

Lorenzo Guidance Research and Development

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12. Version Control/Document History **Error! Bookmark not defined.**

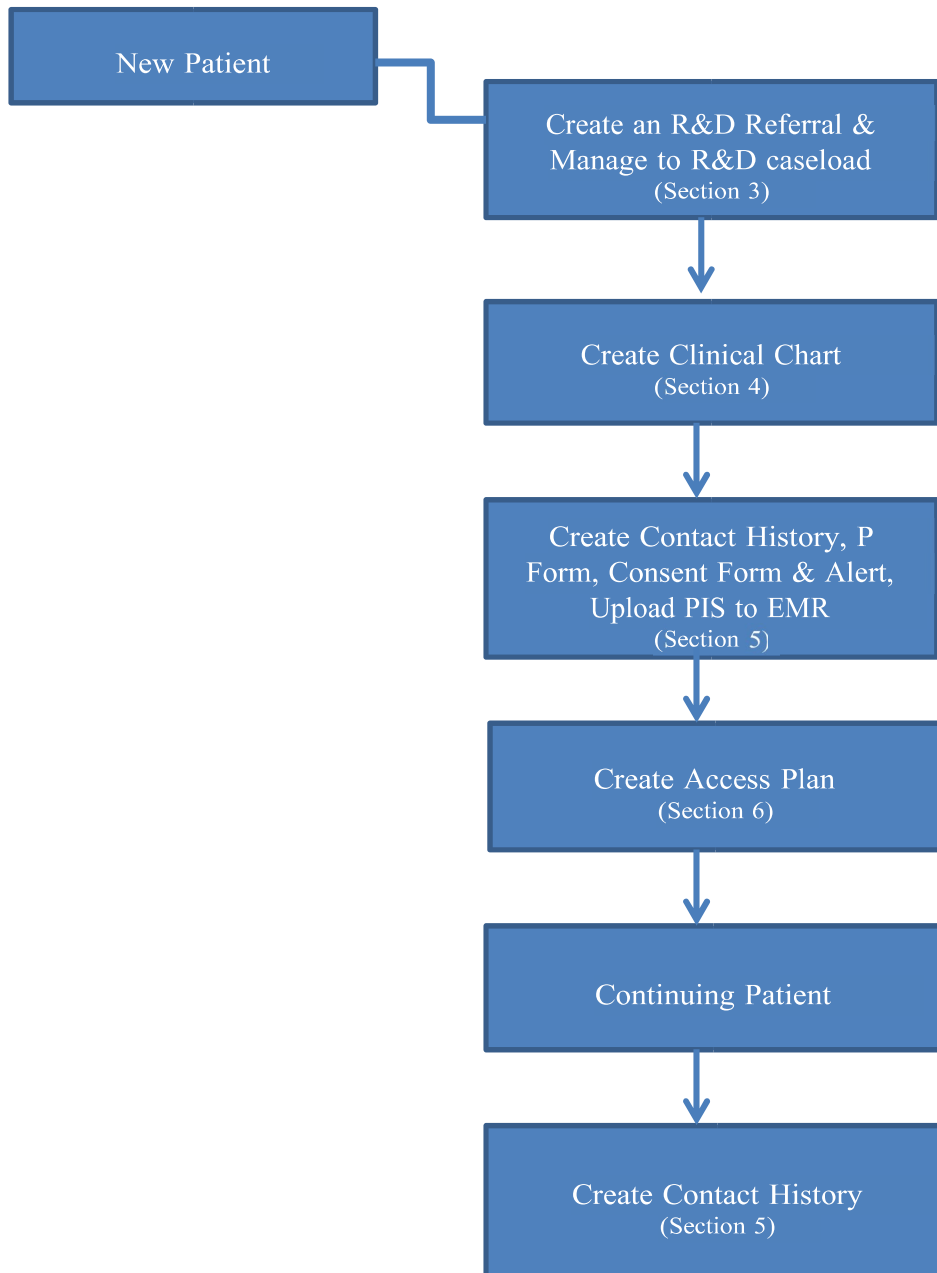
1. Purpose

This guidance document describes how Lorenzo can be used to manage patient referrals, appointments and Access Planning within the Research and Development (R&D) department of Royal Papworth Hospital.

For further information and support, visual ‘Quick Reference Guides’ and R&D Lorenzo e-learning modules can be accessed here: <S:\shared\R&D\Lorenzo\QRG>

2. Process

The following flow diagram demonstrates the order in which activities should be completed for new and continuing patients.



