq), Consultation start (26-Aug-05 01:52:45), and Consultation finish (26-Aug-05 02:00:26). The 'History' section contains a text box with the note: 'Stomach pain for a few days. Hasn't eaten anything which might have caused it. Can move around but more comfortable lying down. Pain is getting worse tonight. Vomiting with sever pain in right iliac fossa started yesterday but worse.' The 'Examination' section has a text box with 'Stomach tender to touch'. The 'Diagnosis' section contains '? appendicitis. Refer to hosp.'. The 'Treatment' section has 'Drink plenty of clear fluids.' On the right, there is a 'Coding' section with a search field and a 'Prescribed Drugs' section listing '[HandWritten]GAVISCON EXTRA STRENGTH tab Mitte (12) lemon tablet(s) as directed'. A vertical menu on the right side of the coding section lists examination fields: HEAD/NECK, LUNGS, HEART, ABDOMEN, GROIN, LIMBS, SKIN, and TESTS.

Examination fields

For face-to-face consultations, there is a comprehensive series of examination fields to support the structured recording of data. Selecting a general heading from the examination list, the clinician is presented with a selection of specific fields appropriate to that heading.

This screenshot shows the 'HEAD/NECK' examination fields. The fields are: Temperature (39.0), Pupil size (Dilated), Meningitis (Meningism absent), and Pulse (90). Each field has a dropdown menu for selection.

Error checking helps validate data - a temperature will only be accepted in the range 25°-42° C, for example. Each entry in these fields is also automatically coded in the background.

Provider services can elect to make certain examination fields mandatory and can vary such controls by individual user, clinical specialism or location.

The examination fields are invaluable to clinicians in evidencing a more complete record of their own actions and findings; they are more supportive of delivering quality service and effective clinical audit; they extend the range of information against which provider services can evaluate activity and develop improved clinical protocols; and they provide a flow of structured information following case closure or onward referral that can then populate core clinical records and other interoperable systems with an interest in the patient journey.

This screenshot shows the 'Abdomen' examination fields. The fields are: Pain on palpation (Yes), Guarding (Yes), Rebound tenderness (Yes), Rigidity, and Bowel sounds. Each field has a dropdown menu for selection.

Coding

In the UK, Adastra offers a mainly symptom-based read code subset which provides for general statistical evaluation without congesting the database with irrelevant codes which are unlikely ever to be needed in an urgent care environment. Bearing in mind that most urgent care encounters are managed on a snapshot basis, the use of definitive diagnostic codes runs the risk of launching inappropriate care pathways at GP surgery, hence the subset is mainly symptom-based.

Code selections are supported by a keyword search field, and the system will also assist the clinician by narrowing its code-search to general headings corresponding to examination fields which have been populated. Customers are able to exercise control over which codes they include for subsequent use during the consultation.

The code set is user definable and may be varied locally, although some consistency is needed for the effective marshalling of outcome code data at regional or national level. In Holland and the Republic of Ireland, Adastra customers use the ICPC code convention, and Adastra is ready to support the adoption of SNOMED-CT codes as and when that standard is introduced into everyday use.

What is Medical History?

'Medical History' provides a facility for clinicians to record the patient's current medication, allergies and conditions. The information recorded here is attached to the patient record, so that it is available for reference and amending as appropriate.

There is a link between the medical history record and the prescribing module; prompting the clinician of any applicable drug warnings when selecting a drug to prescribe.

Please note - There is currently no link between the 'Medical History' tab and the 'Summary Care Record' (SCR) or 'Emergency Care Summary' (ECS) information. If you access 'SCR' or 'ECS' information you will still need to maintain the 'Medical History' tab to ensure warnings are displayed when prescribing or issuing stock.

How to use Medical History

When you open the 'Medical History' module, you are presented with the following screen.

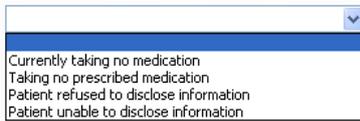
The screenshot shows a software interface for 'Medical History'. At the top, there are tabs for 'Patient Details', 'Medical History', 'Event List', 'Previous Encounters', 'Previous Odyssey Reception', and 'Current Consultation'. The 'Medical History' tab is active. Below the tabs, a message states 'Medical history has not been checked during this case' with a 'Mark checked' button. The main area is divided into five sections: 'Current medication', 'Drug sensitivities', 'Non drug allergies', 'Medical conditions', and a 'Mark checked' button. The 'Medical conditions' section contains a list of checkboxes for various conditions: Diabetes, Asthma, Epilepsy, High blood pressure, Glaucoma, Peptic ulcer, Renal disease, Liver disease, Heart disease, Chronic chest problem, and Patient pregnant.

