

What's New in



The latest version of PPM+ goes live on 22nd of May 2018

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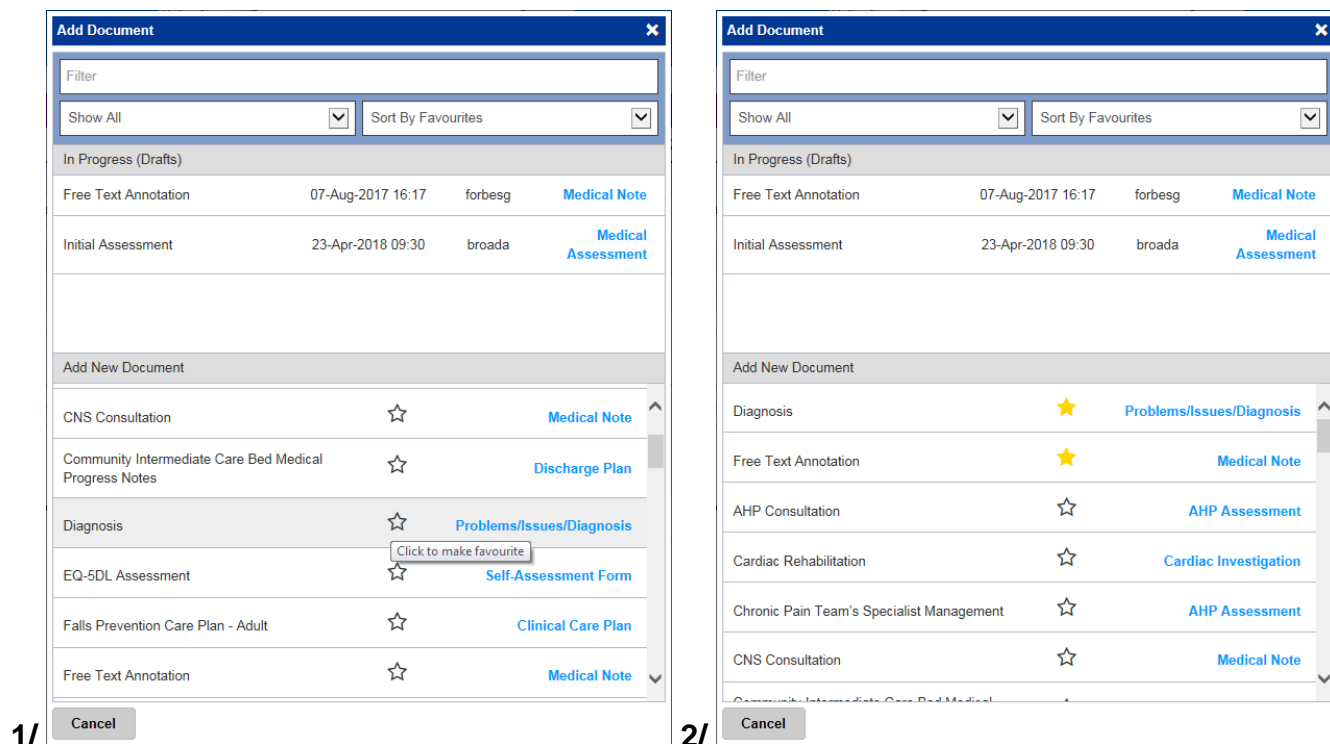
Favourite eForms

Applies to: LTHT Users

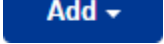

You can now favourite your frequently used eForms so that they appear at the top of your list when adding a Clinical Document:

1/ Click on the star  of your frequently used form

2/ They will then appear at the top of your list the next time you add a Clinical Document 



These favourite eForms will also appear on your [PPM+ Mobile](#).

Remember, you can add clinical documents to a patient's record through the  button in the Single Patient View or the  in the *Action* column on the Ward Patient List.

