NHS
Greater Glasgow
and Clyde

Reference Guides

TRAKCARE CLINICAL LETTERS - AHP

DOCUMENT CONTROL

Authors:	Margaret,Hastings@ggc.scot.nhs.uk
Date:	20th October 2012
Version:	1.1

Document Location

Document title	Clinical Letters Reference Guide – AHP Adapted

Version History

Version	Date	Summary of changes
1.2	09/11/12	Updated with Generic Clinical Letter and comments from team.
1.3	08/05/14	Adapted for AHP services
1.4	09/06/14	Updated following feedback from Project Officers.
1.5	30/06/14	Updated with new screenshots

## Contents

USING THIS DOCUMENT

This document considers the current Clinical Letter functionality within TrakCare. It has been abbreviated for AHPs who will use Out Patient Clinic Letter and Generic Clinical Letters.

- Outpatient Letter – auto-populates with patient demographics, GP address clinic and appointment details.
- Generic Clinical Letters – various types only auto-populate with patient demographics.

OVERVIEW OF TRAKCARE CLINICAL LETTERS

TrakCare has Letter types which correspond to the National Document Heading Standards for Correspondence. This means that the correct metadata will be attached to the letter when it is sent to SCI Store to be viewed in the Correspondence lists in Portal. Letters to GPs will go electronically over Electronic Document Transfer (EDT) to the practices' Document Management System.

Letter type workflows are accessed through the Discharge Letters and Generic Letters Tabs.
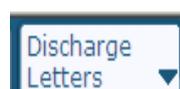
DISCHARGE LETTERS (CLINICAL SUMMARIES)

Out-patient Clinical Letter (OPCL)

This is a letter to the General Practitioner, which can be completed following an Out-patient Attendance or at Discharge. Updated letters can be created as new versions of the original letter. Copy to names and addresses can be added as free text.

GENERIC CLINICAL LETTER

These letters have been designed as a single screen (known as a Chartbook) to allow multiple different letters being in progress / completed per episode. There is a free text field to add further description within the letter.

| Letter	Menu name	Index standard	Example
Letter to Patient	Patient (LP)	CO10	Changes to treatment, medication etc.
Clinical Letter to GP	GP (CLGP)	CO03	Follow up; Results letter;
Clinical Letter to Others	Clinical (CLO)	CO03	Letter to Dentists; Opticians; Therapists;
Referral letter	Referral(RL)	CO14	Onward referral; tertiary referral; Out of area referral.
Social Services letter	Social Srvcs (SS)	CO15	Letter to Social Services / Care Agencies
Transfer letter	Transfer (TL)	CO16	For transfer out with the Board; Transfer back to Community team

| MDT letter	MDT (MDT)	CO20	Cancer MDT reports; Rehabilitation MDT reports
Generic letter	Other (GL)	CO99	Catch all
Operation note (Med sec / admin view)	Op Note (ON)	CL12	Allows Operation notes and procedures in TrakCare to be viewed in Clinical Portal.

