

## 1. Entering Patient and Clinical Information in Medical Director


<b>Privacy</b>	
<b>Setting up a screen saver</b>	Desktop → right click in blank area → properties → screen saver tab → choose screen saver → select time → OK Set up screen saver to turn on after 10 minutes. Setting up a password for the screen saver is optional → Tick the box "On resume, password protect". This will activate a screen saver with a password (same as your log on password).
<b>Passwords</b>	To be able to setup Doctors, Nurses, Staff etc, you must be logged in as a User with top level access. MD Main Screen → Users → Set up Users
<b>Show desktop</b>	Windows key + D. Press again to return to program
<b>Lock computer</b>	Windows Key + L. You will need to re-enter your password to log back in.

<b>Controlling MD</b>	
GP's and practice staff should not be in the habit of ignoring pop-ups as they are part of the recall process. Thus, everything that pops up in a patient screen should be relevant. By configuring your system, users can be sure that each pop up will be a helpful management tool. Each computer must be changed individually. Configuration of pop-ups is particular to each PC.	
<b>Bypass pop-ups</b>	Press <b>Esc</b> when each screen appears
<b>Control pop-ups and Advertising</b>	Tools → Options → Prompts → tick/untick prompts (Ensure action list is checked) → Drug Support → untick boxes or Deselect All
<b>Opening in patient summary</b>	MD Main Screen → Tools → Options → Clinical → Open patient in → eg. Summary The benefit of this is that you are alerted to new files added to the patient file, and you can see family and social history at a glance. Both of these would otherwise have to be searched for.

## Adding a Patient

If a billing program is linked to MD, check whether you need to add patients through the billing program. This will depend on whether the billing and clinical software are linked and if the information can be transferred two ways.

For IT assistance please contact **Michael Zagami** at GP Network Northside on **9477 8777**

<b>Adding a new patient in Pracsoft</b>	Pracsoft → Click the 'Add New Patient' button  <b>or</b> F6
<b>Adding a new patient in MD</b>	Main Screen → Patient → Add → New <b>or</b> F2 → New (minimum: Name, DOB, Address)
<b>Find a patient FAST</b>	Main Screen → F2 → enter first letter of surname → comma → first letter of first name → hit Enter twice (eg. A,T)
Adding Patient Details	
<b>Adding ATSI information</b>	Patient Screen → Double click "Patient information" area (Ctrl F7) to edit → Patient Details Tab → check/uncheck Aboriginal/Torres Straight Islander
<b>Adding Next of Kin/Emergency Contact in Pracsoft</b>	Pracsoft → Patient → find patient → in Select Patient window click Edit → Personal Details Tab → select a Next of Kin → Choose from the list (of patients currently in the database) or add new (will be shown in italics).
<b>Adding Allergies or 'No known allergies'</b>	Patient Screen → Double click on 'Allergies' field (Ctrl F7) to edit → click 'Add allergy' or tick 'No known allergies'. This information shows up in red text on patient screen
<b>Adding Warnings</b>	Patient Screen → Double click on 'Warnings' field (Ctrl F7) to edit → enter text in warnings section (eg Had Gestational Diabetes, CHD, Pacemaker). This information shows up in blue on patient screen. Elite Sportsman and Breastfeeding tick boxes are also available – when ticked they prompt additional related drug warnings
<b>Adding smoking and alcohol information</b>	Patient Screen → Double click "Smoking" field (Ctrl F7) to edit → Smoking Tab → update information Patient Screen → Double click "Alcohol" field (Ctrl F7) to edit → Alcohol Tab → update information
<b>Adding Family/Social History</b>	Patient Screen → Double click "Patient information" area (or Ctrl F7) to edit → Enter Marital Status, Sexuality, Occupation, Family and Social History. <b>Date this information for future reference.</b>

## Entering Diagnoses

When selecting a diagnosis, choose from the drop down list. Data cannot be extracted and a search cannot be performed on free text.





- If you are on EQIP, your diabetic, asthmatic and IHD patients will show up in the registers
- When pharmaceutical companies undertake research or perform clinics with patient groups (e.g. those with osteoporosis, diabetes), they often search the database by patient condition. Only those coded will be searchable.

The coded list cannot be added to. To see the list → **MD3** Main Screen → Resources → 'What's new in Docle' → Print



<b>Entering Diagnoses Through Progress → Reason</b>	You will notice that previous visits will be given a title if reason for contact is entered. This will help you when looking through progress notes in 5 years time to find clinical information. MD Patient Screen → Progress Notes Tab → Reason → double click reason from list. Tick PMH (Past Medical History) Summary and Confidential as appropriate.
<b>Entering Diagnoses Through Past Medical History</b>	MD Patient Screen → Past History Tab → + button → Add diagnosis. Tick/untick Summary, Confidential, active and change dates as appropriate. To alter other conditions in the list, double click the condition.
<b>Adding Care Plans and Health Assessments as PMH</b>	Add GPMP's, TCA's, Health assessments in Past History – so that opening the past history tab will allow you to see a list of dates of items claimed to know when a review or new plan is due. Ensure that Summary is not ticked so that the items will not be included in referral letters etc.
<b>Entering Diagnoses Through Reason for Prescription</b>	MD Patient Screen → Current Rx → + button → type drug → double click on drug → fill in dose, frequency, once only or regular and reason for prescription. Tick/untick PMH, Summary and Confidential as appropriate. Note: Pressing the - button will delete a highlighted medication
<b>Enabling "Reason for Prescription" pop up</b>	Tools → Options → Prescribing → Prompts → tick "Reason for Prescription"