3. Referrals

Process for a Participant who is sent a Participant Information Sheet and then declines participation

For a Participant who has received a PIS and then declined to participate, please follow the steps below:

- Click on the “Patient Tab”
- Use the Patient ID search on the left hand side and enter the RGM number
- Click on the Clinical Notes tab on the right hand side
- Then click on Create Note on the left hand side

- Tick the box next to select the row for R&D RGM clinical note, the additional details box on the right hand side should auto-complete
- Then NEXT
- The R&D clinical note template will appear. Please complete your note.
- Then FINISH

For all other participants, please follow the instructions as below:

Process for creating an R&D Referral

This section describes the process to create a new R&D referral for a patient. This process should be completed when a patient has been approached for a study. This process will only need to be completed once for each patient.

- Click on the “Patient Tab”.
- Use the Patient ID Search on the left hand side and enter the RGM number
- Click the green arrow to the right
- Click on the hyperlink to the patient’s RGM number to open the EPR.
 - o If the patient cannot be traced then register the patient and continue with the recording of the referral as described in the next section.
- Click on the Referrals EPR tab down the right side
- Click on “CREATE REFERRAL” within the details box on the left hand side. The referral details window should open.
 - o Please note: Blue fields are mandatory and should not be left blank
- Service type requested defaults to “Advice/Consultation”. For research purposes please select “OTHER” from the dropdown list
- For Referral Priority please select “ROUTINE” from the drop-down list. Ensure referral type has defaulted to Outpatient
- For referral source select “CONSULTANT other than in Accident & Emergency Department Emergency” from the drop-down list.
 - o Please note: Admin Category defaults to NHS Patient. Private Patient can be selected from the drop-down list if applicable
- Referral media defaults to Paper. The available choices in the drop-down list are limited.
 - o Please select the option you feel is most applicable.
- Click on the SFS button next to the Organisation field. Type in “RGM” in the identifier box and click “FIND NOW”. Papworth Hospital NHS Foundation Trust should appear. Select and Click “OK”.
- For referral creation date/time, click on the drop-down arrow to reveal the calendar and select the appropriate date.
- Click on the SFS button near team field and type in “%R&D” into the name box. Click “FIND”. □
Click on the most appropriate team for the study. Once selected click “OK”.

The remaining mandatory fields should auto populate (Speciality and treatment function). Click “FINISH NOW”.

Process for Managing an R&D Referral and Allocating a Referral to a Caseload

This section describes managing an R&D referral and allocating the referral to a specific research team caseload.

- Once a referral has been made, a care activity choice box should appear. Select “MANAGE REFERRAL” and Click “OK”.
- A Manage referral box should appear. For Select action choose “ACCEPT” from the drop-down list
 - For Referral outcome, click “ALLOCATE TO CASELOAD” from drop-down list then click “FINISH”.
- An Allocate to caseload box should appear.
 - o Please Note: Blue fields are mandatory.
- Click on the SFS button next to the caseload profile name. For criteria box, type in the name of the R&D team you want to allocate the patient to within the caseload profile name box (For example “Cardiology” followed by “%”. Click “FIND NOW”.
- Click on appropriate team and click “OK”.
- Reason for allocation should default to “assessment”, if it doesn’t then select “ASSESSMENT” from drop-down list
- Click “ADD” and then “FINISH”.
- Lorenzo asks if you wish to print an allocation letter or labels- click “NO”
- It is very unlikely that you will need to allocate the patient to the caseload of another team, however, if necessary a patient can be allocated to more than one caseload by repeating this process. All patient facing staff have access to allocate a patient to all specialities within R&D.
-

4. Clinical Chart

Creating a Clinical Chart within an R&D referral

This section describes how a R&D specific clinical chart is created within an R&D referral. This process will only need to be completed once per patient.

Process

- Click on the Patient Tab,
- Use the Patient ID Search on the left hand side and enter the RGM number □ Click the green arrow to the right.
 - o Alternatively use the Patient Search link □ Find Patient as per mandatory fields.
 - o If the patient cannot be traced then they will need to be registered □ Select correct Patient and click “Finish Now”.
- Within the Patients EPR, click on the “CLINICAL CHART” tab button on the right.
- Click on “CREATE CLINICAL CHART” from the left menu.
- Click on the SFS button next to the template name field. Type “RESEARCH%” into the template name field and click “FIND”.
- Select the “RESEARCH AND DEVELOPMENT CLINICAL CHART” and click “OK”.
 - o Ensure correct start date and time have been recorded.
- Click “FINISH”.

5. Contact History Form, P Form, Consent Form & Alert

Recording a contact history

This section describes how to create a contact history form to document patient activity. Research staff will need to create a new contact history to document every time they have any activity with a patient. i.e. face-to-face, telephone contact or administrative activities.

