Wentworth Healthcare

Blue Mountains | Hawkesbury | Lithgow | Penrith

Nepean Blue Mountains PHN

Practice Nurse Digital Health Training Workbook

phn NEPEAN BLUE MOUNTAINS

An Australian Government Initiative

Contents

Practice Nurses can upload a new Shared Health Summary after administering vaccinations

Introduction

Since the conclusion of the My Health Record Opt out trial, more than 350,000 people are now registered in the Nepean Blue Mountains region. Implementing My Health Record into the practice and uploading Shared Health Summaries and Event Summaries will ensure that all relevant health providers have access to important clinical information.

This training pack has been put together with information and suggestions gathered from different healthcare providers on how to best integrate uploading to the My Health Record system.

Please read and follow the booklet and attempt the interactive tasks set throughout. Please keep this booklet for evidence of continual professional development.

Please note that all screenshots have been taken from an online training environment and therefore all patient names and details are fictitious.

A certificate of completion will be provided on receipt of the tasks specified through the workbook (with the exception of task 2).

For assistance on tasks, please use the following contacts:

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Learning Objectives

1. Successfully interview a patient to update clinical software data.
2. Learn about Advanced Care Planning (ACD) and Advance Care Directives (ACD).
3. Select appropriate documents to upload to My Health Record.
4. Understand the appropriate opportunities to upload documents to My Health Record.
5. Understand how PENCAT can assist managing workflow.

Who is allowed to upload and view documents on My Health Record?

"To be a nominated provider, the person must be a medical practitioner, registered nurse, or an Aboriginal and/or Torres Strait Islander health practitioner with a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)."
(My Health Record, 2017)

What if the patient does not want something uploaded on My Health Record?

"*There may be information about your health that you don't want available on your My Health Record. If so, you can: ask your healthcare provider not to add it to your record, and they must comply with your request; or remove specific information from your record."*
(*Department of Health, 2016).*

Clinical opportunities to upload

There are occasions where as a nurse, you are required to perform assessments which are billed under particular item numbers. The most common ones will be discussed below.

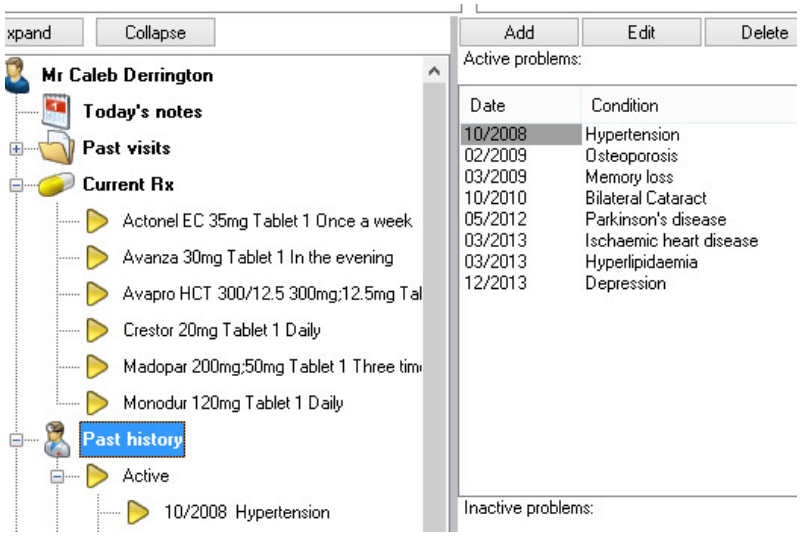
GP Management Plans/Team Care Arrangements (721/723)

Patients who have chronic health conditions are prime candidates for My Health Record. Other health professionals will be able to easily see any updates that you have made (provided they have registered to use it).

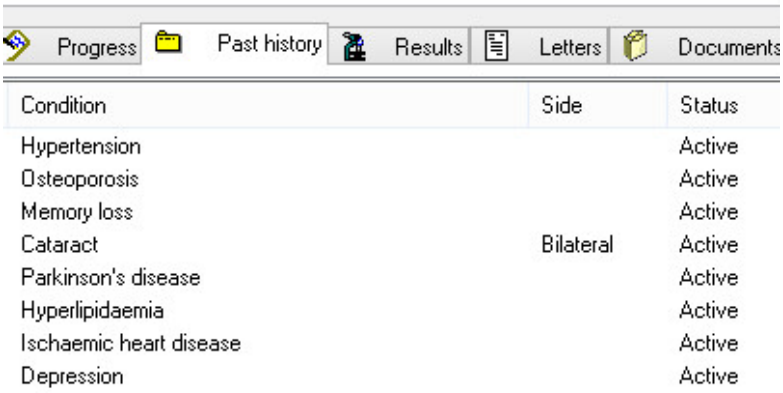
STEPS:

- Recall your patient for a GP management plan if eligible.
- Check patient demographics are up to date.
- Check the patient's allergies and reactions.
- Discuss the patient past and current medical history and update that in the clinical software.