The 'Medical History' tab is broken down into five areas.

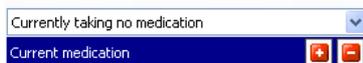
1. Current medication
2. Drug sensitivities
3. Non drug allergies
4. Medical conditions
5. Mark checked button

1. Current Medication

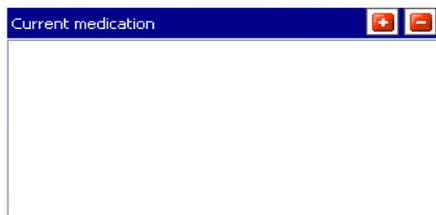
Where there are no current medications to be recorded the user can record the appropriate reason by selecting from a drop down list above the 'Current medication' header.



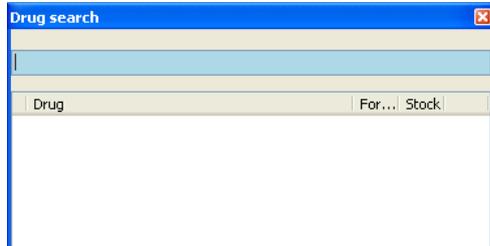
For example, the patient may not be currently taking any medication.



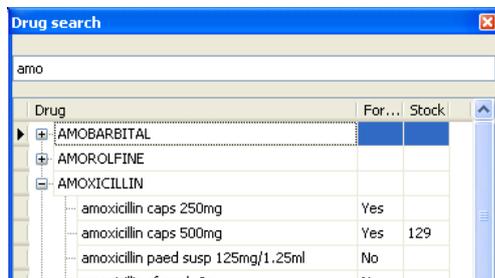
To add current medication to the patient record, click  in the 'Current medication' area.



This will open the 'Drug search' dialog box.

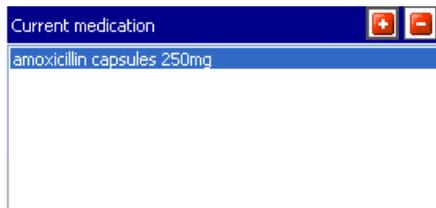


Type the first 3 letters of the drug that you are searching for into the search field. Any matches will be listed below the search field. Click on the  button next to the relevant drug to expand the list of preparations.



To the right of the preparation you may see a 'Yes' or 'No' in the 'Formulary' column and a number in the 'Stock' column (this is only applicable if you are utilising the 'Stock Control' functionality). It highlights if the drug is in a formulary or not, and how many you currently have in stock.

To add a drug to this patient record, double click on the required preparation in the list.

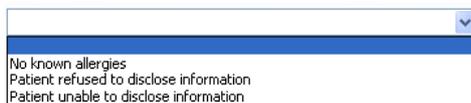


Further drugs can be added in the same way if appropriate.

To remove a drug from the 'Current medication' area, click on it to highlight and click .

2. Drug Sensitivities

Where there are no drug sensitivities to be recorded the user can record the appropriate reason by selecting from a drop down list above the 'Drug sensitivities' header.



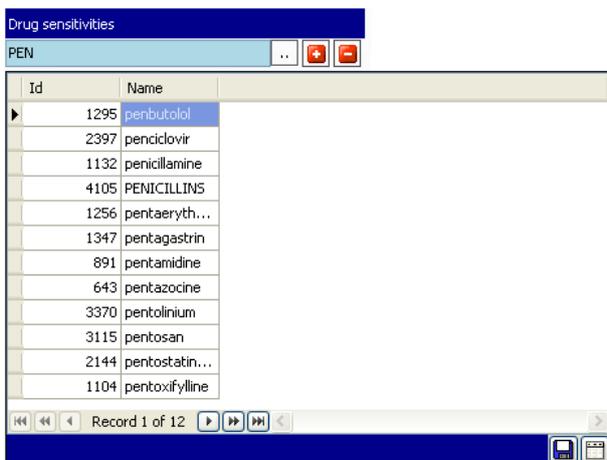
For example, the patient may have no known medicine allergies.



To add drug sensitivities to the patient record, type the first 3 letters of the drug name in the search box.



Any matches will be listed below the search field.



Double click on the drug you are searching for to select it and click  to add it.



Further drugs can be added in the same way if required.

To remove a drug from the 'Drug sensitivities' area single click the drug to highlight it and then click .