Out Patient Clinic Letter (OPCL)
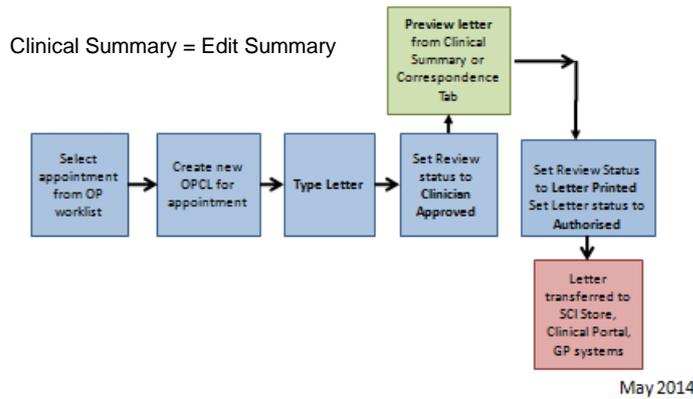
For OPCL each letter clinical note must be attached to an appointment so the letter is started by highlighting the patient appointment on your OP worklist.
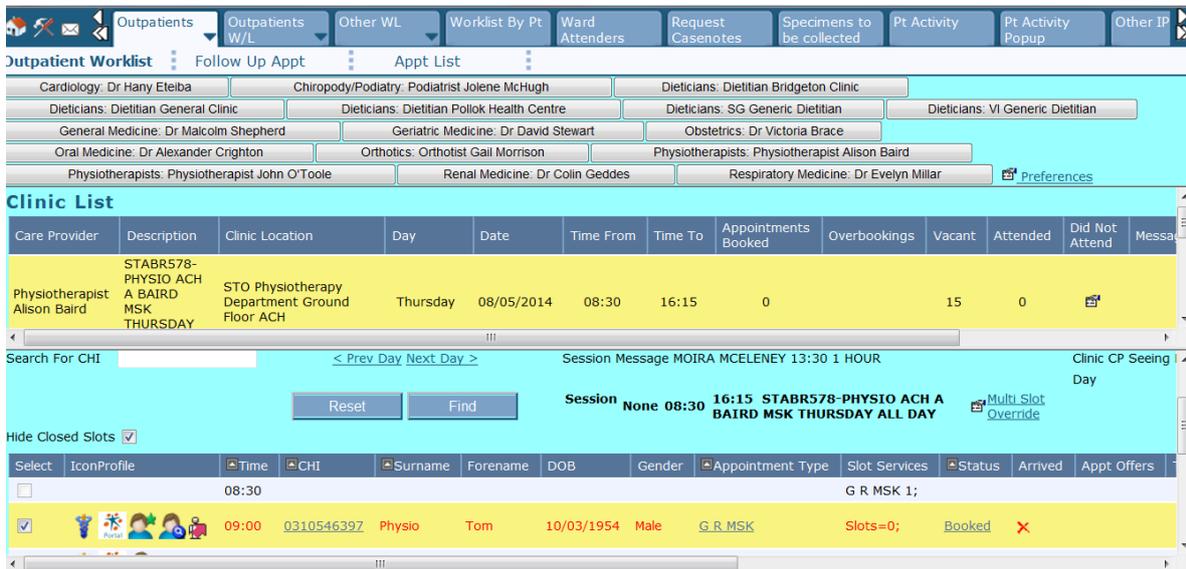
Click on Discharge Letters tab and then select New OPCL
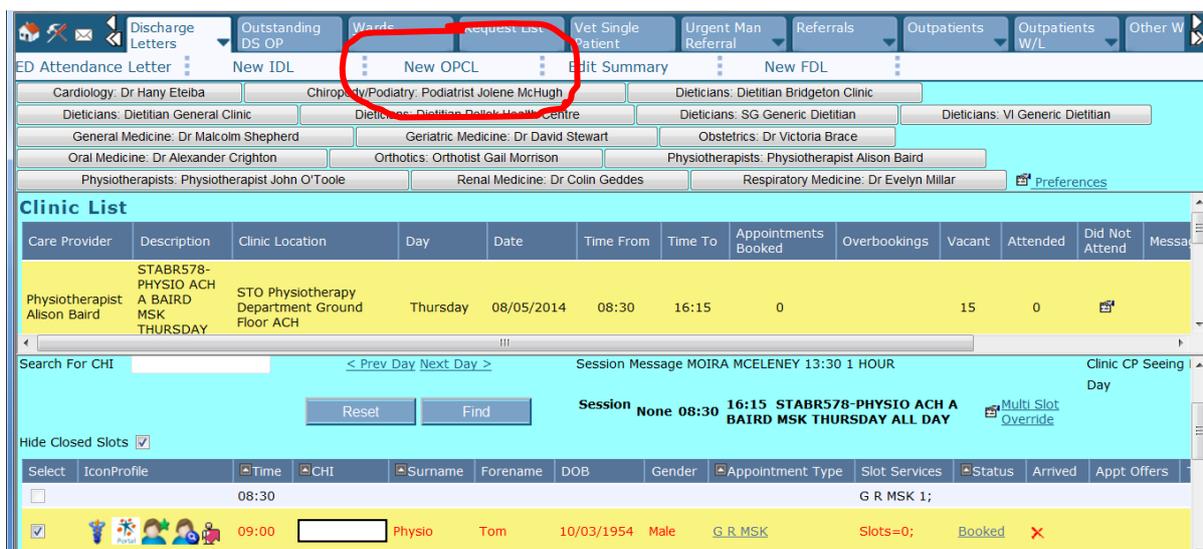
The OPCL chartbook opens. Normal workflow would be Notes / Edit Summary (top left hand tab) -> Additional OPCL Info tab -> Clinical Assessment if you want to put in a Diagnosis or Procedure (can be ignored) and finally the Notes/ Edit Summary to save the chartbook (letter). After first save a hyperlink will appear which will allow you to view the draft letter.
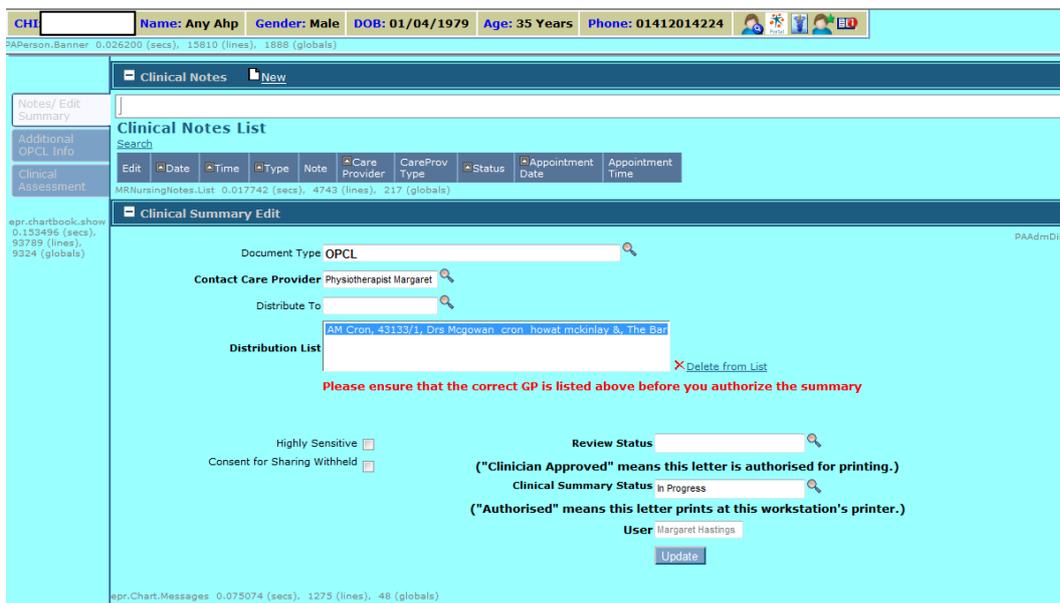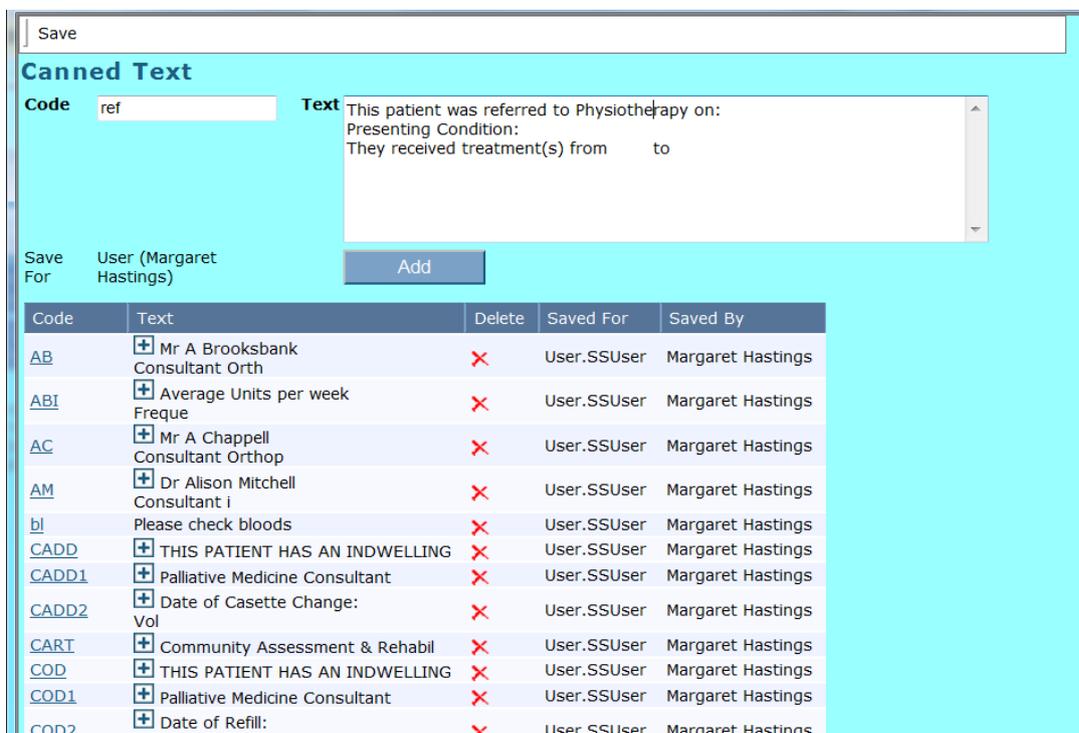