Adding clinical history in Best Practice: Click past history and then click the 'Add' button.

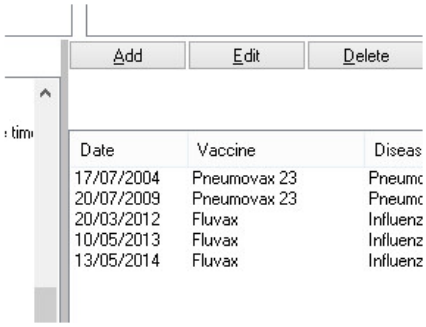


Adding clinical history in Medical Director: Click Past history tab and then right click on the screen. Click 'New Item'.

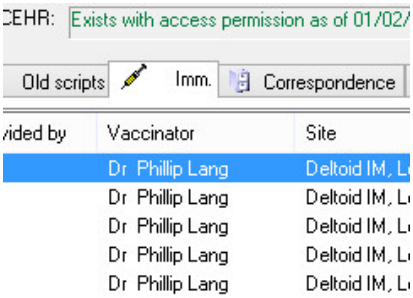


- Develop the care plan in consultation with the patient.
- Add any relevant information to the past history that may have arisen through the care plan development.

Checking immunisation tabs in Best Practice and Medical Director



Best Practice: Click 'Add' to update immunisations.



Medical Director: Right click on screen to update immunisations.

- Check that the current medication list is complete.
- Check that the immunisation history has been completed.
- Discuss with the patient before uploading a Shared Health Summary.
- Offer the patient some information on Advance care planning.

Health Assessments for patients aged 75 and over

The process to follow in this instance would be the same as the GP management plan workflow as described above, instead using the health assessment template.

Task 1:

When completing a health assessment or GP management plan, finalise the consultation by creating a Shared Health Summary for the patient.

Reflect on the experience and benefits of establishing rapport with the patient. Please add your answer under task one at the back of the booklet with a de-identified answer.

See the '**PENCAT TAB'** for identifying eligible patients aged 75 and over who have not yet had a health assessment using PenCat (if you do not have PenCat, you will need to do a search through your clinical software).

Immunisations

An updated Shared Health Summary includes the vaccination history. This is an opportunity to upload a Shared Health Summary once an immunisation has been administered. This is inclusive of people of all ages (babies, toddlers, and elderly) and those having vaccinations for overseas travel.

Many of the high risk patients that would receive vaccinations such as the flu shot, will benefit from having a Shared Health Summary uploaded.

The immunisation history can be updated as shown above.

Health Care Home

Patients who have their health managed under the Health Care Home (HCH) scheme, should have their My Health Record updated regularly. This is to improve the coordination and communication between healthcare providers, especially in the event of adverse events, such as attendance to an Emergency Department (Australian Digital Health Agency, 2016).

If your practice has applied and is accepted to be part of HCH all patients registered need to have their Shared Health Summary updated regularly.

Advance Care Directive and Advance Care Plan development

Advance Care Directives (ACD) are legally binding across Australia (RACGP, 2017). Any treatment plans for the patient will be decided in alignment with that document. Even an Enduring Guardian is bound by the rules of an ACD (NSW Health, 2004). If the patient, however, still has the capacity to make an informed decision, the ACD does not need to be applied (Lam, 2012).

Lam (2012) reports that some legal firms feel that ACD can hinder the process of allowing the Doctor to make clinical decisions based on the patient's current condition.

An ACD must not contain the requests of any activity that can be illegal, such as euthanasia (NSW Health, 2004).

Advance Care Plans (ACP) ensures that the patient's wishes are strongly taken into account when a patient can no longer make informed choices regarding their health (RACGP, 2012). The RACGP (2012) recommends that discussions surrounding the development of these plans take into account the patients overall life goals, their values and beliefs and how they determine their quality of life.