- Within a patient R&D clinical chart, right click on the “CONTACT HISTORY” tab and scroll down to “CARE EVENTS” and select “CREATE SINGLE CONTACT”.
 - Please note: you will need to create a single contact before attempting to complete the P Form.
- For purpose select the reason for the contact from the drop-down list. Please note: the available choices in the drop-down list are limited, please select the option you feel is the most applicable. If you are creating a contact in order to add a research active patient to Lorenzo please select “ADMINISTRATIVE”.
- For contact type, please select an option from the drop-down list. If you are creating a contact in order to add a research patient to Lorenzo please select “NON PATIENT BASED CONTACT”.
- For location type, please select an option from the drop-down box. If you creating a contact in order to add a research active patient to Lorenzo please select “OTHER LOCATION”.
- The Contact will ask to be linked to a referral. In order to find the R&D referral click on the SFS button next to the referral received field. An active referral box will appear. Select the R&D referral and click “SELECT”.
 - For team field, click drop-down box and select appropriate team if this hasn’t been auto populated.
 - For treatment function, you may need to select the speciality from the drop-down list if it hasn’t been auto populated.
- Click “NEXT”
- A Scheduling box should appear. Update the Planned/Actual contact start time and Planned/Actual contact duration fields.
 - Ensure the correct date is displayed in the Planned/Actual date box.
 - If you are creating a contact in order to add a research patient to Lorenzo, please input the current time and record duration as 00:05 Hrs:Mins.
 - If another colleague was present when you had contact with the patient they can be added here.
- Once you have clicked out of the box, click “NEXT”.
- An attendees box should appear. If the patient was accompanied by someone else, please record the relevant information here. Click “ADD” and then “NEXT”.
 - Please Note: if patient was not accompanied then just click “NEXT”.
- A Outcome window may open. For this select the most appropriate outcome. For example “ONGOING ASSESSMENT”. Once selected click “NEXT”.
- The document box should appear, click “NEXT”.
- A activity choice box will appear, select “CREATE NEW NOTE”
- Lorenzo will then ask for a template selection, to search for R&D, click “ADVANCED SEARCH” and enter “RESEARCH%” into the template name box and click “FIND”. Select the R&D clinical note and click “NEXT”. The R&D clinical note should appear

Document the visit within this template. When finished, date and time stamp in the box at the top of the page using the “AUTHOR DATE AND TIME STAMP” and tick the “COMPLETED” box before clicking “FINISH NOW”.

- Your entry is now complete.

Creating a P Form

This section describes how to create and complete a P Form. This will only need to be completed by research staff once per patient.

- Within a patient’s R&D clinical chart, right click on the “P FORM” tab and scroll down to “FORMS”. □ Select “RGM RESEARCH”.
- A select encounter box should appear. Select the single contact you have created by clicking in the first column of the appropriate row and then click “OK”.
 - o If only one contact exists for the research patient, this window will not appear as the P Form will automatically associate with the only contact recorded.
- The P Form should then be created. To fill out the P Form, type in Study specific information in the boxes provided. If you have completed the form and will not need to make any further changes the form should be finalised by clicking the “FINALISED” button.
- Once finished, Click “FINISH”. The completed P Form is now visible under the P Form tab.

Uploading a Consent Form

This section describes how to upload a scanned consent form to Lorenzo.

Please note the relevant Patient Information Sheet must be uploaded to EMR which can be accessed via the ‘globe’ button on Lorenzo. Full instructions are available in the reference guides saved here:

<S:\shared\R&D\Lorenzo\QRG>

- Within a patient R&D clinical chart, right click on the “CONSENT FORM” tab and scroll down to “UPLOAD AND...”.
- An Upload and associate document box should appear.
- Select CLINICAL NOTE
- For document type field, select “SCANNED ITEM” from the drop-down list.
- To attach the consent form to the EPR click on the browse button to locate file and double-click on the file
- The name of the document should appear in the ‘file to be uploaded’ box.
- Type RD_Patient consent at the beginning of the text that appears in the ‘Document Name’ field (if you do not type this then the consent form will not be visible under the Consent Form tab).
- Click “FINISH”. The consent form should now be visible under the consent form tab. o Please note, more than one consent form can be uploaded if needed.

Creating a Patient Alert

This section describes how to create an ‘Active Research Patient’ alert. This will only need to be completed by research staff one per a patient.

- Within the patient’s EPR, Click on the “HEALTH ISSUES” Tab and then “ALERTS”. Click on “RECORD ALERT” within the alerts tab of the left hand side.
- A select encounter box should appear. Select the single contact that you have created and Click “OK”.
 - o Please note: if only one encounter exists this window will not appear and the alert will automatically associate with the only encounter made.
- For alert type, select “RESEARCH PATIENT” from the drop-down list.
- For alert name select “RESEARCH PATIENT” from the drop-down list.
- Ensure that the scope of the alert has been recorded as “ALL ENCOUNTERS AND EPISODES” by ticking this box.
- Click “ADD”. The alert has now been added to the EPR. Click “FINISH NOW”.