Canned Text - needs to be built for each individual user. The service should agree standard letter wording for discharge letters etc. This can be produced as a word document and then transferred to the TrakCare canned text function. It needs to be done once only – but can be edited as required. This is built from the Additional OPCL Info tab (2nd tab left hand side).

Use a field with the Canned Text Icon .

Type in the field, highlight it and then the canned text icon will go green. Click on the icon to open the Canned text build screen.

You can also get to a canned text icon from any Clinical Notes using the Paste from Word Icon.

Code	Text	Delete	Saved For	Saved By
AB	Mr A Brooksbank Consultant Orth	✗	User.SSUser	Margaret Hastings
ABI	Average Units per week Freque	✗	User.SSUser	Margaret Hastings
AC	Mr A Chappell Consultant Orthop	✗	User.SSUser	Margaret Hastings
AM	Dr Alison Mitchell Consultant i	✗	User.SSUser	Margaret Hastings
bl	Please check bloods	✗	User.SSUser	Margaret Hastings
CADD	THIS PATIENT HAS AN INDWELLING	✗	User.SSUser	Margaret Hastings
CADD1	Palliative Medicine Consultant	✗	User.SSUser	Margaret Hastings
CADD2	Date of Casette Change: Vol	✗	User.SSUser	Margaret Hastings
CART	Community Assessment & Rehabil	✗	User.SSUser	Margaret Hastings
COD	THIS PATIENT HAS AN INDWELLING	✗	User.SSUser	Margaret Hastings
COD1	Palliative Medicine Consultant	✗	User.SSUser	Margaret Hastings
COD2	Date of Refill: Volume remainin	✗	User.SSUser	Margaret Hastings

The Users Canned Text Table opens with the text added enabling to allow the user to add a suitable code. E.g. ref code and referral information as above. Click on Add and it will be added to the table.

Whenever \ ref and the spacebar clicked the referral information will be added to the letter.

From the Canned text table additional text can be added as required by clicking on Add. Enter the code and Text in the table and Save as User. The text for a whole document can be added including all options, this can then be edited in the letter. You can add the names and addresses of frequently used consultants, other AHPs etc. Include a Yours sincerely with your name and designation to make it quick to finish the letter.

Inserting Canned Text into a field

Type F6 – your personal canned text list opens. Select the text you require and double click to enter it into document.

You can also enter canned text using the short code in many text fields. This is done by typing \code (e.g.\ref) and pressing the space bar.

Entering Text for OPCL

To start a letter from the Clinical Notes tab (top left tab) click on New
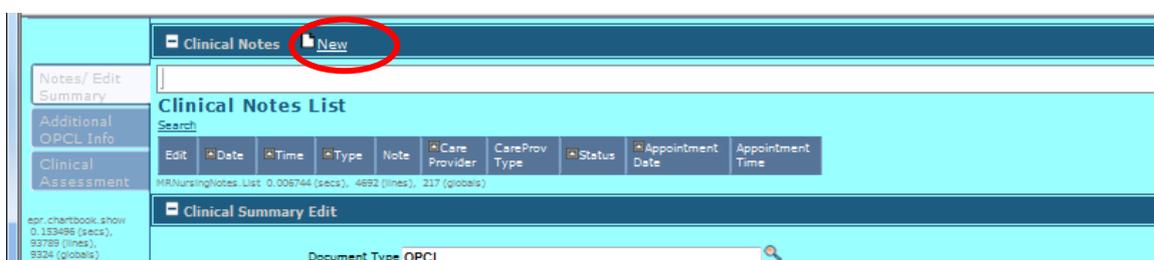
The Outpatient note opens and includes the Care Provider (if you are doing the letter yourself – secretary will have to add the user name if dictated), the specialty, appointment date and time. It is important that the clinic and appointment details are correct (if not you've probably selected the wrong appointment).
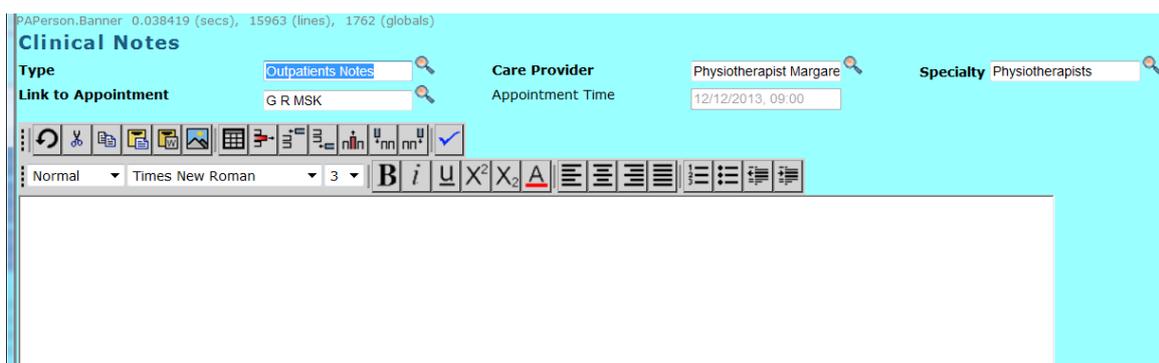
You can now start to build the letter using Canned text – or free text as you want. There is limited formatting and you can paste from a text file. The Clinical Notes has spell check ☑ (full clinical terms; diagnosis; procedures and medications and English – additional English words can be added but not by user). The formatting menu below has the ability to cut; paste (internal TrakCare) paste from Word (removes any Microsoft formatting); spacing, offset, bullets.
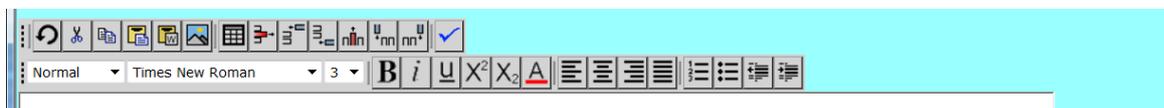
While the formatting menu has the ability to import a picture / chart it appears that this has to be generated within the patients' clinical record and GG&C has not yet reached the required level of development of the Clinical Record to enable this. It is recommended to use very little formatting to prevent corruption of documents.