Cardiac Rehabilitation Improvements

Applies to: All Users

Based on clinical feedback we have improved the Cardiac Rehabilitation eForm:

The screenshot shows the 'Cardiac Rehabilitation' eForm for patient TESTPATIENT, Helene. The form is titled 'Cardiac Rehabilitation' and includes a close button (X) in the top right corner. The patient's details are displayed at the top: TESTPATIENT, Helene, Born 01-Jan-1974 (44y), Gender Female, NHS No. 010, Address Leeds, LS, Phone 0113, and PAS No. 001. A sidebar on the left contains a list of sections: Assessment Type, Recovery Advice, Healthy Living Advice (highlighted), Smoking Status, Recovery Information, and Community Referral. The main content area is divided into sections: Diabetes, Risk Factors, and a table for cholesterol data. The Diabetes section asks 'Is the patient known to have diabetes?' with 'No' and 'Yes' buttons. The Risk Factors section includes questions about cholesterol levels and family history, each with 'No' and 'Yes' buttons. The cholesterol data table has columns for Date, Total Cholesterol, and Low Density Lipoprotein. The form also includes a 'Cancel' button, an 'Unsaved changes' indicator, and a 'Close' button.

Cardiac Rehabilitation

TESTPATIENT, Helene Born 01-Jan-1974 (44y) Gender Female NHS No. 010

Address Leeds, LS Phone 0113 PAS No. 001

Assessment Type

Recovery Advice

Healthy Living Advice

Smoking Status

Recovery Information

Community Referral

Diabetes

Is the patient known to have diabetes?

Selecting Yes will display an alert icon (amber symbol) on the e-whiteboard to show this patient is known to have diabetes.

No Yes

Risk Factors

Cholesterol

4.5

HbA1c

60

Highest total cholesterol >7.5

No Yes

Highest LDL cholesterol >4.9

No Yes

*1st degree relative = parents, siblings and children / **2nd degree relative = grandparents, uncles and aunts

Total cholesterol >7.5 in *1st or **2nd degree relative

No Yes

Tendon Xanthoma in patient or *1st or **2nd degree relative

No Yes


MI < 60yrs in *1st or <50yrs in **2nd degree relative

No Yes

Highest Total Cholesterol (TC) / LDL known to patient (pre-treated if available):

Date	Total Cholesterol	Low Density Lipoprotein
------	-------------------	-------------------------

Cancel Unsaved changes Close

Remember, you can add clinical documents to a patient's record through the **Add** button in the Single Patient View or the  in the *Action* column on the Ward Patient List.

Children's Tuberous Sclerosis Complex (TSC) Assessment

Applies to: All Users

The Children's CSU are embarking on a new service model for this patient group in line with national strategy.

In order to monitor health progress and identify deteriorations or improvements we require a database for data collection. The data will also be vital in service planning and coordinating care nationally with the other centres in this national programme of change.

To assist in this data collection, there is now a Tuberous Sclerosis Complex Assessment in PPM+:

The screenshot shows a web-based form titled "Tuberous Sclerosis Complex Assessment". At the top, a purple header bar contains patient information: "TESTPATIENT, Helene", "Born 01-Jan", "Gender Female", and "NHS No. 010". Below this, a white bar shows "Address Leeds", "Phone 0113", and "PAS No. 001". The main form area is titled "Renal Ultra Sound Scan" and contains several sections with checkboxes and text input fields. The "Cysts" section has "No" and "Yes" buttons. The "AMLs" section has "No" and "Yes" buttons. The "Subependymal Giant Cell Astrocytoma" section has "No" and "Yes" buttons. The "Blood test results" section has a text input field. The "mTor Data dose side effects" section has a text input field with a red "mTor" link. The "Outcomes" section has "Everolimus prescribed" with "No" and "Yes" buttons, and "Anti-Epileptic Drugs changed" with "No" and "Yes" buttons. The "Speciality Referrals" section has a list of checkboxes: "Dermatology" (checked), "Ophthalmology", "Dental", "Cardiology", "Neurosurgery for consideration of a VNS", "Dieticians for consideration of Ketogenic Diet", "Local Therapy Services" (checked), and "Other". At the bottom, there is a red "Cancel" button, a green "Submit" button, and a red "Unsaved changes" indicator.

Tuberous Sclerosis Complex Assessment

TESTPATIENT, Helene Born **01-Jan** Gender **Female** NHS No. **010**

Address **Leeds** Phone **0113** PAS No. **001**

Renal Ultra Sound Scan

Cysts

AMLs

Subependymal Giant Cell Astrocytoma

Blood test results

Blood test results

mTor Data dose side effects

[mTor](#) Data dose side effects

Outcomes

Everolimus prescribed

Anti-Epileptic Drugs changed

Speciality Referrals

☒ **Dermatology**

☐ Ophthalmology

☐ Dental

☐ Cardiology

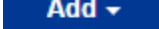

☐ Neurosurgery for consideration of a VNS

☐ Dieticians for consideration of Ketogenic Diet

☒ **Local Therapy Services**

☐ Other

Unsaved changes

Remember, you can add clinical documents to a patient's record through the  button in the Single Patient View or the  in the *Action* column on the Ward Patient List.