3. Non Drug Allergies

To add 'Non drug allergies' to the patient record, click the drop-down arrow and select from the list of specific allergies.



To choose an allergy, click on it in the drop down list, and then click .

To remove an allergy from the 'Non drug allergies' area, click on it to highlight and click .

You can also add additional non drug allergies if required by free typing into the drop-down lookup field.

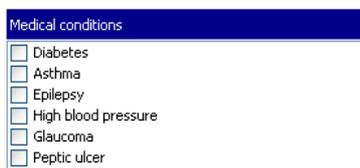


To add the non drug allergy to the list, click .

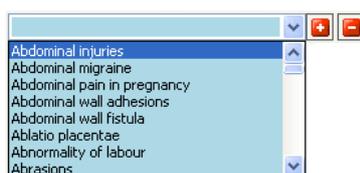
4. Medical Conditions

There are 2 areas where medical conditions can be recorded. Tick the checkboxes in the upper area to select a condition. It is possible to select multiple conditions if appropriate.

To remove a condition from this list, click in the checkbox to un-tick the option.



The lower area has a drop down menu with a list of conditions.



To choose a condition, click on it in the drop down list. Click  and it will be added to the patient's 'Medical conditions' list.

It is also possible to jump straight to a condition, by starting to type it into the search box.

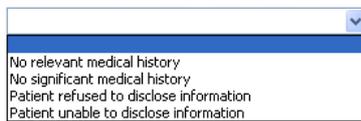
Further conditions can be added in the same manner if required by free typing them into the drop down list.



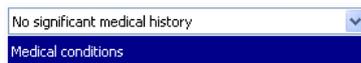
To add the new condition, click .

To remove a condition from the lower 'Medical conditions' area, click on it to highlight and click on the  button.

Where there are no medical conditions to be recorded the user can record the appropriate reason by selecting from a drop down list above the 'Medical conditions' header.



For example, the patient may have no significant medical history.

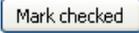


5. Mark Checked Button

The message 'Medical History has not been checked during this case' will be displayed at the top of the screen if a user has not yet recorded that they have checked the medical history details with the patient as part of the case.



This message is a reminder to the user to check the patient's medical history as it may have changed since it was last updated.

Once the history has been checked, and amended if appropriate, it can be marked as checked by clicking on the  button to the top right corner of the 'Medical History' screen.

When marking the patient medical history as checked, if any of the 3 sections (Medications, Allergies, and Conditions) have been left blank, a warning will be displayed to highlight that mandatory fields have not been filled in.

Product Information

Prescribing

Overview

Central to Aadastra's drug management capabilities, Prescribing enables clinicians to generate prescriptions electronically within the Aadastra system and print them on preprinted prescription forms. Utilising the Multilex Drug Database from First Databank, Prescribing meets the requirements of the new English legislation covering computer records for controlled drugs and corresponding requirements established in other countries.

Introduction

For English provider services it is necessary to prescribe in conformance with the 2005 Out-of-Hours Medicine Supply guidance. Regulations may vary elsewhere across the UK, but it is still of growing operational importance for services to use their IT system to manage the supply, dispersal and issue of drugs. Prescribing allows clinicians (both doctors and nurse prescribers) to:

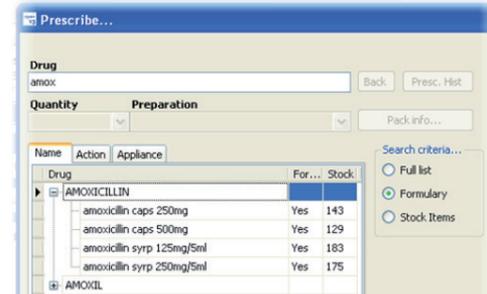
- Check important drug information before prescribing
- Check that sufficient stock exists before issuing a prescription
- Safely control those drugs which can be prescribed by formulary, including Patient Group Directions (PGD) support
- Print the prescriptions on pre-printed stationery
- Reduce the length of time normally associated with hand writing prescriptions
- Significantly reduce the risk of prescribing errors
- Control drug expenditure through offering generic alternatives

Quick and powerful search

The doctor or nurse can quickly find the drug(s) which they wish to prescribe using Prescribing's powerful search facility. Simply type in the first few letters of the drug to display a list of those matching the search criteria.