Once the letter is complete - remember to Update the Clinical Note. This will close and save the note and return it to the Chartbook. Save will save the text and not close the note.

Additional OPCL info

Add information to the OPCL tab. Remember to Update to save the information. The Additional OPCL Info tab is a questionnaire that holds information not held anywhere else in TrakCare (or that is accessible for a Clinical Letter).This is where you have to add contact details; Copies to; Dictated Date (legal date of letter at which you had relevant information); Department e.g MSK/ PFD etc. In the OPCL if information is not entered in the Requested OP Investigations; Follow Up; Medication Notes then these headers do not appear as place holders in the Letter output.

Using the Document Summary Tab

Click on the Notes / Edit summary tab (top tab) - the Clinical Summary edit screen controls the review status of the draft letter. The OPCL is always sent to GP. If the registered GP is not the GP who made the referral you can change it in the Distribution List field.
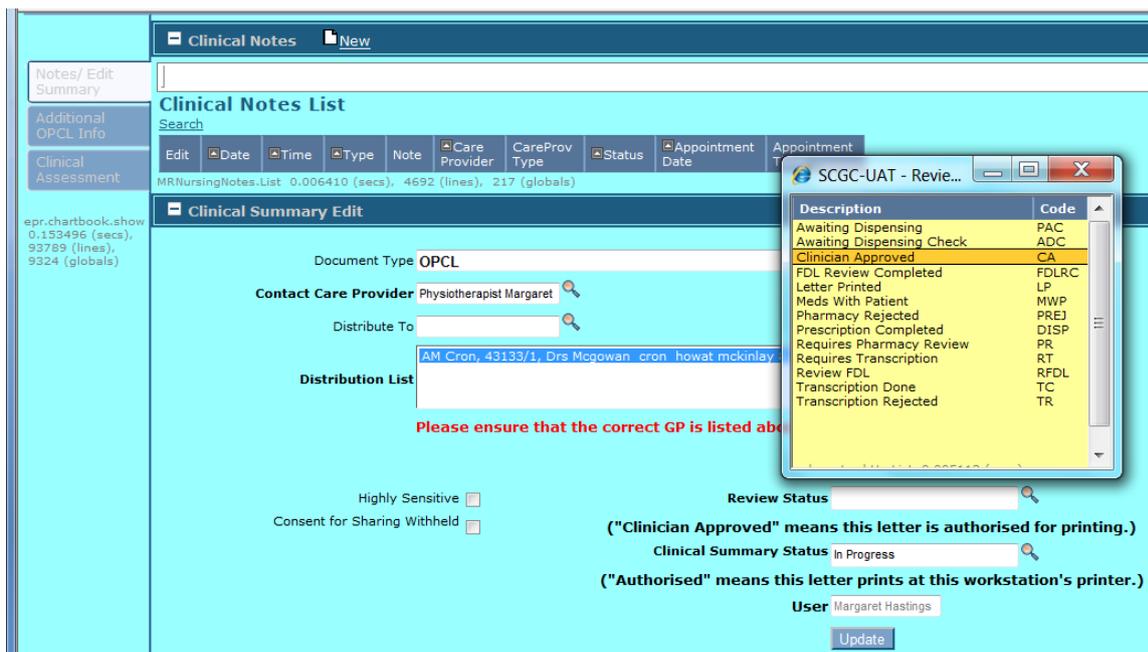
When you have completed the letter you need to change the review status to "Clinician Approved" (CA). You can use the short code or the spyglass for the drop down list. Clinician Approved adds Electronically Signed care provider to the letter and generates the report to allow you to preview the letter.

Clicking Update closes the screen, generates a draft copy of the letter and returns you to the OPWL.

Viewing Letters in TrakCare

Letters can be found in the

1) Clinical Record icon in Patient Header Bar 👤. Click on the clinical record icon for the patient and click on the Documents tab. This opens at Correspondence and there will be a hyperlink to your letter. Click on the hyperlink and the Chartbook will open.

2)   Discharge Letters tab, click on Edit Summary you will launch the Clinical Summary List. From here you can click on letters to preview using the Document hyperlink.

Opening Draft letter

Clicking on the Hyperlink will launch the draft pdf document for viewing. At this stage you can use the Windows print function to print the letter – for correction, but remember the Board policy of working paper light.