6. Access Planning

Search result:				
<input type="checkbox"/>	Profile Name	Profile Code	Profile	Care Provider
<input type="checkbox"/>	R D Cardiology	2019AP0000072	R & D Cardiology	Nurse G
<input type="checkbox"/>	R D Cardiac Surgery	2019AP0000073	R & D Cardiac Surgery	Nurse G
<input type="checkbox"/>	R D Cross Divisional	2019AP0000074	ILD/LD/TX/CS/C	Nurse G
<input type="checkbox"/>	R D PVDU	2019AP0000075	R & D PVDU	Nurse G
<input type="checkbox"/>	R D CCLI	2019AP0000076	R & D CCLI	Nurse G
<input type="checkbox"/>	R D Oncology	2019AP0000077	R & D Oncology	Nurse G
<input type="checkbox"/>	R D RSSC	2019AP0000078	R & D RSSC	Nurse G

Adding patient to an Access Plan from a first referral

This section describes the process required to add a patient to an appropriate access plan. All research patients should be added to an access plan after an R&D referral has been made. However an access plan will closed after an outpatient appointment has been attached to it, therefore a new access plan will need to be created. Above are the appropriate R&D assess plan names and profile codes for each speciality.

Process

From patients EPR tab

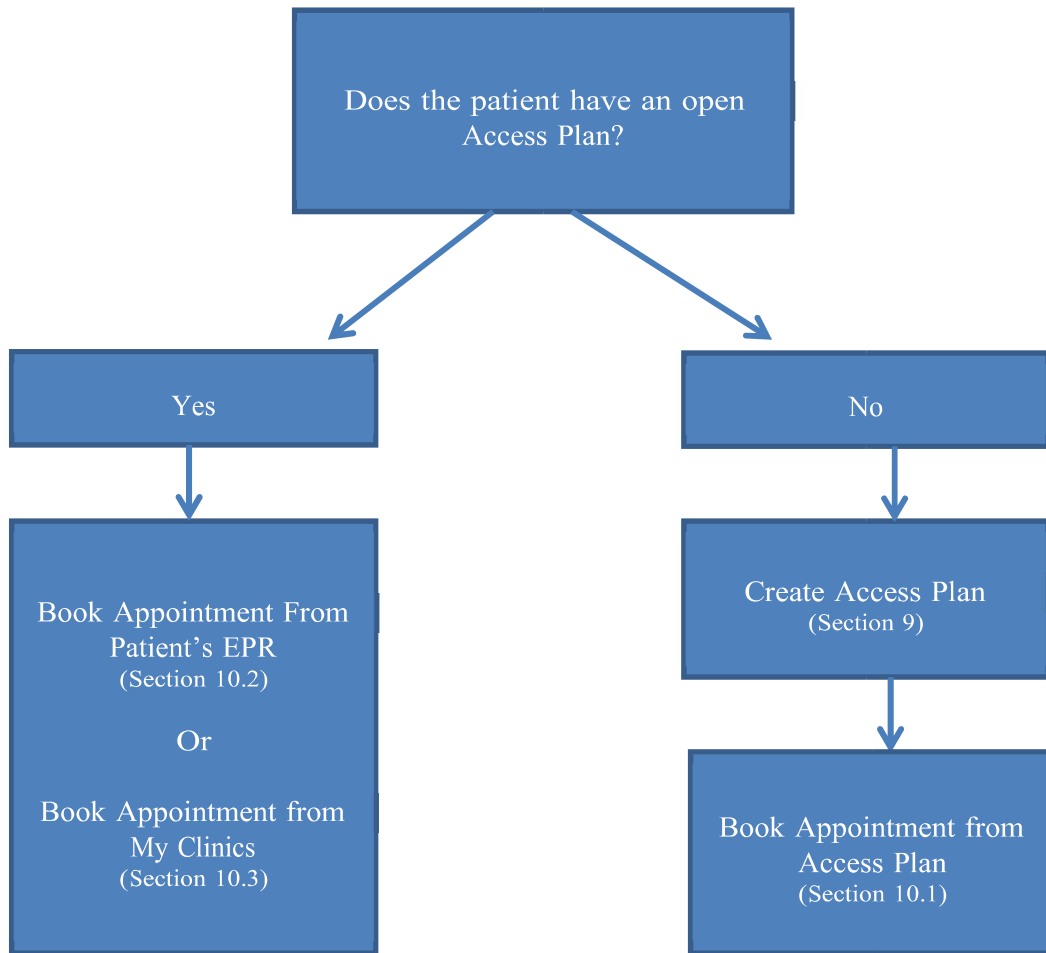
- Click “REFERRALS” tab

- Select R&D referral and Click “CREATE ACCESS PLAN ENTRY” from the menu on the left Review the presented referral details then click on “NEXT”.
- Select Access Plan type: Outpatient
- Click the SFS and search for the Profile Name using “R D%” and select it and click “NEXT”.
 - o Please note: Make sure there is a space between the letters R and D
 - o An Assess plan details box will appear. Select “TEAM” and then Click Team magnifying glass. Type in “%R&D” and click “FIND” to populate correct R&D sub-speciality.
- Complete Appointment type: Select “NEW”
- Complete Access plan start date: populate with the date that the decision was made to add patient to the access plan. This date will also need to be after the referral date.
- Click “NEXT”
- Within the “General Resource Requirements” tab. If none of these are applicable click “FINISH NOW”
 - o In “clinical requirements” tab record if interpreter is required and the preferred language (This will not automatically request an interpreter - Complete normal trust process for booking).
 - o In “transportation requirements” tab complete if required
 - o In “outpatients scheduling” tab, record if a patient is available at short notice. “FINISH NOW” for all Resource monitoring and coding and grouping

Lorenzo will offer to book appointment now. Click “YES” when asked ‘Do you wish to create an offer?’ if you wish to book a patient appointment straight away. Click “NO” if you do not wish to.

7. Appointment Booking

This section describes how to book R&D outpatient appointments.



Please note that in order to book a room you need to email papworth.clinicroomrequests@nhs.net and ask if a clinic room is available on the day and time you want (we are not guaranteed a room every day). If a room is available they will book you in on the outpatient system and allocate you a room. You can then follow the steps below to create the booking on Lorenzo which will feed into flow manager and allow you to create a letter.