Categorisation of eForms in the Single Patient View

Applies to: All Users

We have improved the Event List categories in the Single Patient View to replace the *File Link* type with a more clinically relevant description, like in the example below:

Actions		Filter Events...	Show Booked and Delivered
View Patient Details			
View Audit Log			
Clinical Record Types			
TEST, Beryl (Ms)			
All			
Alerts (2)			
Allergies			
eMeds Allergies			
Audits/Tracking (2)			
Clinical Documents (239+)			
Dictation (EPRO)			
Scanned Case Notes			
Encounters/Events (2)			
Medications			
eMeds Prescription Chart			
Observations (2)			
Orders (1)			
ICE Request			
Outpatient Referrals			
Plans			
Problems/Issues/Diagnoses			
Procedures			
Results (2+)			

All			Add
2018			
11-May-2018	Vital Signs	Heart Failure Out-Reach Review	
09-May-2018	AHP Asses	AHP Consultation Generic: daltond	
09-May-2018	AHP Asses	AHP Consultation Generic: daltond	
09-May-2018	AHP Asses	AHP Consultation Generic: daltond	
02-May-2018	Medical Note	VTE Ward Round: broad	
02-May-2018	Clinical Note	HIV Clinic note: broad	
02-May-2018	Nursing Assess	Pressure Ulcer Risk Assessment -...	
02-May-2018	Clinical Note	Microbiology Infection Advice	
30-Apr-2018	Pre-Op Assess	Surgical Booking: MWAMBA, Pete...	
25-Apr-2018	Medical Assess	IV Antibiotics: broad	
25-Apr-2018	Audit	Preventing Ill Health Audit: broad	
23-Apr-2018	Medical Assess	generic Initial Assessment: broad	
20-Apr-2018	Epro	Unknown clinic letter	
12-Apr-2018	Summary	Adult Height and Weight	
12-Apr-2018	Summary	Nutritional Screening Tool	
12-Apr-2018	Nutrition	Nutritional Screening Tool: broad	
15-Mar-2018	Nursing Assess	Pressure Ulcer Risk Assessment -...	
15-Mar-2018	Care Plan	Falls Prevention Care Plan - Adult:...	
15-Mar-2018	Discharge Plan	Practice Nurse Discharge Informat...	
15-Mar-2018	Discharge Plan	CHC Checklist	

These descriptions will also be searchable from the *Filter Events...* box at the top.

As well as appearing like in the example above, the new categorisation will appear when you add a new Clinical Document:

Add Document

Filter

Show All

Sort By Favourites

In Progress (Drafts)

Free Text Annotation	07-Aug-2017 16:17	forbesg	Medical Note
AHP Consultation	09-May-2018 09:47	daltond	AHP Assessment
ReSPECT	16-May-2018 10:20	robinsst	Other Legal Information

Add New Document

Cardiac Rehabilitation	☆	Cardiac Investigation
Chronic Pain Team's Specialist Management	☆	AHP Assessment
CNS Consultation	☆	Medical Note
Community Intermediate Care Bed Medical Progress Notes	☆	Discharge Plan
Diagnosis	☆	Problems/Issues/Diagnosis
EQ-5DL Assessment	☆	Self-Assessment Form

Cancel

This improvement only currently applies to eForms; exported documents from other clinical systems such as ADAMS Endoscopy reports and manually uploaded documents will stay displaying as *File Link*.

Patient Search Improvements

Applies to: All Users

We have improved the search functionality to enable users to accurately search for hyphenated names as well as other patient IDs such as:

- PAS number
- NHS number
- Surname
- DOB

Where more than one record is found, these will be presented for selection.

Further, users can search by any partial matching record e.g. 24/07/2017 and 24th July 2017, name dependencies and matches found.

Filter Events Improvements in the Single Patient View

Applies to: All Users

Users are now able to combine filters when they search for events in the Single Patient View to show a customised result. You can do this by typing in *OR* (in capitals) between keywords.

