Vision Quick Reference Guide for Clinicians

Locums

Registrars

New Clinical Users

Refresher for Existing Users
## Contents

**VISION QUICK REFERENCE GUIDE FOR CLINICIANS**  
5

**What this Quick Reference Guide covers**  
5
Who is the Quick Reference Guide designed for?  
5

**Starting Vision and Sign on**  
6

**Vision Front Screen**  
7

**Consultation Manager Overview**  
9
- Starting a Consultation  
10
- Select a Patient  
11
- Appointments List  
12
- Finding Data  
13
- Adding Data  
14
- Updating an Entry  
17
- Add Acute Prescription and Print  
18
- Drug Checks  
21
- Add Medication to problem  
22
- Print the Prescription  
22
Make an Acute into a Repeat  
24
Add Repeat Prescription  
24
Issue Repeat Prescription  
26
- What if you cannot find the repeat master in Step 5  
27
Re-authorise Repeat  
28
Drug Check Displays  
29
- Drug Interactions warning signals  
29
- Drug Doubling Warning Signals  
30
- Contraindication warning signals  
30
Add Drug Allergy  
31
Add Med 3  
32
Add Smoker / Non-smoker/ Ex-Smoker / Smoking Cessation advice  
33
- Add Smoker  
33
- Add Smoking Cessation Advice  
33
- Add Non-Smoker  
33
- Add Ex-Smoker  
34
Add Blood Pressure and List BPs and Graphs  
34
Graphs  
35
Add Weight and Height  
36
Add Immunisations  
37
- Add Contraindicated immunisations  
39
- Add Parental Consent  
39
Add Contraception and Prescribe Oral Contraceptive  
40
Add Peak Flow Record  
41
List Test Results  
42
Add Cervical Cytology  
43
Add a Referral (non-electronic)  
44
Vision Quick Reference Guide for Clinicians

What this Quick Reference Guide covers

This Quick Reference Guide is designed to help a clinical user find the simplest and quickest method to carry out a task in an unambiguous way. It concentrates on which keys to press. There may well be other ways to carry out the same task and many of these are explored in other relevant sections of the INPS user guides with accompanying screenshots.

Some of these basic tasks in Vision are covered:

- Login to Vision
- Getting Started in Vision
- How to select a patient
- Using your Appointments List
- How to find and add clinical data in Consultation Manager
- Adding and issuing therapy

Who is the Quick Reference Guide designed for?

- Locums
- Registrars
- New clinical users to Vision
- Users just trained, wanting an aide-memoire
- Any user wanting a quick recap of a simple task
Starting Vision and Sign on

To sign in to Vision:

- **Note** – If you are in England and are logging into Vision with your Smartcard, you need to authenticate your card first by putting it in the card reader and entering your passcode.

1. Either double click with the left-hand mouse button on the Vision icon; or click on the minimised Vision icon on your Task bar.

   - **Note** – If you are in England and have authenticated your Smartcard, you are taken to the Vision front screen after double clicking on the Vision icon. You do not need to enter a password on the Vision login page.

   
   ![Vision Login Screen](image)

   
   **Vision Login screen**

2. At the Vision Login screen, select your Login Name.

   If the Login Name box appears empty (this is may be your practice setting), type in your login name - if you are not sure what this is, see your system administrator.

3. Once your login name is displayed, click in the Password box and enter your password. ******** display as you type.

4. If you have more than one surgery location, select your required location from the Site list.

5. Click OK.

6. The Vision front screen is displayed.
Vision Front Screen

The Vision front menu gives quick access to Vision modules.

- There are five main sections: **Home, Reporting, Messaging, Utilities** and **Management Tools**, each with options to further Vision modules.
- The **Home** menu includes **Consultation Manager** - where clinical entries are made and where you can access your appointment list.
- The modules that are visible for selection are the ones that you, as the logged on user, are permitted to see.
Vision Front Menu

Menu Bar

ToolBar - Tabs and contents are displayed depending on user access rights and location

INPS Announcements

Helpline Blog

My Daybook Tasks - Lists your tasks as in your 'To-Do' list in Daybook, ordered by descending due date

Daybook - Notifications and Announcements

Double-click to open a task or announcement in Daybook

Web Content Area

Vision Front Menu
Consultation Manager Overview
Starting a Consultation

In Consultation Manager, you cannot add new data until a consultation is started. It is usual for a Consultation to be started automatically, however:

1. **If there is no consultation open**, the Consultation icon looks like this and the status bar displays the text No Open Consultation:

   ![No Open Consultation icon](image)

   *No Open Consultation on bottom task bar*

2. Clicking on this icon starts a consultation.

3. You can tell a consultation is open by the following:
   - The Consultation icon appears depressed on the toolbar.
   - The status bar at the bottom of the screen, just above the Windows Task Bar, shows your name (as the current user signed on), the date, and the start time of the consultation, followed by the current time (so you know how long the consultation has been). Any data entry will bear your initials on the audit trail.

   ![Surgery Consultation open displayed on bottom task bar](image)

   *Surgery Consultation open displayed on bottom task bar*

- **Note** - The easiest way to start a consultation automatically when you select a patient is to set this up in advance. Click on Consultation (top menu) – Options - Setup. On the Consultation tab, tick **Start New Consultation Automatically When a Patient is Selected**. Also tick **Deselect the Patient Automatically When a Consultation is Closed**. Click OK.
Select a Patient

This section explains how to select a patient.

1. Within Consultation Manager, click on the Select Patient icon.

2. In Search Details, type a few letters of the patient's surname, space, then the first letter(s) of the forename, e.g. SMI CH for Charles Smith, and then press Enter. This should list patients who match what you typed in.

3. Once the patient list is displayed, find the patient you want (you may need to scroll down) and double click on that patient line, or single click and click OK.