10.1 Booking appointments from an Access Plan

Process

- From creating an access plan, Lorenzo will ask “DO YOU WISH TO CREATE AN OFFER?” CLICK “YES”. Alternatively, click on “ACCESS PLANNING” tab within a patient EPR, Select R&D access plan and click “MANAGE OFFER”
- Clear “TEAM NAME” field. For clinic name, search using name by using the drop down box. Within this box search “RESEARCH CLINIC”. Search using the magnifying glass. Select research clinic and click “OK”.
- The individual research clinics will then appear within the session name. Select the most appropriate clinic according to the day of the week you wish to book the appointment for.
 - o Please note: Clinic named N REARPH Research Clinic runs on a Monday, Tuesday, Thursday and Friday. NREARPH/3 Research Clinic runs on a Wednesday only.
- Amend Date fields to the date you wish to book an appointment. And Click “CHECK AVAILABILITY” Expand criteria and date using the “+”. all available slots will now show.
- Select time you wish to book.
- Click “NEXT”.
- The selected appointment will appear at the top of the next page. Ensure this is selected.
- Complete mandatory fields: OFFER TYPE: Verbal, PROIRITY: Routine & Appointment TYPE: New or Follow-up
- Complete PATIENT RESPONSE: Accept
- Add to comments: Study name, PI Name and PO Number, Visit number and contact details. Also add in any additional tests the patient will undergo this appointment.
- Click on “FINISH”. This confirms the appointment immediately.
- The Select Document Template window appears. Select R&D Letter template. Click “NEXT”
- Lorenzo will open the R&D letter template. This is a generic letter to R&D. please amend as needed.
 - o Please note: This letter is for appointment checking in information and parking only. Staff will still need to send a study letter to accompany this.
- Once the letter has been amended. Tick “PRINT” & “COMPLETED” & “FINISH NOW”.

10.2 Booking appointment from Patient’s EPR

- Click “ACCESS PLANNING” tab on the right hand side
Select R&D access plan
- Click “MANAGE OFFER” on the left hand side. From creating an access plan, Lorenzo will ask if you wish to create an offer, Click “YES” Clear “TEAM NAME” field.
- Click the little arrow to drop down a box to search “NAME”. In this box type “RESEARCH CLINIC” and search using magnifying glass Select Research Clinic and Click “OK”.
- Click appropriate Clinic:
- Specific R&D clinic codes are as follows:
- Clinics running on a Monday, Tuesday, Thursday and Friday bookings to use clinic code: N REARPH Research Clinic. Wednesday clinic should use clinic code: N REARPH/3 Research Clinic
 Amend DATE FIELDS. Patient/Staff preferences can be filled in or can be left blank. Click “CHECK AVAILABILITY”
- Expand criteria and date. All available slots will then appear
- Select appointment and Click “NEXT”