For example, if you wanted to show AHP events as well as Obs for a patient, you can type in *AHP OR Obs* into the *Filter Events...* section:

AHP OR Obs	Show Booked and Delivered <input type="checkbox"/>
All Add ▾	
2018	
15-May-2018	File Link NEWS Observation Summary
09-May-2018	AHP Asses AHP Consultation Generic: daltond
09-May-2018	AHP Asses AHP Consultation Generic: daltond
09-May-2018	AHP Asses AHP Consultation Generic: daltond
2017	
08-Nov-2017	File Link NEWS Observation Summary

You can add further event types by adding another *OR* and then the keyword. For example if you wanted to show AHP events, Obs and Admissions, type *AHP OR Obs OR Admission*.

Height and Weight (Adult) eForm

Applies to: All Users

Height and weight should be recorded for all patients within 24 hours of admission and this can now be done electronically through a new eForm.

The eForm can assist with estimating a patient's height, useful when an actual height cannot be obtained. Factors that will affect a patient's BMI calculation (e.g. amputation) can also be recorded.

Height and Weight Record (Adult)

TEST, Beryl (Ms)

Born 17-Oct-1990 (27y)

Gender Female

NHS No. 999

Address Leeds

Phone 0113

PAS No.

Author

Author
robinsst

Date
10-May-2018

Time
10:09:10

Please Note

All patients must have a height and weight recorded within the first 24 hours of admission.

Height

* Measurement type

Actual

Recalled

Estimated from ulna length

Unable to assess

* Measurement units

Metric

Imperial

* Current height (feet)

6

* Current height (inches)

0

Weight

* Measurement type

Actual

Estimated

Unable to assess

* Measurement units

Metric







Imperial

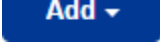

Cancel

Unsaved changes

Submit

Historic height and weight records can be viewed as an aggregated summary via the event list.

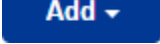

Show All ▾	17-May-2018			16-May-2018			▸
	14:09	14:08	14:08	14:07	14:06	14:06	
Page 1 of 1 <							
Height Measurement Type	Actual	Actual	Recalled	Actual	Estimated from ulna length	Estimated from ulna length	
Current Height (cm)	178	178	178	178	178	178	
Estimated Current Height (cm)					180	181	
Weight Measurement Type	Actual	Actual	Unable to assess	Actual	Estimated	Estimated	
Current Weight (kg)	95	85		75	67	67	
Factors Affecting Current Weight				Oedema	Ascites	Oedema	
Other Factors Affecting Current Weight							
Calculated BMI	30	26.8		23.7	20.7	20.5	
Interpretation	Obese	Overweight		Healthy Weight	Healthy Weight	Healthy Weight	
Created By	waterhoj	waterhoj	waterhoj	waterhoj	waterhoj	waterhoj	
Last Edited By							
Date Last Edited							

Remember, you can add clinical documents to a patient's record through the  button in the Single Patient View or the  in the *Action* column on the Ward Patient List.

Standardised Height and Weight Section

Applies to: All Users

In conjunction with the [standalone Height and Weight \(Adult\) eForm](#), all existing eForms with a Height and Weight section have been standardised to ensure a consistent user experience. In whichever eForm height and weight is recorded, it will contribute to the aggregated summary shown above.

Remember, you can add clinical documents to a patient's record through the  button in the Single Patient View or the  in the *Action* column on the Ward Patient List.

Ward Configuration Changes

Applies to: LTHT Users

Users are now no longer able to add or remove beds in the *Configure Ward* section.

Users will still be able to reorder beds as well

Edit

their names, unless they are Surge or NDA beds.

Bed Description	Action	Order
Bed 1 (Occupied)	Edit	≡
Bed 2 (Occupied)	Edit	≡
Bed 3	Edit	≡
Surge 1		≡
Surge 2 (Occupied)		≡
NDA 1		≡
NDA 2 (Occupied)		≡

If you like to close an empty bed you can update the status like in the example below:

Bed Management

Bed:Bed 3

Status:

None
AMBER - Source isolation clean
GREEN - Standard discharge clean
RED - HPV and SI Clean
Closed - Infection
Closed - Unstaffed
Closed - Unspecified
Reserved
Ward Attender

If you do need to add or remove new beds from your ward, please contact the Informatics Service Desk on x26655 or InformaticsServiceDesk.LTH@nhs.net.

Initial Assessment - Head Injury and Shunt Care

Applies to: All Users

We have introduced variants of the Initial Assessment eForm to include *Head Injury Acutes* and *Shunt Care Pathway*. This will allow for a more specialised recording of the Initial Assessment.