Clinical Notes Audit

Bottom left of the Clinical Note is the Audit trail menu. Clicking on Audit trail opens the list of all the changes that have been made to the Clinical Note.

Time and text versions are available to view. Click on the magnifying icon to view the changes to the field.

Authorise the printing of the letter

If there are any letter sensitivity issues for storage on portal then these check boxes can be ticked in this screen. The Highly sensitive and consent for sharing can be ticked – these letters will still be viewable within TrakCare but restrictions will apply in SCI Store and Clinical Portal.

Once you are happy with the letter content - change the review status to **Letter printed** and change Clinical Summary Status from In Progress to **Authorised**. The OPCL is print rendered sending it to SCI Store / Portal and electronically to the General Practice.

When paper-lite is switched on there will be NO auto-print of the OPCL. If you require a printed copy to send you need to reprint the letter. You may be able to save a copy of the finalised pdf and email it to a consultant's secretary for their attention rather than printing and posting a letter.
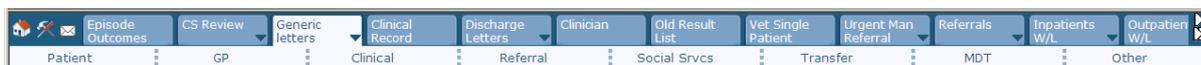
GENERIC CLINICAL LETTERS

# Process map – Generic Clinical Letter
(AHP typing)
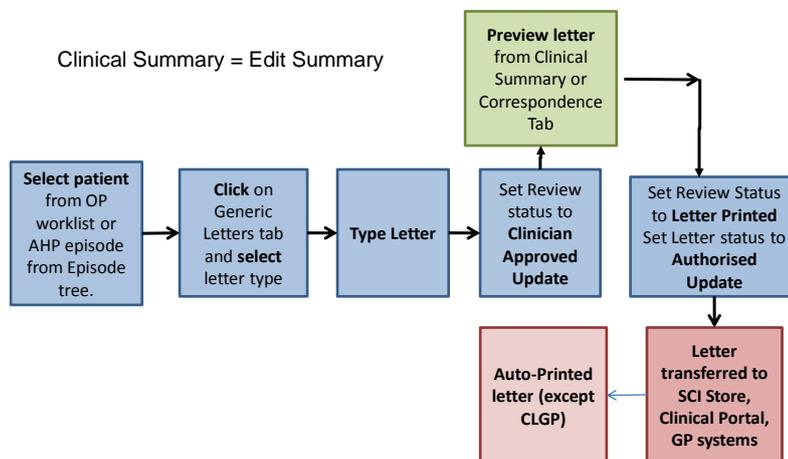
May 2014

These letters combine the Clinical Note, Additional Information and edit Summary screens of the OPCL into one screen, making them easier to use, but you do not pull through any clinical detail to the letter.


For Generic Clinical Letters you need to select the letter type you wish to use. You need to have the patient in context through either using the OP Worklist or Episode Tree / Patient Activity tab to select the correct AHP episode. (To get the correct hospital / health centre address).

Click on the letter type (this example is referral) and the screen for completing this letter open. These letters only pull through the patient demographic details and the episode hospital, everything else has to be entered in the fields.
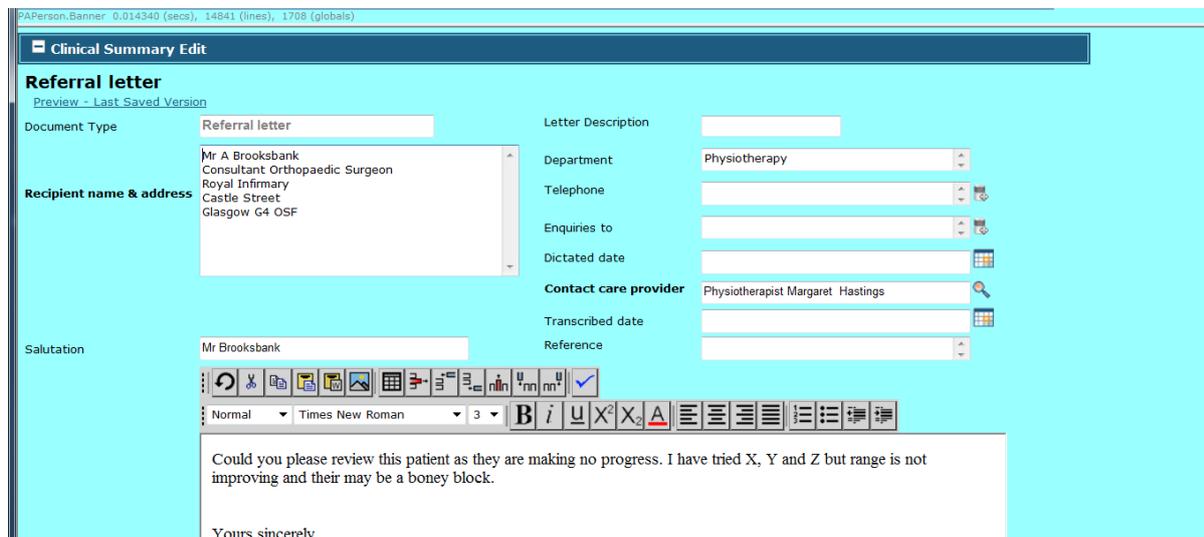
You can have frequently used names and addresses saved in your canned text, you need to enter it in the body of the letter and drag and drop it to the recipient name and address. You can also have the body of standard letters saved as canned text. NB you can only use \code to enter canned text in Clinical Note here.
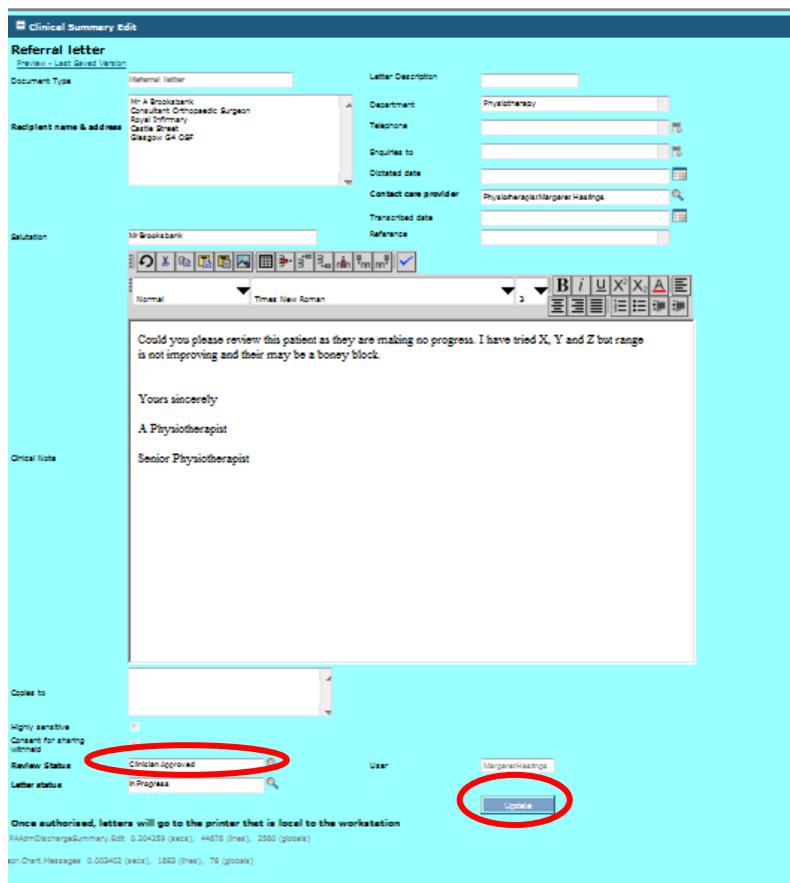
Canned text can be used in the body text of clinical note and in the Telephone and Enquiries field.