- The selected appointment will appear at the top. Ensure this is the correct appointment you have chosen.
- Complete OFFER TYPE: Verbal, PRORITY: Routine & APPOINTMENT TYPE: New or Follow up Complete PATIENT RESPONSE: Accept
- Add to comments: Study name, PI Name and PO Number, Visit number and contact details. Click “FINSIH”
- A Select document tab will appear. Select R&D letter template. Click “NEXT”
- Lorenzo will open letter template. This template is generic to R&D, please amend as needed. Please note: this letter is for appointment checking in information and parking only. Staff will still need to send a study specific letter to accompany this.
- Once letter has been amended. Tick “PRINT” & “COMPLETED” & “FINISH NOW”

10.2 Booking appointment from Clinic List (Recommended method)

- Click “MY WORK” tab
- Click “CLINICS” within the left hand tab. If you have already added Research Clinics “MY VIEW” tab then Click “MY VIEW” tab now.
- For first time use, Search for “REARPH%” within Main identifier Enter From date and To date.
 - o Please Note: Before the hospital move: From date needs to be after 6th May (as this is when clinics for the New Hospital Go live.
- Click “FIND”
- All Research Clinics should appear. Select all.
 - o Please note:

N REARPH Research Clinic= Clinic used for Monday, Tuesday, Thursday & Friday Appointments

N REARPH/3 Research Clinic= Clinic used for Wednesdays Only

REARPH Research Ad Hoc= Clinic used for Overbooking

- Select “ADD TO MY VIEW”
- Click “MY VIEW” tab
- Select appropriate clinic depending on which day of the week you wish to choose.
- Select appropriate date and press “REFRESH”
- Select appointment time slot and click “MANAGE OFFER”
- Fill out profile code, Click the three dots to search
- Within Profile name type “R D%”. Please note: there is a space between R D.
- Select appropriate access plan sub-speciality and click “SELECT”
- Within the Access plan entry status, Select “CREATED” & RESOURCES INDENTIFIED”
- Select Patient you wish to book for using the three dots next to Patient ID
- Complete Mandatory boxes to search for patient. Click “FIND”
- Select patient and click “OK”
- Select access plan and click “NEXT”

- The selected appointment will appear at the top. Ensure this is the correct appointment you have chosen.
- Complete OFFER TYPE: Verbal, PRORITY: Routine & APPOINTMENT TYPE: New or Follow up
- Complete PATIENT RESPONSE: Accept
- Add to comments: Study name, PI Name and PO Number, Visit number and contact details. Click “FINSIH”
- A Select document tab will appear. Select R&D letter template. Click “NEXT”
- Lorenzo will open letter template. This template is generic to R&D, please amend as needed. Please note: this letter is for appointment checking in information and parking only. Staff will still need to send a study specific letter to accompany this.
- Once letter has been amended. Tick “PRINT” & “COMPLETED” & “FINISH NOW”

Amending Booked Appointment

Amending a pre-booked appointment to a different time and date

Process

- Go into clinic and select appointment you wish to amend.
- Click “RESCHEDULE BOOKING”
- Lorenzo will ask if you want to automatically reschedule appointment, click “NO”. Select most appropriate reschedule reason and click “NEXT” Click “NEXT”.
- Select appropriate clinic
- Select appropriate time
- Click “CHECK AVAILABILITY”
- Expand clinic and select new appointment time. Once selected, click “NEXT”
- Complete any mandatory information and click “FINISH” o NB: Appointment will show Cancelled and new appointment will be made for newest date and time. You can this that the old time slot of 10:00am has repeated itself underneath for someone else to be booked in here.

Canceling an Appointment

Canceling a pre-booked patient appointment.

Process

- Select appointment you wish to cancel
- Click “MANAGE BOOKING CANCELATION”
- Lorenzo will ask if you wish to close down the associated referral, Click “NO” Click “FINISH”
- Select appointment

- Complete Cancellation reason with the most appropriate reason o NB: the appointment status will change to cancelled and a duplicate time slot will appear underneath

8. Clinic Attendance

This section describes the process and integration of Intouch and Lorenzo to recording patient clinic attendance, seeing a patient and patient departure to booked appointments. This section also covers walk-in appointments for patients that do not have an appointment and shows how booking a patient in real time is completed and patients that do not attend.