Please select an Assessment

- Generic
- Acute Gynaecology
- Haematuria Clinic
- Head Injury Acutes Assessment
- Shunt Care Pathway Assessment

Initial Assessment

TEST, Beryl (Ms)

Born 17-Oct-1990 (27y)

Gender Female

NHS No. 999

Address Leeds

Phone 0113

PAS No.

History of Current Episode

Previous History

Clinical Management

Specialist Assessment

History of Current Episode

Route of Admission

Comments

Previous History

Examination

GP

Self

Speciality

Ward

Other

Self-Admission

Shunt Details and Surgical History

Indication

Shunt Details and Surgical History

Type

Shunt Details and Surgical History

Valve

Shunt Details and Surgical History

Settings

Shunt Details and Surgical History

Blood pressure

120/80

Pulse

70 bpm


Temperature

Respiratory rate

Cancel

Unsaved changes

Close

Remember, you can add clinical documents to a patient's record through the **Add** button in the Single Patient View or the  in the *Action* column on the Ward Patient List.

Discharge / Transfer Planning eForm Improvements

Applies to: LTHT Users

The *Needed for Discharge* options in the Discharge / Transfer Planning eForm have been extended to provide more detail in the daily report used to improve patient flow and reduce delayed transfers of care:

Discharge / Transfer Planning

TESTPATIENT, Mike (Mr)

Born 05-Jan-1990 (28y)Gender MaleNHS No.

Address LeedsPhone 0113PAS No.

What is the patient's Expected Date of Discharge?

2018-05-22

22-May-2018

Is the patient Medically Fit For Discharge?

No

Yes

Does the patient need to be on this ward?

No

Yes

Is the patient Fit To Lodge?

No

Yes

Planning

What needs to happen before the patient can be discharged or transferred?

☐ CCB: Community Care Beds

☐ CH: Care Home

☐ CST: Community Stroke Team

☐ DtA: Discharge to Assess

☐ EMI: EMI Care Home

☐ EoL: End of Life, Fast Track / Hospice

☐ INT: Completion of eDAN

☐ INT: Test - Pathology

☐ INT: Test - Radiology

☐ INT: Therapy Services

☐ NT: Neighbourhood Team

☒ PoC: Package of Care

☐ RPAT: Awaiting bed at receiving Hospital

☐ SWA: Social Worker Assessment ongoing

☒ Other

Cancel

Unsaved changes

Submit

Remember, you can access the Discharge / Transfer Planning eForm from the *EDD*, *MFFD*, *Planning* and *Needed For Discharge / Transfer* columns in the Ward View.

IV Antibiotics eForm

Applies to: All Users

We have introduced an IV Antibiotics eForm to allow staff to record and review a patient's antibiotic use. This will encourage timely switching from IV antibiotics where clinically appropriate for the patient, and will enable audits of these 3 day reviews.

IV Antibiotics

TEST, Beryl (Ms)

Born 17-Oct-1990 (27y)

Gender Female

NHS No. 999

Address Leeds

Phone 0113

PAS No.

Relevant imaging results:

N/A

Yes

Test and Results:

Test and Results info

Patients on IV antibiotics, is an oral switch possible? 4 Yes's = oral switch strongly encouraged

A - Afebrile >24hours

No

Yes

C - Clinically improving over the past 24hours

A. Improving signs and symptoms of infection B. No unexplained tachycardia C. Blood pressure stable with no unexplained hypotension D. Respiratory rate normal E. High white cell count is falling F. C-reactive protein (CRP) is falling

No

Yes

E - Eating suitable (oral antibiotic available and the patient is able to take it)

A: Can tolerate oral fluids or have fluids via a tube into the gut B: No signs of malabsorption

No

Yes

D - NOT suffering from certain Deep-seated/high-risk infections

A. Liver abscess B. Osteomyelitis, septic arthritis C. Inadequately drained abscesses or empyema D. Cavitating pneumonia E. Staphylococcus aureus bacteraemia F. Severe necrotising soft tissue infections G. Severe infection during chemotherapy related neutropenia H. Infected implants/prosthesis I. Meningitis/encephalitis J. Intracranial abscesses K. Mediastinitis L. Endocarditis

No

Yes

Antibiotic plan: (please ensure the antibiotic is correctly prescribed on the drug chart, with indication and duration, plus a microbiology code is needed for a restricted antibiotic)

Antibiotic(s):



Route (PO/IV)

Review/Stop Date

Cancel

Unsaved changes

Submit

Remember, you can add clinical documents to a patient's record through the  button in the Single Patient View or the  in the *Action* column on the Ward Patient List.