- Ideally diagnoses in Past History should have a complete date e.g dd/mm/yyyy so that they can be searched; show up in the Canning tool etc. Use 01/01 if you are unsure of the day or month but know the year
- When the **PMH** (past medical history) is ticked, the diagnoses will appear in past history for the current dates. Untick PMH if a diagnosis has already been entered. e.g. If this is a medication that will be prescribed regularly for an ongoing medical condition then untick the "Save in PMH" box to avoid the condition being printed as individual diagnoses on referral letters or other correspondence.
- When **confidential** is ticked, the diagnosis or reason for contact will not appear in printed summaries
- When **Summary** is ticked, the diagnoses will appear in patient summaries. This can be changed under the past history tab by double clicking the diagnoses and checking/un-checking summary.
- The **differential** diagnosis can be used when unsure of a diagnosis. This adds a question mark next to the diagnosis while still coding it.

## Entering Medications

<b>Adding Prescription Medications</b>	Patient Screen →  → type drug name → double click on drug → fill in dose and frequency → <b>select "Once only" or "Regular" (MD2) / "Limited" or "Long Term" (MD3)</b> → add reason for prescription.
<b>Adding 'OTC' Medications</b> e.g. Aspirin	Patient Screen →  → type drug name → double click on drug → fill in dose, frequency → click "Product Advised Here" → <b>select "Once only" or "Regular" (MD2) / "Limited" or "Long Term" (MD3)</b> → add reason for prescription. This will list the drug without an asterisk/ printer icon indicating a script needs to be printed.
<b>Printing Prescriptions</b>	<p>Medications which are ready to be printed are indicated by an asterisk * or printer icon  next to the drug name in the medication list). The asterisk is automatically set when prescribing new medications.</p> <p><b>To deselect an item for printing</b> → Double click to remove * /  (e.g. Aspirin doesn't need a script)</p> <p><b>To select an existing item for printing</b> → Double click on the drug's name in the current medication list</p> <p><b>To delete an item</b> → Highlight the item and press delete on your keyboard. Right click medication for more options.</p>

## Entering BP

<b>Through Progress Tab</b>	Patient Screen → Progress Tab → Examination → BP Fields.
<b>Through BP monitor</b>	Patient Screen → BP monitor icon  . Note that BPs entered this way can be graphed over time
<b>Through Cardiovascular Risk Calculator</b>	<p>Patient Screen → Cardiovascular Risk Calculator  → Save → Close</p> <p><b>MD2</b> will save BP here and bring previously entered BP into the field</p> <p><b>MD3</b> will NOT save BP here and does NOT bring previously entered BP into the field</p>

## Diabetes Register

Ask all pathology companies to send results in **HL7 LOINC** format which will drop cholesterol and HbA1c into Diabetes record when actioned.

<b>View Diabetes Register</b>	Main screen → Search → Diabetes Register
<b>Patient Summary</b>	Main screen → Search → Diabetes Register → highlight patient → Click Summary
<b>Patient Statistics</b>	Main screen → Search → Diabetes Register → Statistics
<b>Open Patient</b>	Main screen → Search → Diabetes Register → highlight patient → Open patient

## Diabetes Record

See Diabetes Annual Cycle of Care flowchart for requirements

<b>Open Diabetes Record</b>	MD → Patient Screen → Clinical → Diabetes Record
<b>Ongoing diabetic care</b>	Patient Screen → Clinical → Diabetes Record → <b>Add Values</b>
<b>Final Annual Cycle of Care consultation</b>	Patient Screen → Clinical → Diabetes Record → <b>Assessment</b> Micro-albumin values will need to be collected BEFORE commencing the assessment <b>MD2</b> - The patient will turn black in the diabetes register once the Assessment is complete.
<b>Print Assessment</b>	Patient Screen → Clinical → Diabetes Record → Double click an assessment date of a completed Cycle of Care (if available) → Print Assessment This can be used as an education tool, especially if results are at the upper limits of normal ranges.  From here old or incorrect records can be deleted by highlighting the assessment and pressing delete on the keyboard

Childhood Immunisations	
<b>Entering Immunisations for children under 7</b>	<p>This process is essential for reporting immunisations online.</p> <p><b>Schedule Immunisations:</b> Patient Screen → Immunisations Tab → + (add) button → Click Combo button (green plus button) if you gave all immunisations or tick individual immunisations.</p> <p><b>“Other” immunisations:</b> To add immunisations not listed, free-text into “other immunisations”.</p>
<b>Immunisation Print outs</b>	To start or stop Immunisation Print outs → Main Screen → Tools → Options → Clinical → check/uncheck “Print immunisation handout after childhood immunisation”

Height, Weight and BMI	
<b>Adding Height</b>	Patient screen → Progress → Examination → General → add height (cm)
<b>Adding Weight</b>	Patient screen → Progress → Examination → General → add weight (kg)
<b>BMI</b>	Automatically calculated when height and weight are added. Automatically recorded in Progress Notes when saved.

Patient Summary Tools	
<b>Summary</b>	<p>A Full Summary can be used to gain an overview of a patient or when transferring patient records to another GP or RACF. Smoking and Alcohol use status does not show in the summary.</p> <p>Patient Screen → Summaries → Full Summary</p>
<b>Patient Demographic Statistics</b>	<p>Patient demographic statistics window: Shows total number of active patients in the database broken down by age and gender plus percentage of deceased, inactive, pensioners and Veterans’ Affairs patients.</p> <p><b>MD2</b> Main Screen → Tools → Demographic Statistics</p> <p><b>MD3</b> Main Screen → Patient → Demographic Summary</p>