Patient Arrival

This process for the new hospital must be in line with the process for the In Touch Patient Flow Management (InTouch) and patient self check-in. Training for this system can be accessed online via <http://papsvrintra/papworthonline/digitaltraining/index.php?id=patient-flow-management>

Process

To Arrive the Patient:

- From the Clinic Pegboard, select the appointment
- From the Clinics task pane, click on “MANAGE APPOINTMENT STATUS” o If any of the following data is missing then a pop-up message will display: Overseas Visitor Status; Ethnicity; Religion. Always select “OK” for this message to ensure that this data is captured.
 - o The Capture Mandatory Data screen is displayed.
 - o Ask the patient the relevant questions for the data items to be collected and update the patient’s demographics.
 - o On Finish the Manage appointment status will be displayed.
- The Manage Appointment Status window will appear.
- The Event Status field will default to Arrived.
- Click on “MANAGE SUMMARY” which will display the patient’s demographics.
- Check with the patient that the details are correct; make amendments as necessary o NOK may be checked and managed via Manage Relationships Click “FINISH NOW”
- Staff should request that the Patient waits in the designated area until called, or should be directed to the correct location for tests etc.
- If a patient cannot be located on the OP pegboard:
 - o Check that the patient does not have another appointment in another clinic/another date. o If they are attending the wrong clinic – direct them to the appropriate area
 - o If they are attending on the wrong date but insist on being seen, discuss with clinical staff o If the patient does not have another appointment; ascertain if the clinic staff are willing to see the patient and then - manage as a Walk-in – see below

Walk in Patient

Walk-in patients are those patients who arrive for a clinic but do not appear to have an appointment. Walk in patients are recorded in real time. It is not possible to walk in a patient in the future.

Process

- Ensure a current or past time slot is selected within the Clinic Pegboard
- From the Clinics task pane, click on “WALK-IN”. The Patient Search window will be displayed
- Search for and select the appropriate Patient
- Click “NEXT”
- The Manage Patient Details box will appear with hyperlinks to various demographic details: these must be checked as described above in Patient Arrival.
- Click “NEXT”
- The Book Appointment wizard will appear
- Complete the Appointment Details required. The arrival time can be changed if required. This will be used to calculate the patient’s waiting time
- Click on the “FINISH NOW” workflow control

See Patient

Clinicians will have access to the outpatient pegboard and will be aware of who is ready to be seen based on their appointment status. The patient’s medical notes may be viewed (prior to seeing the patient) by access the relevant clinical chart from the OP pegboard.

Process

- Users must record their clinical, findings/notes in the appropriate clinical note template/form accessed via a clinical chart.
- Once the consultation is complete the Seen data must be completed.
- Click on the Manage Appointment Status, this will open and will set the Appointment status to Seen by default.
 - o Note that the status cell in the OP pegboard may also be clicked on with the same result
 - o The following must be completed:
 - o Seen by – record that you have seen the patient, if your name does not appear by default use the care provider SFS
 - o Event status – defaults to Seen
 - o Attend Status – if this is not set to Attended, do so now
 - o Date/Time – record the date time you see the patient – defaults to current date/time which might suffice
 - o If done retrospectively the date/time must be changed as it will default to the appointment date and time if the clinic date has passed; or to the current date and time if it is still the day of the clinic
 - o Departure Outcome – select as required – see additional guidance o RTT status – select value “98 not applicable to RTT”

Depart/Outcome

This describes the processes required to:

- Depart the Patient and Confirm Outcome
- Confirm RTT status update Add to Access Plan

All activities should be undertaken in real time.

Process

- From the clinic pegboard, select the appointment
- From the Clinic task pane, click on “MANAGE APPOINTMENT STATUS”
- The Manage Appointment Status Care Activity will launch
- Ensure there is an Event status of Depart
- Record the Appointment Status Details, including a Departure outcome
- Dependent on the outcome selected and the configuration applied, a prompt asking the User to Close the Referral, Access Plan and Episode. This should only be done if the Patient has completed all their care within this Episode.
- Additional triggers may be configured to automatically launch other care activities such as a Follow-up appointment or to create an admission The following Outcomes are available:
 - o Add to access plan – displays Create access plan entry – Reception Staff can cancel out of this screen
 - o Awaiting clinical decision – displays Create access plan entry – user must select the appropriate access plan profile –
 - Do not Use this Access Plan for DNA’s – see the section below for these
 - o Awaiting Results – displays Create access plan entry – user must select the appropriate access plan profile
 - o Follow Up Booked – displays Create access plan entry – user must select the appropriate access plan profile
 - o Follow Up to be Booked – displays Create access plan entry – user must select the Follow up bookings access plan profile
 - o Admit from clinic – Closes access plan entry
 - o Discharged – Close referral
 - o Self-Discharge – Close referral
 - o Patient died – Record death screen will display - following Depart process – complete as per SOP LZO007 Recording Deaths
 - o Referral to external consultant – Closes access plan entry – and closes referral
 - o Referral to other consultant – Closes access plan entry – and closes referral
 - o Referral to other department – Closes access plan entry – and closes referral

Patients must not be lost to follow-up/Lorenzo – this is avoided by ensuring that where appropriate a patient is added to an access plan.