Task 2:

1. Source an advance care planning document.
2. Fill out the form for yourself and think about your own feelings in how you would like to receive your health care.
3. Scan and save in PDF format if you would like to save document.
4. OPTIONAL: Choose whether to upload a version to your own My Health Record.

A patient can determine their own medical treatment through common law (NSW Health, 2004)

Going through the process yourself, may assist in facilitating conversations with a patient who may wish to discuss their options. Additionally, the patient should also discuss their choices with their family (Australian Digital Health Agency, 2016) and let them know of their wishes regarding end of life care.

Copies of Advance Care Directives or Advance Care Plans need to be available to treating clinicians in order for it to be followed. The next of kin or person responsible should also have a copy (NSW Health, 2004). In the absence of documentation, Doctors are able to make clinical decisions which they deem reasonable and appropriate until such a time the

directive is brought to the attention of the treating Doctor (Johnson, Singer, Masso, Sellars & Silvester, 2015). These copies also need to be kept as current as possible, around every 2-3 years as patients may change their minds about what they want, especially if advances in treatments prolong the quality of life (Lam, 2012).

Enduring Guardians are those people appointed if the patient loses capacity to make informed decisions (Lam, 2012).

> "an individual's right to self-determination prevails over the state's interest in the preservation of life even though the individual's exercise of that right may result in his or her death" *Justice McDougall – Hunter and New England Area Health Service v A, 2009 NSWSC 761 (Lam, 2012, p.17)*

There are ACD and ACP templates available should you choose to offer those. Please contact us if you would like further details.

Advance care plans and directives are not routinely created for people. Many people admitted to nursing homes or hospices did not have any formal directives in place (Johnson, Singer, Masso, Sellars & Silvester, 2015).

Having and ACP/ACD assisted health professionals to plan ahead, communicate and make the end-of-life process easier and more bearable for both family and the patient(Johnson, Singer, Masso, Sellars & Silvester, 2015).

Johnson, Singer, Masso, Sellars & Silvester, (2015) has detailed initially that in order for ACP/ACD to be effective is that they must be seen. Health professionals with My Health Record access can see directives that patients upload through the myGov portal. The second note is that they need to be created in a personalised manner, which makes a Practice Nurse an ideal candidate to talk future plans with regarding their healthcare.

Suggestions to approach creating advance care plans/directives:	
The patient brings up the topic themselves or you may end up broaching the topic with the patient	You could start by asking them how they feel their life would be unbearable, should they be unable to walk/speak etc. In conclusion, pass on some information that you have acquired that they can take home & offer them a ACP template that they can read through. If the patient would like to create an ACD, they will need to make a consultation with their Doctor to discuss.

For future reference, leaflets can be printed out from this website:

http://planningaheadtools.com.au

Using PENCAT to maximise efficiency in the practice cohort

See the next page for instructions on how to access the quantity of Shared Health Summaries uploaded by your practice.

PENCAT can also assist in identifying patients who will benefit from using a digital health record.

Task 3:

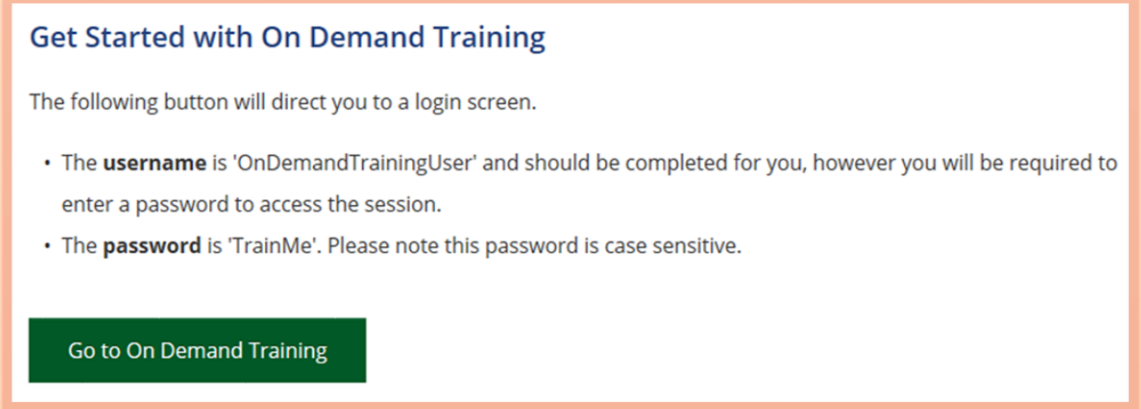
Which cohorts of patients would benefit the most of having a digital health record?