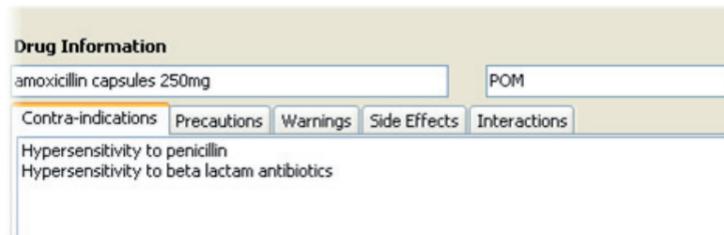
Clinicians are also able to display all medication prescribed to the patient by the organisation within the last six months, enabling repeat prescriptions to be fulfilled. Alternatively the correct drug(s) can be found by searching by action group or appliance type.

The system allows the clinician to select drugs from the full British National Formulary list, their formulary or items normally stocked by their organisation. The presented lists clearly show which items are within the formulary and the current stock quantity for their location. The system effectively 'reserves' stock selected by a clinician to be dispensed so that it is not possible to issue the same stock more than once.



Contra-indications, precautions, warnings, side effects and interactions

To help maintain patient safety and reduce the risk of drug errors the system displays the contra-indications, precautions, warnings, side effects and interactions of each drug as it is highlighted in the list.



Selecting a drug displays the recommended dosage for stock items and allows the clinician to select the quantity and preparation.

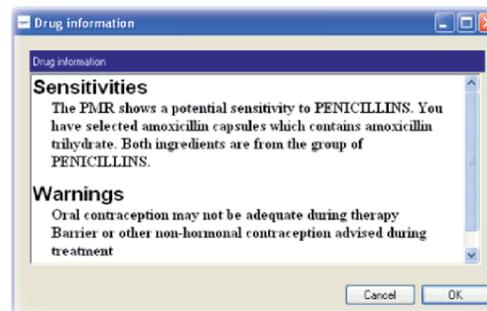
Where the customer is also using the 'Previous Medical History' feature an active check is performed at this time

against any drug allergies, contra-indications, duplicate therapies, precautions, drug interactions or warnings which may have been previously recorded against the patient. Where the selected drug might match any of the criteria a warning message is displayed, alerting the clinician to the potential risk.

The clinician may optionally override the recommended dosage, and standard abbreviations are automatically recognised, eg. 'TDS' is automatically expanded to 'three times a day'. The clinician can also check the pack information to ensure the most appropriate pack size is prescribed. For those drugs prescribed in a formulary an informational message is displayed and the selected drug is automatically changed to its generic equivalent, helping to control drug expenditure.

Once the clinician has entered the correct quantity, pack size and dosage a single click confirms the drug details and adds them to the prescription which is displayed on the screen.

Items prescribed in error may be removed from the prescription by the clinician immediately.



Patient Group Directions

Prescribing provides user-definable PGD prescribing support, guiding the clinician through the prescribing process. This feature is definable on a clinician-by-clinician basis.

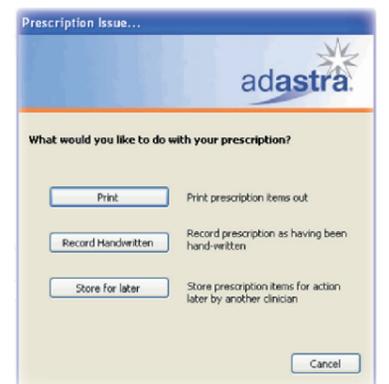
Prescribing history

To support repeat prescribing, the Prescribing module supports the quick and easy review of a patient's prescribing history. Clinicians or prescribers with the appropriate user rights can simply click a button from within the prescribing screen to display a list of everything prescribed for the patient within the last six months.

Printing the prescription

From here the prescription may be printed, recorded as being handwritten (useful if there is a printer problem, for example) or saved for later printing. Alternatively the user can simply press cancel to go back to the prescribing screen.

English customers will be pleased to learn that the system knows from the user login credentials if the prescriber is a doctor, dentist, nurse prescriber or extended formulary nurse prescriber and will over-print the form to make a legal nurse prescription where necessary. A warning is displayed when prescriptions should be printed in different ways, such as under SLS



or ACBS rules. Private prescriptions are also supported and where multiple prescription types are required for the same case the system automatically prints them all in the correct way. So, for example, a clinician could prescribe a drug available on the NHS and another only available privately against the same case. The system would record both drugs and automatically print two different prescriptions.

Printer alignment

Because prescription forms are relatively limited for space the margin for print position is also small. Prescribing includes a prescription printer alignment utility to ensure that the details are printed in exactly the right place on each batch of prescription paper.

Once a prescribing action is completed the screen returns to the main On-line Clinician module and displays the drug(s) which have been prescribed, and the case may then be continued or closed.