Outcome forms (if being used) must still be passed to the relevant persons but the clinic outcome must be recorded by OP Receptionist within the clinic and in real time.

DNA Management

This section describes how outpatient DNAs must be managed. There is a need to ensure that each DNA is recorded (in OP) and that each DNA is then managed appropriately by those responsible for their management.

DNAs should be managed in line with Departmental policies (e.g. number of DNAs prior to being discharged etc.)

Process

In line with Depart: the following data should be collected for a patient who is being recorded as a DNA.

- Event status – set to “DID NOT ATTEND”
- DNA Outcome – “REMAIN ON ACCESS PLAN”

9. Post Clinic

This section outlines any activities that are required to ensure that an Outpatient clinic is managed to completion: including; follow on activities such as DNA Management (booking/discharge), create access plan entries etc.

Process

Dependent on the outcome recorded the following actions may be required; but see the following SOPs for more detail.

- Access Plan Outcomes – create OP or IP access plan entries as determined by the OP outcome
- Discharge – close referral and clinical chart as required
- DNAs
 - o If a DNA patient is to be offered a new appointment then this should be taken via the create offer functionality from within the access plan used to create the original booking.
 - o Use the DNA or Depart Report to ensure that all DNAs are managed
 - Where appropriate rebook using the current access plan entry and create offer etc.
 - Where appropriate discharge; close referral and clinical chart
 - Ensure that all aspects of safeguarding are undertaken so that where a patient is discharged the referring clinician etc. is fully aware and that the patient does not get ‘lost’.

10. AE & SAE Reporting

Adverse event reporting

Adverse events should firstly be detailed within the clinical note under the ‘Adverse event RGM’ form and sent for authorisation.

Process

- Right click on the “Contact History” tab and scroll down the “Notes” on the drop-down menu.

- Select “Adverse Event RGM” from the sub-menu
- Select the single contact the event is associated with by clicking in the first column of the appropriate row. Click Ok
Fill out the AE template table including: Start date, end date, severity, causality assessment, SAE & outcome
- Once completed, tick the “send for authorisation” box to send to PI for review. then click “NEXT”
- Lorenzo will then ask you to complete the “send for authorisation” box. Choose ‘user’ from the drop down list.
- Insert the PI surname followed by % and click “FINISH”
- Users are asked to update this table as the AE’s resolve or change.
- When all events have resolved, click the “COMPLETED” box and then “FINISH NOW”
-

Serious Adverse event reporting

Serious Adverse event reports should be uploaded via the upload tab. For Papworth sponsored studies, use current templates. For commercial studies, use study specific forms.

Process

- Right click on the “SAE” tab within the clinical chart and select “upload and...”
- For document type box select “Scanned item”
- To attach the SAE form to the EPR click on the browse button to locate it within the saved directory. The name of the uploaded document appears in the file to be uploaded box. Click “FINISH”. The SAE form is now visible under the SAE form tab. Please note: more than one SAE form can be uploaded if necessary if needed.

11. End of Study- Referral and Access Plan Closure

Close Referral

Once a patient has finished on a study, their referral should be closed. This section describes the process in which this is completed.

Process

- From within the patient’s EPR; select the Referrals tab
- Locate and select the referral you wish to modify
- Click on Close Referral from the List and Details menu.
 - o If there are outstanding encounters/activities associated with the referral then the system will not allow you to select/use the Close referral care activity; a pop up message will be displayed.
 - o If this message is displayed click “YES”. A list of encounters for that patient will appear. Expand each category (click on the +) and check which episodes relating to the referral you wish to close. Select the episode you wish to close by clicking on the relevant box on the left. Click the “MODIFY CONTACT” tab on the left. A new window will open. Press “NEXT” on this page. This will then open the “scheduling” page. Change the “STATUS” box on the

- right from Planned to “ACTUAL”, and click “NEXT”. Click “NEXT” again until you get to the “OUTCOME” page where in the Outcome box you’ll need to select “ONGOING ASSESSMENT” from drop down list, then click Finish “NOW”. Then click “FINISH” on next page that opens. Do this process for each of the episodes you need to close. Click on “REFERRALS” tab on right. Once this has been completed click again on “CLOSE REFERRAL”
- The Close referral screen will be displayed: complete mandatory data as required o If there are no outstanding encounters associated with that referral, the referral will be closed.

Closure of Access Plan

A patient’s access plan should also be closed once they are finished on a referral. This section describes the process in which this is completed.

Process

- Select “ACCESS PLANNING” from right hand tab. Check to see if any R&D access plans are open (Use Checking Access Plan Guide for this).
- To close an open access plan, select open access plan
- Click “CLOSE ACCESS PLAN” on the left hand tab
- Complete Requested by & Reason. Click “FINISH”. The access plan will then remove itself