PPMplus Whats New v18.2.0f.docx

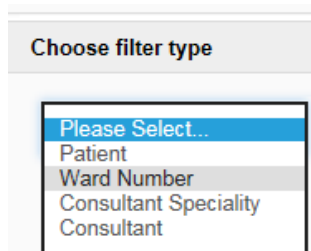
13 of 20

Last updated: 17/05/2018

Improved Custom Patient Lists

Applies to: LTHT Users

We have improved Custom Patient Lists to allow you to manually add patients to a list of your own creation, along with combinations of Wards, Consultants and Specialities:

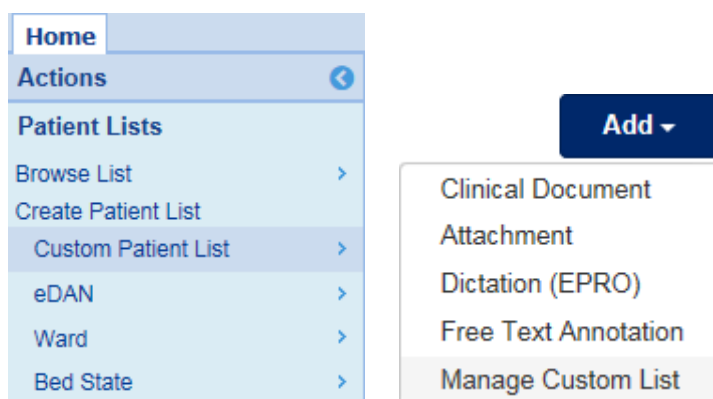


The example below is showing a custom list of one ward with a few manually selected patients:

A screenshot of the "Custom View" interface. At the top, there are fields for "Name" (containing "My Ward and Custom Patient") and "Category" (containing "Custom Patient Lists"). Below these is a "Filters" section. On the left, under "Choose filter type", there is a list of patients with checkboxes. "TESTPATIENT, Laura (Mrs)" is checked and highlighted in green. On the right, under "Filter Criteria", there are sections for "Ward Number" (containing "TEST EPR ZZZ") and "Patient" (containing a list of selected patients, including "TESTPATIENT, Laura (Mrs)"). At the bottom, there are "Cancel" and "Save" buttons.

You can also view that Custom List as a Handover using the option in the *Actions* bar on the left.

Remember, you can create, manage or edit a Custom Patient List from the *Actions* bar on the *Home* tab or through the **Add** button in the Single Patient View:



In a future update, we are going to introduce new filter types and enable users to share their custom lists with other colleagues and teams.

Community Clinical Documents

Applies to: All Users

Leeds Community Healthcare NHS Trust (LCH) have a number of clinical documents which other care settings such as LTHT have said will find useful to view in order to understand the holistic view the care community is providing as a patient comes into Hospital.

The initial clinical documents which are being shown relate to **Community Paediatric care only**.

The presence of the clinical documents is supported by a message alerting a clinician to the fact that they are there.

The screenshot displays the 'Community' tab in a clinical system. At the top, patient details are shown: Current Location **92 (SJUH)**, Born **2005 (12y)**, Gender **Female**, NHS No. **945**. Below this, a table lists patient information: Address, Phone, GP, PAS No. **002**, and Allergies: see GP tab or eMe... (with a dropdown arrow). The main content area is divided into tabs: Hospital, General Practice, Mental Health, Community (selected), Children's Social Care, and Results. Under the 'Community' tab, there is a 'Filter Documents...' search bar and an 'Expand' button. A list of 'LCH Documents' for 2018 is shown, with columns for date, speciality, and document type. The documents listed are: 18-Apr-2018, Speciality, Education and Healthcare Plan; 20-Apr-2018, Speciality, Education and Healthcare Plan; and 20-Apr-2018, Speciality, Clinic letter. On the right, a preview of the 'EHC1 Proforma (v2)' is visible, featuring NHS Leeds and Leeds City Council logos, and a form for professionals to complete.

Hospice Virtual Ward

Applies to: Hospice Users

To ensure consistency with the user experience in general practice, St. Gemma's and Wheatfields can now see a multi-patient view showing which of their patients are currently in an LTHT Ward and the associated details around treatment and contacts.