   Note - If you are in England and have logged into Vision with your Smartcard, patient demographics in Vision are checked against those held on the Spine and you may be prompted with a screen showing any discrepancies, you can accept or ignore differences.

4. When the patient has been selected, their name and address appears on the title bar at the very top of the screen.

5. Their Patient Record screen is displayed, and a consultation is usually started automatically.

   Note - The view of the Patient Record that is displayed is the one that has been chosen by this user currently logged on. The setting up of the screen is very flexible and can vary from practice to practice.
Appointments List

To view your Appointment list and call the next patient in:

1. In **Consultation Manager**, click on the Appointments tab or List Appointments icon.

2. Your own appointment book is displayed by default as the user signed on. If you cannot see your list, click on to the right of **Booked only** and select your name or the correct session.

3. The appointment list defaults to Today AM if it is morning or Today PM if it is afternoon.

4. **Select Next Patient by double clicking on a booked appointment line** – This brings up their patient record.

5. If the patient is not marked as *Waiting* by the receptionist, then a warning may be shown telling you the patient has not arrived: *Are you sure you wish to select the patient? The patient has not arrived;* click either **Yes** to select the patient, or **No** to cancel selection.
   
   - **Call Patient** button or right click – This is only for practices using an appointment call display system. It selects and displays the patient’s record and visually calls the patient in.
   - **Select Patient** button or right click – selects the highlighted patient’s record.

6. Once the patient is selected, a consultation is either started or not. This depends on the set up (see *Whenever you are adding data, start a consultation first* (page 10))
7. When the Patient Record is displayed, switch to the Journal tab for a Read Term Add (page 14) window, or to the Therapy (page 18) tab to prescribe.

Note - Press this Refresh icon now and again so that any last minute appointments or waiting status are updated on your Appointments list.

Finding Data
The easiest way to view patient clinical information in Consultation Manager is to use the navigation pane:

Click on to expand the text beneath a heading. Click on collapse to collapse text to the heading only. For keyboard users, press ← to collapse and → arrow to expand the subheadings when the focus is on a heading.

You can also use the tabs in your Consultation Manager view (your tab set depends on your practice configuration):

Or the icons and menus at the top of the screen:
Adding Data

Vision stores its records either in a generalised Medical History or in Structured Data Areas, such as Blood Pressure, Epilepsy, Serum Cholesterol, and so on. You can let the system do all this for you.

1. In **Consultation Manager**, select the patient , or select from the Appointments list. Make sure a consultation is started .
2. Go to the **Journal** tab of the patient record.

3. In the **Read Term - Add** window either:
   - Type in a keyword, such as headache, cough, asthma and press Enter. This should display the first matching entry. Then use the up ↑ and down ↓ keys to display the next or previous entry until you find what you want. Click OK.
   - Enter a known Read code preceded by #, e.g. #H33 (for Asthma) and press Enter.
If this is not the correct entry, double click or press the `<F3>` function key to display a Read Dictionary screen which gives a list based on the keyword entered. This will include Read descriptions from different parts of the Read dictionary, shown by the different codes, e.g. chapter 1 History and Symptoms, 7 Operations, N Musculo-skeletal and connective tissue diseases.

**Read Dictionary screen**

If the required entry is shown on the list, double click on it.

The following options are available if the required entry is not listed:

- Deselect **Display from Formulary** by removing the tick from the box (click with the left mouse button). This will display all matching entries from the whole Read dictionary.
• Bearing in mind the fact that many Read Terms do not have keywords, it may be necessary to display entries by Read code. To do this, highlight a suitable line and click on Display by Hierarchy to tick/check the box.

A Find Read Code screen will be displayed (see above). To open one of the closed folders and view the contents of that branch of the hierarchy, double click on the symbol \[ \text{\textbullet} \]. The path through the hierarchy is clearly visible by following the open folder symbol up the branch. The selected entry is highlighted. To close an open folder, double click on \[ \text{\textbullet} \]. Any entries with a 'piece of paper' symbol \[ \text{\textbullet} \] cannot be expanded any further - they are at the bottom of that branch of the hierarchy and can be selected.

• Once the correct entry has been found and highlighted, click on the OK button.

4. Vision will then present you with the appropriate Add screen. In many cases this will be a History Add screen, for example, after entering headache or cough. For others, such as peak flow, diet, exercise, you will see the appropriate Add screen.

5. Complete this screen - you can open up the picklist in Read Term by clicking on \[ \text{\textbullet} \] if you want to select another term.

6. Click OK.
Updating an Entry

You can view all a patient's entries on the Journal tab of the patient record in Consultation Manager, where they are listed chronologically, latest at the top.

If you have made a mistake, editing an entry is easy:

1. In Consultation Manager, go to the Journal tab of the patient record.
2. Right click on the line you want to amend. This means pointing to the line, and clicking the right mouse button. A menu pops up.
3. Move the highlight down and select Edit with a left mouse click.
4. The data is displayed in the bottom pane. Make your amendment and click OK.
Add Acute Prescription and Print

An acute prescription is for a one-off therapy item which you do not envisage repeating. If you find later that you do want to prescribe it again, you will enter a second acute prescription, copy this one or set up a new repeat master prescription.

1. In Consultation Manager, select the patient - Either click on , or select from the Appointments list (see page ). Make sure a consultation is started .

2. On the Patient Record, click on the Therapy tab.

3. Click on the Current tab which lists all repeat masters , and any acute issued within a recent period.

4. Press Esc to display the Acute Therapy - Add screen in the bottom pane, if it is not already displayed.

   **Note** - You may find you have by mistake selected Repeat Master - Add. If so, press Cancel. Click on the Current tab and press Esc to display the Acute Therapy - Add screen.

