

# What's New in



*The latest version of PPM+ goes live on 18th of September 2019*

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# Speciality Assessment Record

**Applies to:** All Users

We have introduced a *Speciality Assessment Record*:

The screenshot shows a web-based form titled "Speciality Assessment Record". At the top, there is a header bar with patient information: "TEST," (Name), "Born 12-Dec-1970 (48y)" (Date of Birth), "Gender Female" (Gender), and "NHS number" (NHS Number). Below this, there is a section for "Address" with the value "Leed General Infirma, LS1 3EX" and a field for "PAS number".

The main content area is divided into several sections:

- Presenting Complaint/s**: This section is highlighted in blue. It contains a list of options: "Review of Systems", "Medications", "Allergies and Adverse Reactions", "Previous Medical History", "Smoking, Alcohol and Recreational Drug Use", "Family History", "Social History", "Medical Examination", and "Diagnosis".
- Type of Episode**: This section contains a label "Type of patient episode \*" and three buttons: "Elective admission", "Acute admission", and "Same day emergency care". The "Same day emergency care" button is highlighted in blue.
- Chief complaint**: This section contains a label "Date \*" and a text input field with the value "19/08/2019". Below this, there is a label "Chief Complaint \*" and a text input field with the value "Backache (no recent injury) (Trauma / musculoskeletal)".
- History of Presenting Complaint**: This section contains a label "History of Presenting Complaint" and a text input field with the value "History of Presenting Complaint".

At the bottom right of the form, there is a green "Submit" button.


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.

# MARAC Alert

**Applies to:** All Users

We have introduced a *MARAC Alert* eForm:

Once the form has been submitted, the alert will show in the Single Patient View *Patient Clinical Alerts* section:

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.

# 4AT Assessment Test For Delirium and Cognitive Impairment

**Applies to:** Pilot Users

We have introduced a *4AT Assessment Test For Delirium and Cognitive Impairment* form:

4AT Assessment Test For Delirium And Cognitive Impairment

TEST, Beryl

Born 12-Dec-1970 (48y)

Gender Female

NHS number

Address Leed General Infirma, LS1 3EX

PAS number

4AT (Rapid Clinical Test for Delirium)

Alertness \*

Mild sleepiness for <10 seconds after waking, then normal

AMT4 - Please indicate if the patient answered the following 4 questions correctly

Age \*

Yes No Untestable

Date of birth \*

Yes No Untestable

Place \*

Yes No Untestable

Current Year \*

Yes No Untestable

AMT4

1 mistake

Attention - Months of the year backwards \*

Starts but scores < 7 months / refuses to start

Acute change or fluctuating course \*

Yes No Unable to assess

Discard

Autosaved: a few seconds ago

Save Draft

Submit

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.

# PatientPass

**Applies to:** All Users

We have introduced a link to [PatientPass](#) into PPM+:

External Systems	Summary Care Record
BMJ Best Practice	Order Comms
Leeds Health Pathways	Results Server
More ▶	TMS
	EQMS
	PatientPass

# Mental Capacity Assessment

**Applies to:** All Users

We have introduced a *Mental Capacity Assessment* so clinicians can judge whether a patient can make decisions about their care:

Mental Capacity Assessment

TESTPATIENTBorn 01-JanGender FemaleNHS numberAddress LS1PAS number

Mental Capacity Assessment

This Mental Capacity Assessment should be completed when a patient wishes to self-discharge or is refusing treatment. If you wish to document a more thorough assessment then access the MCA1 form on the intranet. If the patient self-discharges and is an adult at risk, please refer to the safeguarding team. If the patient lacks capacity and wishes to self-discharge try to prevent them from leaving with the least restrictive option. If the patient lacks capacity and absconds then utilise the LTH Missing Persons Policy.

There is a duty to provide the patient with the basic relevant information for the decision (including risks, benefits and consequences) in a way that best supports their understanding. Have you met this obligation? \*

NoYes

List relevant information that you have discussed with the patient

List relevant information that you have discussed with the patient

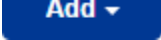

On the balance of probabilities do you think the patient is currently experiencing an impairment or disturbance in the mind or brain?

NoYes

Explain why you think they have an impairment or disturbance in the mind or brain

Explain why you think they have an impairment or disturbance in the mind or brain

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.

# Clinical Note Improvements


**Applies to:** All Users

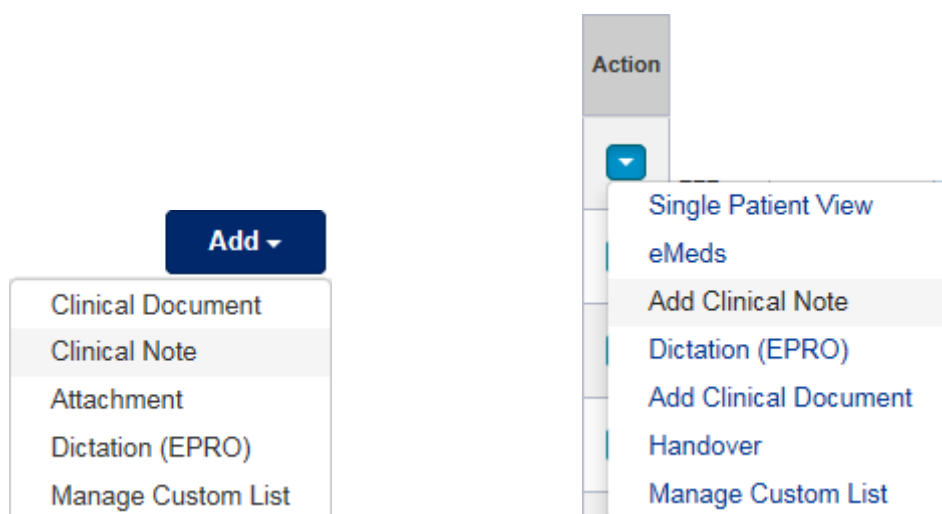
We have introduced additional Types and Professions into the *Clinical Note*:

The screenshot shows the 'Clinical Note' form for a patient named TESTPATIENT. The patient's details include: Born 01-Jan, Gender Female, NHS number, Address LS1, and PAS number. The form fields are as follows:

- Author:** ROBINSON, Stuart (Mr)
- Date Of Activity:** 03/09/2019 (03-Sep-2019)
- Time Of Activity:** 10:18 (Format HH:mm)
- Profession:** Admin
- Specialty:** ENT
- Type of note:** MDT Summary (dropdown menu is open showing options: General, Discussion with family/others, MDT Summary, Outpatient clinic/consultation, Virtual consultation, Ward Round, Clinical trial, Admin)
- Subject Line:** Clinical Note Improvements
- Notes:** Clinical Note Improvements (with rich text editor icons: B, I, U, H1, H2, H3, list, link)

At the bottom, there is a status bar indicating 'Autosaved: a few seconds ago' and buttons for 'Save Draft' and 'Submit'.

Remember, you can add a *Clinical Note* 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:



# Contact Us

Please contact the Informatics Service Desk at x26655 or [informaticsservicedesk.lth@nhs.net](mailto: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+ EHR team at [leedsth-tr.EPR@nhs.net](mailto: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](mailto: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](mailto:ITTraining.LTHT@nhs.net) if you require further training on PPM+ or any other Clinical System.

PPM+ Help Site: <https://www.ppmsupport.leedsth.nhs.uk/>