Hospice users can access this from their *My Recent Lists* on their Home tab.

The screenshot shows the 'My Recent Lists' section for 'StGemmasHospice Virtual Ward'. It lists two categories: 'Category By Inpatient (Wards)' and 'Custom View - eDAN'. The 'Category By Inpatient (Wards)' is selected, showing a list of patients with the last viewed date and time: 29-Nov-2017 13:02.

The screenshot shows the 'My Recent Lists' section for 'WheatfieldsHospice Virtual Ward'. It lists one category: 'Category By Inpatient (Wards)'.

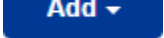

Hospital ReSPECT eForm

Applies to: Pilot Users

ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning.

LTHT Pilot users can now complete a ReSPECT eForm to record the patient's preferences for their advance care needs using the [nationally recognised ReSPECT format](#) so that anyone encountering the patient thereafter has the ability to view these preferences in a single place.

The screenshot shows the ReSPECT eForm interface. At the top, a blue header bar contains the title 'ReSPECT' and a close button. Below this, a purple bar displays patient details: 'TEST, Beryl (Ms)', 'Born 17-Oct-1990 (27y)', 'Gender Female', and 'NHS No. 999'. A white bar below shows 'Address Leeds', 'Phone 0113', and 'PAS No.'. A left sidebar contains a list of sections: 'Patient Involvement' (checked), 'Diagnosis/Prognosis', 'Advance Statement / Decision / Preferences' (selected), 'CPR / Treatment Escalation', and 'Responsible Clinician'. The main content area is titled 'Advance Statement/Decision/Preferences'. It contains two sections: 'Patient has advance statement' and 'Patient has advance decision to refuse treatment', each with 'No', 'Yes', and 'Unknown' buttons. Below these is the 'Personal Preferences of patient (when patient has capacity)/Parent/Legal Guardian/Other to guide this plan' section. It includes a question about balancing priorities for care, a scale for patient selection (with the 5th option selected), and two radio buttons for prioritising sustaining life vs. comfort. The 'Preferences' section has a note to ensure the patient involvement section is up to date, and dropdowns for 'Preferred place of care' (Home), 'Preferred place of death first choice' (Home), and 'Preferred place of death second choice' (Hospice). The 'Additional Information' section has a text area for recording other relevant information, with a 'remaining: 80' indicator. At the bottom, there is a 'Cancel' button and an 'Unsaved changes' indicator.

Remember, you can add clinical documents to a patient's record through the  button in the Single Patient View or the  in the *Action* column on the Ward Patient List.

PPM+ Mobile App

Applies to: All Users

The new PPM+ Mobile App allows you scan a patient's wristband to access their EHR (Electronic Health Record) using technology implemented as part of the [S4S \(Scan 4 Safety\)](#) programme.

As well as [accessing eForms](#) and [assigning patients to beds](#), this will facilitate the location tracking of patients and provide improved visibility of the patient pathway.

Patient safety will be improved by the scanning of wristbands for positive identification before entering data into the EHR.

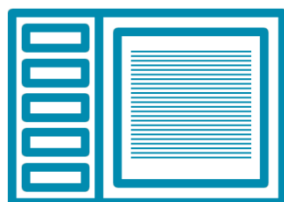


Currently this is being rolled out in line with electronic nursing documentation implementation schedule. [Click here for more information regarding the roll-out.](#)

PPM+ Mobile - eForms

Applies to: Pilot Users

Using PPM+ Mobile, staff can now complete eForms via mobile devices such as an iPads:



eForms

iPad 12:37 87%

< Patient Dashboard Select eForm Category

TESTPATIENT, Bev (Mrs)

Born 01-Jul-1990 NHS No. 999 999 9557

Q Search eForms

- All eForms >
- My Favourites >
- In Progress >
- Living wills & advance directives >
- Medical assessment >
- Medical note >
- Nursing assessment tool >

You can also favourite eForms ★ by swiping left and tapping on *Favourite*:

iPad 12:39 86%

< Select eForm Category All eForms

TESTPATIENT, Bev (Mrs)

Born 01-Jul-1990 NHS No. 999 999 9557

Q Search eForms

Pressure Ulcer Risk Assessment (Purpose T)

otation Favourite

These favourite eForms will appear in *My Favourites* on the iPad, as well [as PPM+ via a desktop computer.](#)

Swipe again to *Un-Favourite* a form.