5. The cursor is flashing in the Drug selection window. Type in the first few letters of the drug name, e.g. losec (optionally followed by a space and the form - caps, tabs etc, followed by a space and the strength, e.g. losec cap 10) and press Enter. Alternatives at the Drug name window are to press F3, or just to double click, without typing anything in first. Both go straight to the Select Drug screen.

6. If the displayed drug is the correct one, move to Step 8.

   If the displayed drug is not the correct one, you have the following options:
   
   - Use the up and down arrow keys to display the next or previous entry.
   - Click on the Switch to generic button to replace the selected drug with a generic.
Double click or <F3> on the Drug field to access the Gemscript dictionary on the Select drug screen.

The Select Drug screen lists the drug dictionary or formulary from the nearest match you typed in. When the required drug name has been found, click on the button to confirm.

7. Further options on the Select Drug screen:
   - When typing a drug name, you do not need to specify the form and strength at this stage – just type the first few letters of the therapy item and press Enter, e.g. LOS Enter.
   - To find appliances or codes, type in # then the code.
   - The red box in the middle displays Drug Allergy and Intolerance information for the patient.
   - The bottom pane has more Gemscript product information about the selected therapy item. Clicking on an individual heading can expand it.
   - Check the currently highlighted drug against the patient’s other therapy and clinical data, by pointing to it and clicking with the right mouse, selecting Drug Check for any potential contra-indications, interactions or drug doubling.
8. You are returned to the **Acute Therapy-Add** screen. The **dosage** and **quantity** are entered automatically for most drugs (if in **Consultation – Options – Setup – General** – the option **Use Gemscript Posology defaults** is selected).

Consultation Manager with completed Acute Therapy – Add screen

9. **Quantity, Preparation, Packs** – Pack Information for the selected drug can be displayed by clicking on the bottle icon by **Preparation**. This lists packs for the therapy item, whether divisible or indivisible, and the number per pack. If more than one pack, select a suitable pack or quantity by double clicking. You can amend a quantity by overtyping in **Quantity**.

- **Note** - The prescription will show the quantity and preparation exactly as displayed on the screen.

If the preparation details need to be changed, delete the displayed details and enter the required preparation, e.g. *5 ml bottle(s)*
10. **Dosage** - Click in the **Dosage** field and enter the dosage, e.g. 1 tds. The system accepts standard dosage codes, e.g. 1 om, which can be displayed by right mouse clicking anywhere on the screen and selecting **Dosage Codes** and **List** from the displayed menus. You can build up the dosage message, for example, *od ac (Every day before food)*. Any free text can be typed in the **Dosage** field and this will be printed exactly on the prescription, e.g. a flavour – chocolate – for some children's preparations.

11. Check the other default entries are correct.

12. If you have chosen a brand name, you can change to its **generic** equivalent by clicking on **Drug**. Once you have done this, the icon will disappear.

13. If you need to **re-select the drug**, double click within the **Drug** name window to return to the **Select Drug** screen.

14. To add **free text** that will print on the right-hand side of the prescription form, click on the **Additional Information** button, type in your free text and **OK**. The icon is then ticked.

15. Finally, after checking the entries and entering the dosage and quantity (see below), accept **Acute Therapy - Add** screen by clicking **OK**.

**Drug Checks**

1. Drug Checks are then performed, showing any warnings of contraindications, interactions or drug doubling before you proceed with the prescription (see page ). Depending how it is set up in **Consultation – Options – Setup – Drug Checks**, you will either see a full Drug Check Results screen; or flags on the status bar which you can double click on to display the full screen:

   ![Drug check indicators on the bottom task bar](image)

   **Drug check indicators on the bottom task bar**

   If you answer **Yes** to **Do you still wish to prescribe this drug?** The Therapy Records screen is re-displayed, from which you can print the prescription.
Add Medication to problem

1. Some practices have switched on the option medication linked to problems. If you see the following screen, then tick the appropriate related diagnosis or problem associated with this medication.

![Add Medication to Problem screen]

Print the Prescription

1. To print the prescription, press <F9> or press (depending on your country, you may have a Finalise button instead of Print).
   - The Therapy Print Records / Prescription Manager screen is displayed after the first F9. All acutes added with today’s date will be listed.
   - At the Therapy Print Records – Add / Prescription Manager screen, check the prescriber (Doctor to sign prescription) – this is the GP signed on, but you can change it to another (if the setup allows on Consultation – Options – Setup – General, check the box Print Signing GP Name), so the name of whichever doctor is selected in Doctor to sign prescription will print on the prescription.
Proceed to print by clicking on the **Print** icon or pressing `<F9>` again (depending on your country, you may have a **Finalise** button instead of Print). The second Print command starts the printing.
Make an Acute into a Repeat

1. Find the acute prescription on the Current tab.
2. Hold down the left mouse button over this line and start to drag the line away. A Floating Drop Target is displayed.

3. Drag until the cursor is over the "pill" icon (Make Acute into Repeat) and drop it by releasing the mouse button. Then complete the Repeat details on the Repeat Prescription Master - Add then click on OK.

4. Alternatively, you can drag an acute line on to the Another icon for a copy of the Acute Therapy with the same drug, details and dosage already selected. Fill in the details and click OK.

Add Repeat Prescription

Note - This is the same as adding an acute item EXCEPT in addition you enter a number in the field Repeats before pressing OK.

A repeat master is for therapy items which the patient can repeat, usually in a month from the initial prescription, and for some months after that before the repeat master needs re-authorising by the GP. Each repeat has a repeat master line, from which issues are printed.

Adding a repeat is very similar to adding an acute therapy, with a few extra fields. Note in step 3, however, that the starting screen is different.

1. In Consultation Manager, select the patient - Either click on , or select from the Appointments list. Make sure a consultation is started .