Copies to – names and addresses can be added.

Ticking the Highly sensitive box, means that the letter requires password access on Clinical Portal.

Ticking the Consent for sharing withheld means that the letter cannot be viewed on Clinical Portal.

The Review status and Letter Status work as for OPCL.

The letter is typed and Review Status of Clinician Approved is selected and Update Clicked. This adds a statement to the letter that it has been electronically signed by the user including their designation.

Once Updated you will return to the original screen from where you started letter production. To Preview the letter you can click on the Clinical record icon to go to the Correspondence tab or you can find the letter in the Clinical Summaries tab.

PRINTING

TrakCare is set to auto-print all clinical letters not addressed to the General Practitioner. Letters to the General Practitioner will go electronically over the Electronic Document Transfer (EDT) software to the GP Practice.
The document should print immediately at the nearest TrakCare printer provided it is switched on and has the correct paper in the correct tray (see print test guide)

Printing process
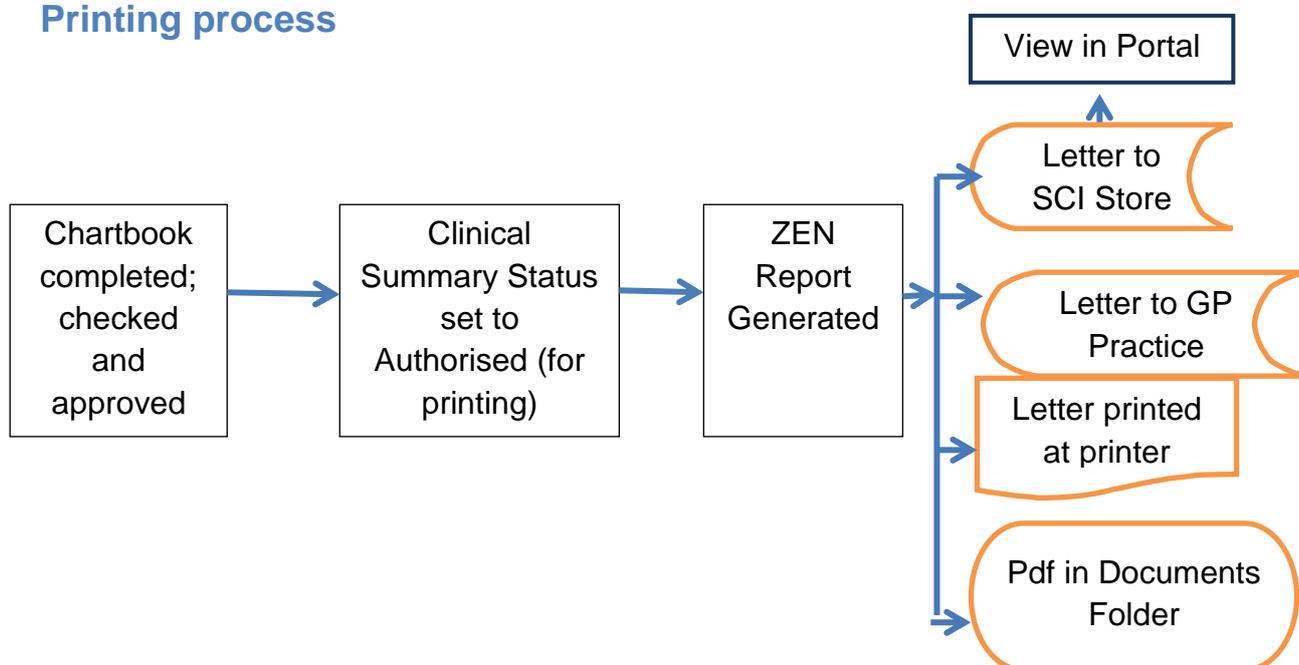
Additional copies can always be printed from TrakCare and these are logged in the system. From the Authorised Document hyperlink pdf of the letter you can save it and send it as an email attachment to a consultant / other AHP.