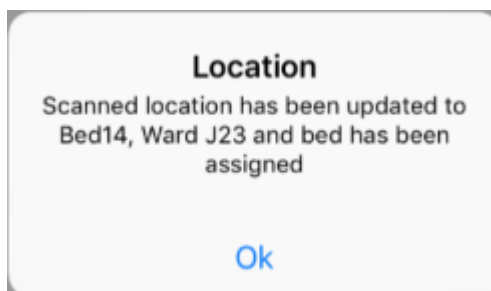
PPM+ Mobile - Bed Status and Assignment

Applies to: Pilot Users

As well as being able to access a patient's EHR (Electronic Health Record) when scanning their wristband, you can also assign a patient to a bed via PPM+ Mobile:

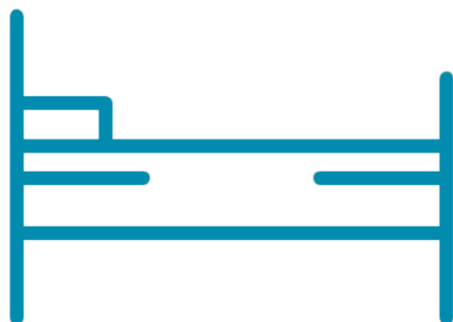


Update Location
Scan new location

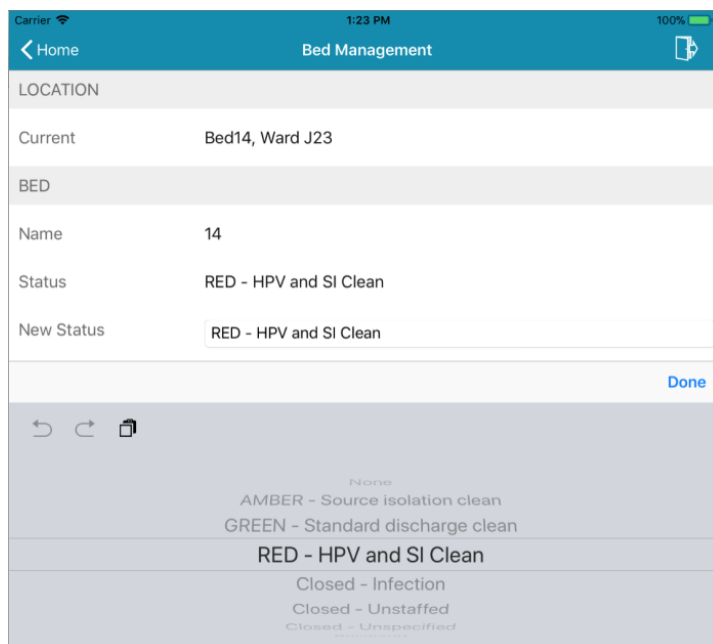


Once you have scanned the bed location this will also appear on the eWhiteboard.

Also via PPM+ Mobile, you will be able to update the status of an empty bed once you have scanned it:



Bed Management

A screenshot of the PPM+ Mobile app's "Bed Management" screen. The screen has a teal header with "Home" and "Bed Management" buttons. Below the header, there's a "LOCATION" section with "Current" set to "Bed14, Ward J23". A "BED" section shows "Name" as "14" and "Status" as "RED - HPV and SI Clean". There's a "New Status" dropdown menu also set to "RED - HPV and SI Clean". At the bottom, there's a list of status options: "None", "AMBER - Source isolation clean", "GREEN - Standard discharge clean", "RED - HPV and SI Clean" (which is highlighted), "Closed - Infection", "Closed - Unstaffed", and "Closed - Unspecified". A "Done" button is in the top right corner of the status list area.

If you don't currently have bed barcodes in your area, these will be rolled out in coming months.

Contact Us

Please contact the Informatics Service Desk at x26655 or informaticsservicedesk.lth@nhs.net to:

- Reset your password
- Report a problem you are having within PPM+ functionality
- Report a data quality problem within PPM+
- Request new user accounts for PPM+
- Disable PPM+ accounts for any leavers from your department

Please contact the PPM+ EPR team at leedsth-tr.EPR@nhs.net if you have any development ideas or comments on your experience of using the EPR.

If you would like to make a request for change to PPM+, please contact us at: leedsth-tr.EPR@nhs.net with a completed [request for change \(RFC\) form available here](#)

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

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