2. On the Patient Record, click on the Therapy tab, then Repeats tab.

3. Press Esc to display the Repeat Master Add screen if not already displayed.

4. Enter the first few letters of the drug name, eg ibupro and press Enter. Follow the steps to add the required medication.
5. BEFORE PRESSING OK, move the cursor to the **Repeats** field (nearly top right of the **Repeat Master - Add** under **Private / Print Script**) Enter the required maximum number of repeats that the patient can make of a prescription, before the GP must see him or her again in order to re-authorise the prescription (e.g. 6 repeats). This is a mandatory entry.

6. **Repeat Until Date** is an optional field. Note that a drug will become expired if either the maximum number or the Repeat Until date is reached. To enter a date, use the date abbreviated format: e.g., 56D (56 days) 3M (three months), or 6W (six weeks). 1Y (one year).

7. **Days between Issues** is an optional field. Note that a drug will not be prescribable if the maximum number of days between issues has been exceeded and / or the minimum number of days between issues has not been reached.

8. When the number of issues (**Issues Made**) equals the maximum number allowed (the figure in **Number of Repeats**), no further prescriptions can be issued until the repeat is re-authorised. The repeat master is then said to have expired and will be listed under Expired with this icon 🍏 on **Repeat Masters**. On the **Repeat Prescription Master - Add** screen:

9. If **Force Re-Authorise** is blank, anyone can re-authorise a repeat master.
   
   If this box is checked, prescribers can re-authorise the master (Prescribers are all GPs or clinicians entered with a GMP number).

   ⚠️ **IMPORTANT**: The **Force Re-authorise** field should only be checked if only prescribers are to re-authorise the medication. Otherwise, to enable any user to re-authorise the medication when it expires, do not check this field.

10. If you have Gemscript defaults switched on in **Consultation – Options – Setup – General – Use Gemscript Posology defaults**, the dosage and quantity will be entered automatically. If not, enter these now manually e.g. 2 bd

11. **Quantity, Preparation, Packs** – See step 9 of Add an Acute Prescription.

12. **Dosage** - See step 10 of Add an Acute Prescription.

13. To add free text, which will print on the right-hand side of the prescription form, click on the **Notes for Patients** button 📝, type in your free text and OK. The icon is then ticked.

14. Check the details and click on the **OK** button to confirm the new entry.

15. At the **Drug Checks** screen, look for warnings of any possible contra-indications, interactions or drug doubling. See **Drug Checks** (page 21). To continue, answer **Yes** to **Do you still wish to prescribe this drug**?

16. See **Add Medication to problem** (page 22) if necessary.

17. The new repeat master can now be issued.
Issue Repeat Prescription

**Summary** - First select the repeat items on the Therapy - Repeat tab, then press <F9> and <F9> again as follows:

Betnovate is ticked as the repeat to be printed. Note that the other repeats have a blank symbol - they have "expired" and need re-authorising before being re-issued.

1. In Consultation Manager, select the patient: Either click on the Select Patient icon, or select from Appointments list. Make sure a consultation is started.
2. If you are a receptionist issuing repeat scripts and this is a fresh consultation, keep the consultation statistics accurate by changing the Consultation Type from Surgery Consultation to Repeat Issue - double click on the name or Surgery on the status bar at the bottom of the screen to display the Consultation Update screen, and re-select the Type of Consultation as Repeat Issue, then OK.
3. Click on the Therapy tab then on the Repeats tab, or press <F5>.
4. When the Therapy Repeats screen is displayed, check that the requested items are shown.
   - If this is the case, continue to Step 6.
   - If the requested item(s) is not shown, click on Filter Expired Repeats and Filter Inactive Repeats to give a list of valid repeats (leave Filter Valid repeats undepressed).
   - If the required items are still not shown, proceed to Step 11. There may be an expired item that needs reauthorising.
     - Valid repeat master which can be issued
     - Expired repeat master which needs reauthorising before issuing
     - Inactivated repeat master, i.e. discontinued
     - Prescribed out of practice
5. **Select the lines to be issued** (see back to screenshot above):
   - Either click in the checkbox by each item required to tick it.
   - Or, if all items are to be selected, click on the Select All icon to select all and tick.
• Or, if all except one or two items are to be selected, click on the **Select All** icon to select **All**, then single click on any items NOT required.

6. Click on the **Print** icon \(\text{Print}\) or press the \(\text{<F9>}\) function key to issue the required items (depending on your country, you may have a **Finalise** button \(\text{Finalise}\) instead of Print). This displays the Print Therapy or Prescription Manager screen.

7. When the **Prescription Manager** screen is displayed, check the **Doctor to Sign Prescription** (the Prescriber) is correct.

8. Click on the **Print** icon \(\text{Print}\) or press \(\text{<F9>}\) again to print the prescription (depending on your country, you may have a **Finalise** button \(\text{Finalise}\) instead of Print).

9. Give the patient the prescription and the right-hand repeat re-order form.

**What if you cannot find the repeat master in Step 5**

1. If a required item is not shown in Step 5 above, click on Filter Inactive Repeats \(\text{Filter Inactive Repeats}\) and Filter Valid repeats \(\text{Filter Valid repeats}\) to give a list of Expired Repeats.

2. To re-authorise an expired repeat, click on the required item to tick it, and then click on the Re-authorise icon \(\text{Re-authorise}\). This will display the Therapy details screen and allow you to make changes if required (e.g. change the maximum number or the dosage). Click on the \(\text{button}\) to confirm the details. The repeat master is now valid.

3. Click on Filter Expired Repeats \(\text{Filter Expired Repeats}\) and Filter Inactive Repeats \(\text{Filter Inactive Repeats}\) to give a list of valid repeats (leave Filter Valid repeats \(\text{Filter Valid repeats}\) undepressed).