Printing Additional Copies / Reprinting

Letters can be reprinted either from the Documents tab in the Clinical Record icon
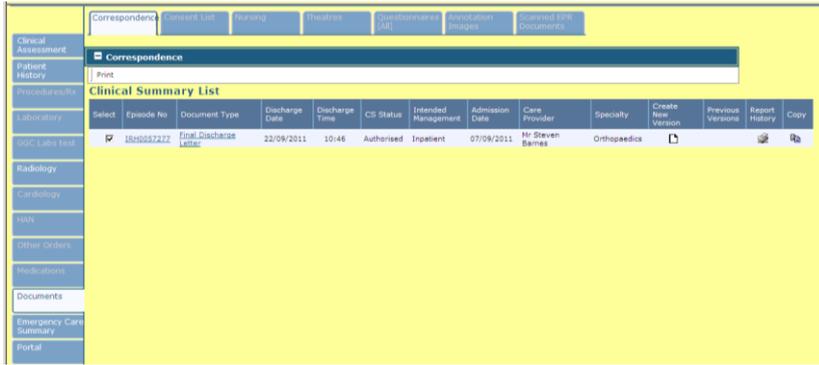
Or from Discharge Letters / Edit Summary
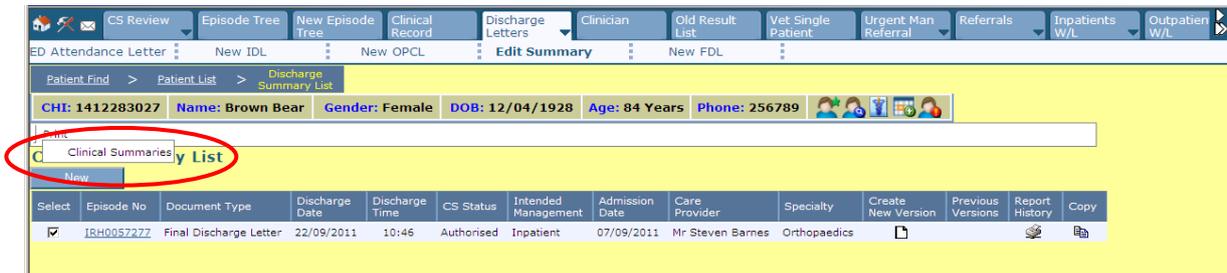
Select the letter to be printed and click on print then Clinical Summaries.
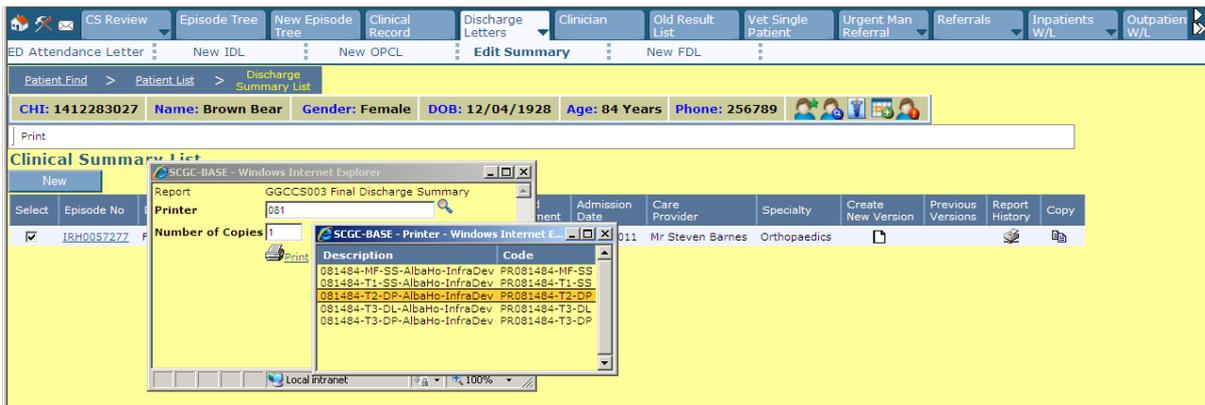
The printer pop up will appear and you need to enter the ID of the printer where you want the document to print and select the correct tray – DP (duplex portrait). You can also select the number of copies you require and then click on the printer icon and the copies will be generated. You need to know the asset number of the printer you wish to use.

Viewing Report History

In the Clinical Summary List – if you click on the Report History icon the list of all the times the report has been generated for printing (through TrakCare) can be viewed.

CREATING NEW VERSION

Full version control is available within TrakCare. Replaced versions become previous versions and the New version is the version in the Document type. Each document is associated with an episode ID No. and the Additional Information Questionnaire applies across all versions of that letter type for the episode. Care needs to be taken when completing OPCL and GCL (multiple versions per episode) to ensure that documents are authorised for printing (pdf version stored in TrakCare) before a second letter is generated.

New versions may be required to add additional findings – for example test results; or because an error was made in the previous letter (letter sent about wrong patient or patient restarts after letter sent).

To generate a new version of the letter in the clinical summary list (either from Edit Summary or the Documents tab in Clinical Record) click on the **Create New Version icon**