4. If the requested item is not shown under the expired view, it may have been inactivated (discontinued). Click on Filter Valid repeats \(\text{Filter Valid repeats}\) and Expired Repeats \(\text{Expire Repeats}\) to list any inactive repeat masters \(\text{Inactive Repeats}\). If the drug is shown here and it can be reactivated (check with the GP first), click on the required item to tick it, and then click on the \(\text{Reactivate}\) icon. This will make the repeat master active again. It may still need to be re-authorised as well (see Step 12).

5. If a requested item is not shown at all and needs to be added, see **Add repeat prescription** (page 24).

6. NHS prescriptions are printed on the left-hand side of the prescription paper, and a repeat re-order form is printed on the right. The repeat re-order form can be customised with your own practice message in Consultation – Options – Repeat Therapy Reorder Form.
Re-authorise Repeat

Once a repeat master has been issued a maximum number of times (determined by the GP when he or she originally adds the repeat), then the repeat becomes "expired" with the icon on the Repeats tab list in Therapy.

1. On the Therapy tab, click on the Repeats tab.

2. Click on Filter Inactive Repeats and Filter Valid repeats to give a list of Expired Repeats masters.

3. To re-authorise an expired repeat, click on the required item to tick it.

4. Then click on the Re-authorise icon.

5. This will display the Therapy details screen and allow you to make changes if required (e.g. change the maximum number or the dosage).

6. Click on the OK button to confirm the details.

If you are a member of staff and find the system prevents you from re-authorising a repeat master, this may be because a GP has ticked the box Force Re-authorise on the original Repeat Master Add screen. In this case, only clinicians can re-authorise the repeat.

Reauthorised Repeat Master – Add screen
Drug Check Displays

The **Drug Check Results** and status bar signal if there are any drug interactions, drug doubling or contraindications of which you should be aware. This checks against the currently selected patient's data.

Drug interactions (circles), Contra-Indications (red bars)

**Example Drug Check Results screen**

If you answer **Yes** to *Do you wish to prescribe this drug?* You are encouraged to enter a free text reason why you are overriding the prescriber warning. This is logged in the Event Log Viewer.

**Drug Interactions warning signals**

The left-hand circles and bars warn of drug interactions, between the drug currently selected and the patient’s existing therapy.

- **Green light** - No Drug Interactions
- **Yellow light** - Context sensitive interactions exist e.g., elderly or females, those on digoxin etc.
- **Red single bar** - Warn that mild interaction exists
- **Red double bar** - Avoid if possible - serious interaction exists
- **Red triple bar** - Life threatening interaction exists
Drug Doubling Warning Signals

Checks are also made for drug doubling. This looks at the patient's current therapy to see if there is any item that has the same ingredients, or is in the same action group, or is the same drug, as the therapy being added. The doubling drug check warnings are shown as a series of blue bars:

One blue bar - Same action group
Two blue bars - Same ingredient
Three blue bars - Same drug

Contraindication warning signals

The contraindications warning signals are shown as flags on the right on the status bar:

- **Green flag**: No Contraindications exist
- **Yellow flag**: General warnings exist for Contraindications
- **Red flag**: Patient specific Contraindications

Contraindications are checked against the patient's clinical history and also include precautions, prescriber warnings and special morbidities such as pregnancy and lactation.
Add Drug Allergy

1. To enter a drug allergy, first select a patient and start a consultation.
2. From the Add menu, select Drug Allergy/Adverse Reaction.
3. If the patient gives a history of previous allergy or intolerance, then enter the approximate date in Date of Recording and remove the tick from the In Practice box.

Drug Allergy and Intolerance – Add screen

- **Read Term for Allergy** – 14L.. H/O drug allergy is the default Read code. Click on the picklist arrow to display further options and click on the Read code required.
- **Drug** - Double click in the Drug window, and select the drug to which the patient is allergic. In Name on the Drug Select screen, type in the drug name, e.g. penicillin, and click on Find. Click on OK.
- **Read Term for Reaction** - Selection here is optional.
- **Reaction Type** - The choice is Allergy, Adverse Effect or Intolerance.
- **Severity** is a mandatory entry. The options are: Blank (no entry), Minimal, Mild, Moderate, Severe, Very severe, Potentially Fatal
- **Certainty** is a mandatory entry. The options are: Blank (no entry), Tentative, Unlikely, Possible, Likely, Certain, Absolute.

4. Enter any free text notes, or recall date, if required.
5. Once you are satisfied with your entry, click on OK.
6. The allergy or adverse effect warning is shown on the Repeat Master or Acute Therapy Add screen. If you try to prescribe items with a severity of Potentially Fatal. The Drug Sensitivities warning is displayed stating that "It will not be possible to prescribe this item due to the presence of potentially fatal reaction."
Add Med 3

To access the MED3 form area in Consultation Manager, and create an electronic MED3 form:

**Important** – Only GPs with a GMC code recorded in Vision can create and print new or follow-on MED3 statements.

1. From Consultation Manager, select a patient and open a consultation.
2. First, enter data as you normally would during a consultation, or at the very least, a diagnosis or symptoms. If you open an active problem, the Problem Header Read term is used to populate the Diagnosis fields.
3. To invoke the MED3 data entry form, select Add – MED3.
4. The MED3 form appears for completion:

5. The MED3 Doctor’s Statement form is arranged into the following four sections: Standard Information, MED3 Information, Additional Information, Printing the MED3 form
6. Fill in the appropriate boxes. Mandatory entries are marked with a red asterisk and print the form.
7. Click OK to save.

**Note** – Practices in Northern Ireland cannot create an Issued by Hand or Duplicate form or print MED3 Statements.
Add Smoker / Non-smoker / Ex-Smoker / Smoking Cessation advice

Add Smoker
1. Select the patient and make sure a consultation is started.
2. From the Add menu, select Smoking.
3. At the Smoking – Add screen, change the Smoking Status to Smoker.
4. In Smoking Read term, click on the selection arrow and scroll down, selecting a suitable Read term, e.g. 1373.00 Light smoker – 1-9 cigs./day. When the line is highlighted, press Enter.
5. Optionally, enter a figure in Tobacco Consumption, e.g. 5 in Cigarettes per day.
6. If you have talked to the patient about giving up smoking, then click on the Health Promotion icon to record smoking cessation advice.
7. Click OK.

Add Smoking Cessation Advice
1. Select the patient and make sure a consultation is started and the Patient Record displayed.
2. From the Add menu, select Health Promotion Interventions - Smoker.
3. At the Health Promotion - Smoking - Add screen, click OK.

Add Non-Smoker
1. From the Add menu, select Smoking.
2. At the Smoking – Add screen, the Smoking Status will be set to Never Smoked, as this is the default selection if the patient has no previous smoking record.
3. In Smoking Read term, the default becomes 1371.00 Never smoked tobacco.
4. Click OK.
**Add Ex-Smoker**

1. From the Add menu, select **Smoking**.
2. At the **Smoking – Add** screen, change the Smoking Status to Ex-Smoker.
3. In Smoking Read term, the default becomes 1375.00 Ex smoker.
4. An optional step - Press the Tab key to reach **Date Started**, and type in a year, e.g. 1964, press the Tab key and enter a year in Date Stopped, e.g. 1980.
5. Optionally, enter a figure in Tobacco Consumption, e.g. 15 in Cigarettes per day.
6. Click **OK**.

**Add Blood Pressure and List BPs and Graph**

1. Select the patient and make sure a consultation is started and the Patient Record displayed.
2. From the Add menu, select **Blood Pressure**.

![Blood Pressure - Add screen](image)

3. At the **Blood Pressure – Add** screen, the cursor is in **Systolic**. Type in a reading and press the Tab key, and type in a **Diastolic**.
4. Optionally, using the keys, change **Laterality** (<None>), **Position** (Sitting), **Cuff** (Standard).
5. Click **OK**.
6. Find the BP entry you have just made at the top of the Journal tab, or select **Blood Pressure** from the **List** menu.
7. Right mouse click on this line and select **Graph** with a left mouse click.
8. This graphs all the patient's BP records. To focus on a particular set of dates:
   - either double click within an area of the graph to expand those dates.
   - Or you can position the cursor to the left and above the area you are interested in, hold down the left mouse button and drag the resulting square around the area. Let the mouse button go. The area will now be expanded.
   - Clicking on the Fit to Graph icon to revert it to the way it was initially.
   - Print the graph out using the print icon.
   - Print Preview first before printing out.
9. Click on **Close** on the left to close the graph and exit.
Graphs

Note - You can right click and select Graph for any numerical result line, such as BP, weight, or test results.

Blood pressure graph

Once the graph is displayed:

- Expand the area you are interested in by positioning the cursor to the left and above the area, holding down the left mouse and dragging the resulting square around that result. Let the mouse button go. The area will now be expanded.

- To revert to the way it was - i.e. unexpand it - use the Fit to Graph icon

- Print the graph out using the print icon.

- Print Preview first before printing out.

- Close graph and exit.
Add Weight and Height

1. Select the patient and make sure a consultation is started and the Patient Record displayed.

2. From the Add menu, select **Height**.

3. Height records are stored in metres, but you can enter the height in either metric or imperial. For example, either type in 1.68, which the system will understand as 1.68 metres; or type in 5'6", or 5ft 6in, which converts into a metric equivalent. Height can be recorded to three decimal places, e.g. 1.765 M, or 35.4 cms. Click **OK**.

4. From the **Add** menu, select **Weight**.

5. Weight records are stored in kilograms, but you can enter the weight in either metric or imperial. For example, type in 72.5 for 72.5 kg, or 11st 6lb, which will automatically convert to its metric equivalent, when you press Enter or the Tab key. Optionally, change the Read Term by clicking on the selection arrow and select another Read term. Click **OK**.

The height and weight together are used to work out the **BMI**, the Body Mass Index for adult screens. The BMI is automatically calculated by dividing the weight in kg by the height squared in metres. If the BMI falls outside the normal range of 19-24 for women and 20-25 for men, the word **Overweight** will be displayed when viewing this record. Once 30 or over, the patient is classed as **Obese**.

A **Target Weight** is given for overweight patients, and the weight they should lose to achieve this. To see this in stones and lbs, click in the **Imperial** box.

6. For subsequent weight records, start at step 5 above. There is no need to keep re-entering the height.

7. Point to any weight or height entry on a form, List screen, e.g. Journal tab, right click and select Graph to graph all the patient's weight records. To focus on a particular set of dates, double click within an area of the graph to expand those dates. Or position the cursor to the left and above the area you are interested in, hold down the left mouse button and drag the resulting square around the area; let the mouse button go to expand the area. Click on Fit to Graph icon reverts it to the way it was initially. Click on Close on the left to close the graph and exit.
Add Immunisations

Immunisations Add record immunisations given. You may also enter refusals to start or complete a course in the Status field, having first selected the type of immunisation.

1. First select a patient and start a consultation.
2. To check what immunisations the patient already has, click on for the Immunisations Summary screen which lists what are due and those that have already been given.
3. Display **Immunisations – Add** by right clicking on **Immunisations Summary** and selecting **Add**. If you skipped step 2, then from the **Add** menu, select **Immunisations**.

![Immunisation - Add screen](image)

4. On the **Immunisations – Add** screen, select the **Type of Immunisation** either by clicking on ☐ and scrolling down, and clicking on your choice. For a full list of immunisations, see on-screen help.

5. Select the **Stage** – e.g. 1ˢᵗ, 2ⁿᵈ, 3ʳᵈ, booster. **Status** defaults to Given. **Due Date** depends on the Type of Immunisation and is worked out automatically. **Method** depends on the Type of Immunisation, e.g. Oral for polio.