The Chart book opens, giving access to all screens.
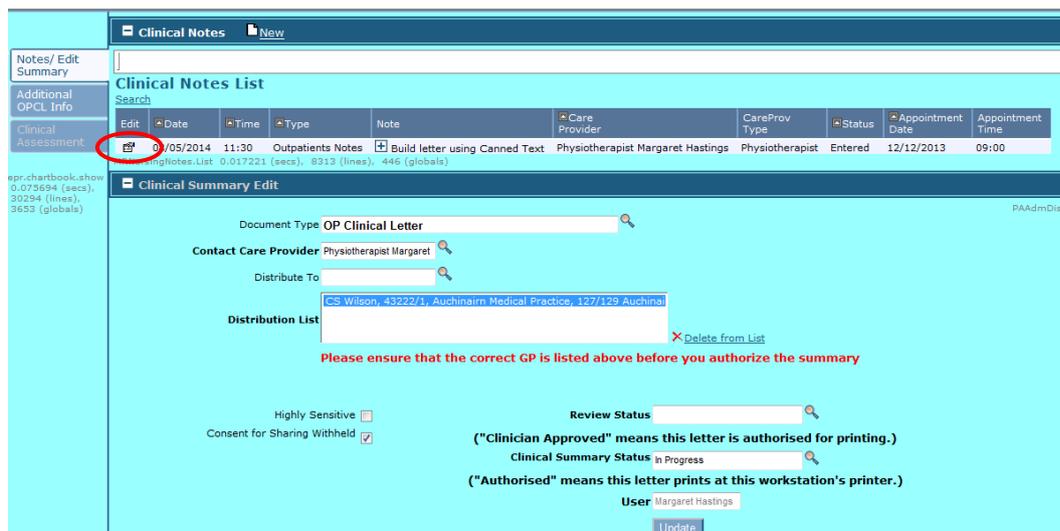
The clinical note can be edited with the additional information by clicking the Edit icon. The Edit History and Audit trail will log what has changed and who made the changes. A statement will appear at the top of the letter identifying that this is a new version of the previous letter. The reason for change should be documented at the start of the clinical note. This will let the recipient know what action they need to take within their document management system.

Remember to update note to save the changes.

The data from the original Additional Clinical Summary Info will be retained. A new Info Summary screen can be generated by clicking New if required or update the original info.

The Clinical Summary status will have to be updated and the clinical approval process applied, prior to generating the letter report for the revised letter.

VIEWING PREVIOUS VERSIONS


```
PAPerson.Banner  0.010709 (secs),  16422 (lines),  1999 (globals)
```
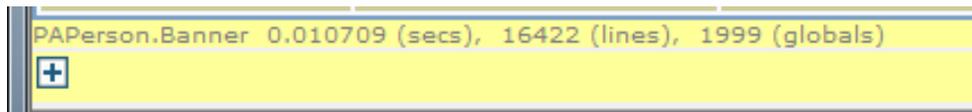
Click on the + under the patient header bar to show all episodes, then click Select All to include all the episode letters in the Clinical Summary List.

In the Documents tab of the Clinical Record you are able to view a list of all clinical letters generated for all episodes. To view previous versions click on the icon

 The previous version will open.

If there are many documents across all episodes you can select only the current episode from the timeline.

CANCELLING DOCUMENTS

Documents generated within TrakCare cannot be deleted. If errors have been made the document needs to be cancelled. This can only be done if "In Progress". If the document has already been sent as an authorised letter, then a new version giving the reason why the document was sent in error will have to be sent to the recipient.
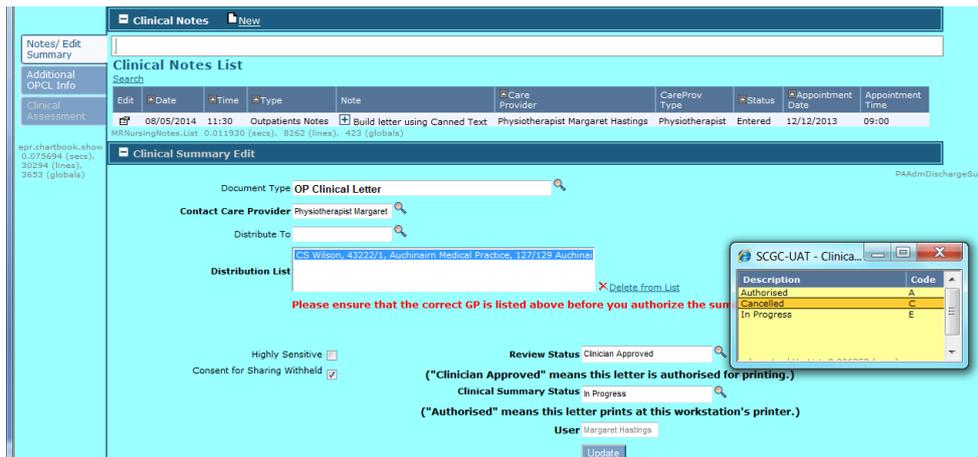
The cancelled document shows in the Clinical Summary List as Cancelled.
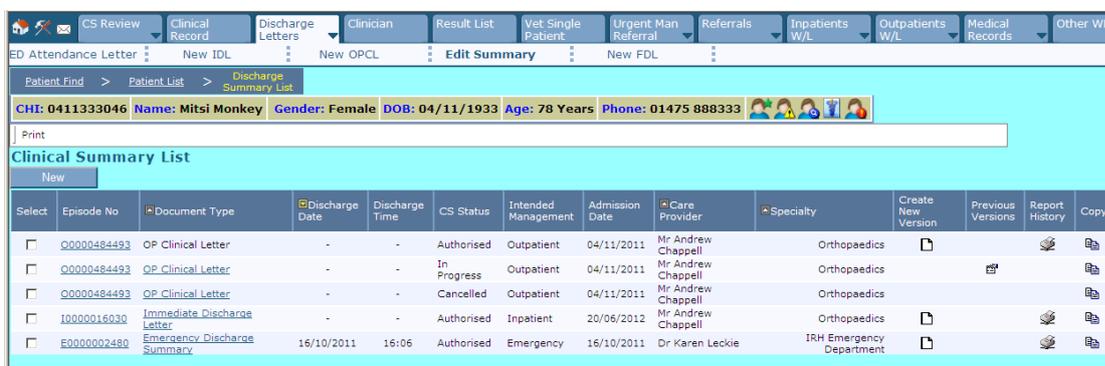
An administrator / manager role can delete in-progress letters – contact your site lead.

STUDENT PROCESS

Students can complete letters for their patients, but they will need to be authorised by their Senior staff. To do this they complete the letter and set the review status to Transcription Complete (TC). They then tell their senior (giving them the CHI to locate the letter in Edit Summary or Correspondence tab) who will then review the letter and change status to "Clinician Approved" which will add "electronically signed by xxxxx" to the letter. The letter can then be printed as normal.