6. Click in **Batch Number** and type in the batch number on the vial.

7. In **Reason - Routine, Epidemic, Special Risk Group or Traveller**. This is optional.

8. In **Country / Nature of Risk**, this depends on the Type of Immunisations and what you have selected in Reason. If you have selected Traveller, click on ☐ under **Country** and select the area to the visited. If you have selected Special Risk Group, in **Nature of Risk**, type in the risk, e.g. Animal lab technician.

9. Click **OK** at the **Immunisations – Add** screen to save and exit, or click on **Next** to enter another immunisation.

10. If you have added a Tetanus or Cholera booster for an adult, you may be reminded if you have not entered the first, second and third stages of Tetanus or Cholera immunisation. Click on **Yes** to continue. There is no obligation to record the previous stages.

11. Click **OK**.
Add Contraindicated immunisations

You can record that a vaccination or immunisation is contra-indicated, and whether it has parental consent.

1. Click on  or Summary - Immunisations. The Immunisations - Summary screen is displayed.

2. To add Contraindicated information: Point to the Contraindicated? Line, right mouse click (it should be headed Immunisation contraindicated) and select Add.

3. Check the box Contraindicated on the Immunisation Contraindicated - Add screen, and optionally select one of the available Read terms.

4. Enter the vaccination type, e.g. Measles, which is contra-indicated in the free text notes window before you click on OK. Any free text is shown on the front screen.

Example of Immunisation Contraindicated – Add screen

Add Parental Consent

1. To add a Parental Consent entry – Display the Immunisations Summary.

2. Point to the row Parental Consent, right click and select Add.

3. In Read Term, scroll down and choose from the various Read terms of parental consent status. For example:
   - Consent status for immunisation - i.e. no consent, full consent,
   - Immunisation refused
   - Immunisation contra-indicated (C/I)

4. In Type of Consent, choose from <None>, Full consent, partial consent, No consent.

5. Enter any free text notes that will be displayed on the front screen.

6. Click on OK.
Add Contraception and Prescribe Oral Contraceptive

1. First select the patient and start a consultation.

2. To list the patient's contraceptive entries, From the List menu, select **Contraception**.

3. To enter a contraception record, from the Add menu, select **Contraception** to display the Contraception Services - Add screen.

4. **Service Type** - The default is <None>. Display the other options by clicking on the down arrow and select as required:
   - Either **First Service** if this is the start of treatment for contraceptive services (this was more relevant under Items of Service)
   - Or **Subsequent Service** if there is a previous claim and this is continuation of care.
   - **Service End** - If contraceptive services have ended (e.g. pregnancy, menopause), select Service End.

5. **Service Read term**. Click on and scroll down to choose another more specific Read term, e.g. **614.. 00 Oral Contraception**.

6. **Date Seen** - This defaults to today. If you recording an entry of contraceptive services given by an outside source, block highlight the date then change it (e.g. type – 7D for seven days ago).

7. **In Practice**: This box is ticked by default, i.e. contraceptive services provided from your practice under GMS. Untick the box if the services were provided by an outside source.

8. **New Claim Expiry Date** – This is no longer relevant.

9. **Date IUCD Fitted**: Leave blank unless a coil has been fitted, in which case enter the fitting date.

10. **Recall, Notes**: To enter either free text notes and recall dates, click on these respective icons. Note that you may want to record a recall date that may be different from the Claim Expiry date. Recall due dates for contraception are usually displayed alongside existing contraception records, for example, on the Journal tab of the Patient Record.

11. **OK**: Once you are satisfied with your entry, click on **OK**.
Add Peak Flow Record

1. Select the patient and make sure a consultation is started and the Patient Record displayed.

2. Click on the Journal tab.

3. To record a peak flow, display the Peak Flow Current - Add screen by typing pfr in Read Term Add, and press Enter for 3395.12 PFR - peak flow rate.

   **Note** - If you type peak flow in step 3, you will enter 3393.11 Peak flow rate normal which leads to the Pulmonary Function Tests - Add screen. The picklist on this screen shows a different selection. This does not show Predicted Peak Flow, Previous Best Ever or Percentage of Best Ever.

4. On the Peak Flow Current – Add screen, the default in Read Term for Characteristic is 3395.12 PFR - Peak flow rate Use the picklist to select another Read term and press Enter.

5. Enter the Device Type - either Wright or EN 13826. This affects the calculation of predicted peak flow.

6. Enter the value into the **Value** field.

7. Click **OK**.

The **Predicted Peak Flow** and **Previous Best Ever** calculations are shown automatically in the bottom left of the Peak Flow Current – Add screen, together with the **Percentage of Best Ever**. The calculation of Predicted Peak Flow is dependent on a height record being present, and on selection of the correct Device Type.

Predicted peak flow will NOT be calculated for children under 16.
List Test Results

- To list test results, click on the Tests tab. Listings are chronological, but by clicking on the column heading of Description, you can sort the test results by type, or by Read code, or alphabetically by Description. You can also see the result and the action via the Mail for Patient button in the Consultation Manager toolbar.

- Test results can also be listed by clicking on the All Test Results line on the left-hand navigation pane. All test results are listed under the Filtered List tab.

- If you first click on the + by All Test Results line, then click on, e.g. Haematology, the Filtered List shows only these specific haematology results.

Note - Any results that have the Result Qualifier selected as Abnormal will be shown in red on the test results list.
Add Cervical Cytology

This method first records that you have taken a smear. The idea is that when the result is through a few weeks later, you update this record with the actual result.

1. In Consultation Manager, select the patient.
2. Make sure a consultation is started.
3. Click on the Add menu and select Cytology.
4. At the Cervical Cytology – Add screen, just press UNLESS you want to change the Date Smear Performed (defaults to today's date). Usually all the defaults can be accepted as displayed. For this first smear entry, do not enter a recall record at this stage, or change the Read term

![Cervical Cytology - Add screen](image)
Add a Referral (non-electronic)

Note - The protocol for adding referrals may be different to the below depending on the country that you are in.

1. Click on the Referral icon to display the Referral Add screen.

2. Read Term for Referral Reason – This is the condition for which the patient needs the referral, e.g. sciatica, dyspepsia.


4. Action Date defaults to 3 weeks from the referral date so you can keep track of responses. This is the date by which you would expect treatment to have started. You can enter a time period here, for example, 7D for seven days, or 3M for three months, which will act as an offset date. Once a default referral is related to a patient, you can search on Action Dates in Searches, but there is no other action triggered once overdue.

5. Select the Provider Unit, Department and Consultant – these details will all merge on to the referral letter. The picklist depends on the organisations you have set up in File Maintenance and ticked as Provider Units.

6. Optionally select the relevant NHS Specialty and TP Specialty.

7. If you want to generate a referral letter, click on the Letter icon (you need to have letter templates set up beforehand).

8. Otherwise, complete the referral by clicking on OK.
Medical Insurance Report

A template allows Vision users to create a medical report for insurance purposes as a Word document. It automatically extracts data from the Vision database to produce a report that can then be edited.

1. From Consultation Manager, select the patient required, and open an Administration consultation.
2. From the **Add** menu, select Correspondence to display **Clinical Correspondence – Add**.
3. Select **Medical Report** in the Type of Letter field.
4. Under Summary enter Medical Report for Insurance Purposes and the name of the insurance Company requesting the report.
5. Click on the Letter button.
6. Highlight the Insurance_Report.doc from the offered files on Select patient Template to Open and click on **Open**.
7. This will open the Insurance Report, and after a few seconds delay the hourglass will be displayed indicating that the report is been constructed by merging in the patient's data. The cursor shape will return to normal on completion of the report; this may take a while on patients with a lot of data.
8. The report will now need to be edited. Some of the sections in the report have Yes/No printed at the end; one of these will need deleting each time and then further comments added if necessary. The data that is imported from Vision can be edited and deleted as required. To alter text, highlight it and type the required text. To delete unwanted text, right click on the line, select Delete Cells and then Delete entire row. This then does not leave a blank line. To delete several rows, first highlight the rows, right click and select Delete Rows. To delete text, highlight it and use the Delete key.
9. To alter text, highlight it and type the required text. To delete text, highlight it and use the delete key.
10. Print the report using the Print button from the tool bar.
11. When the report is closed, a prompt will appear asking if you want to save changes for this report, for example, Do you want to save the changes to 00473000.CLI? Remember this is just for this patient’s report - it does not affect the template.
12. Click on **Yes** to save the changes made. A red tick will now appear on the Letter button showing a Report has been created.
13. To save the record click on the **OK** button. To cancel the whole process, press the Cancel button.
Exit from Vision front menu

On the Modules menu, there is a Close All Modules option that shuts down all open Vision modules.

**Important** - You need to ensure that all users are properly signed out of Vision every night. INPS records show that on average, 15-20% of sites fail to sign all users out. This prevents practices from receiving updates and will stop the overnight re-index running. Please ensure all of your users know of the need to properly sign out of Vision and close down their workstations every night. It will also result in an invalid backup.

Please:

- Don't leave a patient record up on screen if you leave the workstation. Other Vision users can only view details for that patient while you are editing it. Note that a screensaver will be triggered after a certain period of time, or can be invoked with Ctrl-Alt-F12.

- You must log out of Vision when you are not using it, both for security reasons and in order for the daily backup to complete cleanly.

Close each Vision module down when you have finished and return to the Vision Front menu:

- Click on the **x** at the top right of the screen;
- or click on *File*, then *Exit*;
- In **Consultation Manager**, click on Consultation, and then click on *Exit Consultation Manager*.

To exit from Vision Front menu, click on the top left exit**x**; or select Modules – Exit.
Index

A
Add a Referral (non-electronic) • 44
Add Acute Prescription and Print • 13, 18
Add blood pressure and list BPs and graph • 34
Add cervical cytology • 43
Add contraception and prescribe oral contraceptive • 40
Add Contraindicated immunisations • 39
Add drug allergy • 31
Add Ex-Smoker • 34
Add Immunisations • 37
Add Med 3 • 32
Add Medication to problem • 22, 25
Add Non-Smoker • 33
Add Parental Consent • 39
Add Peak Flow Record • 41
Add Repeat Prescription • 24, 27
Add Smoker • 33
Add Smoker / Non-smoker / Ex-Smoker / Smoking Cessation advice • 33
Add Smoking Cessation Advice • 33
Add Weight and Height • 36
Adding Data • 13, 14
Appointments List • 12

C
Consultation Manager Overview • 9
Contraindication warning signals • 30
Copyright Notice • ii

D
Drug check displays • 29
Drug Checks • 21, 25
Drug Doubling Warning Signals • 30
Drug Interactions warning signals • 29

E
Exit from Vision front menu • 46

F
Finding Data • 13

G
Graphs • 35

I
Issue Repeat Prescription • 26

L
List Test Results • 42

M
Make an Acute into a Repeat • 24
Medical Insurance Report • 45

P
Print the Prescription • 22

R
Re-authorise repeat • 28

S
Select a Patient • 11
Starting a Consultation • 10, 12
Starting Vision and Sign on • 6

U
Updating an entry if you have made a mistake • 17

V
Vision Front Screen • 7
Vision Quick Reference Guide for Clinicians • 5

W
What if you cannot find the repeat master in Step 5 • 27
What this Quick Reference Guide covers • 5
Who is the Quick Reference Guide designed for? • 5