Add your response to ‘Task 3’ at the back of the booklet.

Creating a Shared Health Summary from a clinical consult

Task 4:

1. Go to www.digitalhealth.gov.au
2. Click 'On Demand Training' and scroll down till you find the button "Go to On Demand Training" as shown below.



3. Click on your preferred clinical software system (eg/ Medical Director).
4. Create a Shared Health Summary from the following scenario:

You have recalled Caleb Derrington for a health assessment. You begin the health assessment. In addition to his current needs on the computer, you also discover through your consultation that he has also been experiencing bradykinesia. You log onto his My Health Record and discover a discharge summary. It explains that he had a fall and has discharge instructions to see a neurologist. He has also had some medications changed. He hasn't seen his GP about this yet.

5. Add the extra medications that the hospital prescribed
6. Add the bradykinesia to the significant history.
7. Add any other information from the scenario that would help populate the record.

Feel free to make fictitious information should it be unavailable in the scenario.

Take a screen shot of the Shared Health Summary that you have created and send to mhr@nbmphn.com.au for feedback with 'Task 5' in the subject line.

Creating an Event Summary from a clinical consult.

Task 5:

Developing an event summary.

Caleb attended the GP with a painful right forearm after reporting that he had a fall at home. He had x-rays and a fracture of the ulnar has been confirmed.

1. Create and upload an Event Summary in the 'on demand training environment' as shown in the previous task.

Please write down what you would put in the event details box in relation to the case study below. You are welcome to create any fictitious information to assist you in creating a thorough event summary. For feedback on your event summary, send your responses to mhr@nbmphn.com.au for feedback with 'Task 6' in the subject line.

Clinical consultations and My Health Record document

Different occasions of clinical consultations mean that different documents can be uploaded to My Health Record. Taking in

Task 6:

Draw a line to match the appropriate visit to the correct digital health document.

Health Assessment

Flu vaccination

Broken leg

Stroke — **Event Summary**

COPD

Asthma cycle of care — **Shared Health Summary**

Cancer screening

Add your response to 'Task 4' in the back of the booklet.

Continuity of care

There is evidence where a lack of continuity of care has impacted negatively on patients' health.

A connected digital community is beneficial to ensuring that the patient receives reliable and accessible health care.

Task 7:

Who are the health professionals that you need call upon to be a part of your connected community?

Contact those health professionals and establish communication guidelines for discussing your patients. An example would be to ask the Podiatrist to upload an event summary for the first, third and last (5^{th}) visit of the patient's care plan. That way, the practice can see the progress and treatment patterns undertaken.

Write a paragraph on how your connected community impacts on the quality of care for the patient. Add your response to 'Task 7' in the back of the booklet.

Task 8:

List a benefit of digital health to the following people:

1. Patient
2. General Practitioner
3. Practice Nurse
4. Specialist

Add your response to 'Task 8' in the back of the book.

Task 9: True or False

- An Enrolled Nurse can create a Shared Health Summary.
- You should upload a new Shared Health Summary when a vaccination is given.
- A patient can be billed for uploading a Shared Health Summary as long as the patient is also receiving a clinical service
- You need to have access to clinical software to upload an Event Summary or Shared Health Summary.
- You are able to upload a Summary through the online provider portal access.
- A coded diagnosis is a secret message to your patient.
- If a patient doesn't have a Medicare number they can still get a My Health Record.

Write your responses under 'Task 9' in the back of the book.

Some ways to help you keep in contact with your community:

- Practice nurse network meetings.
- Practice nurse leadership meetings.
- Attending CPD events run and supported by NBMPHN.
- NBMPHN Practice nurse private Facebook group. For details on how to join, please email georgina.mchugh@nbmphn.com.au

For Fun: Digital Health Crossword

Solve the clues then find the answer in the find a word.

M	E	D	I	C	A	T	I	O	N	P
S	E	I	G	R	E	L	L	A	D	A
E	E	R	U	T	C	A	R	F	I	B
S	H	A	R	E	D	R	A	H	S	Y
P	P	S	B	V	I	H	M	E	C	C
P	H	K	A	P	G	P	H	G	H	A
I	S	N	Y	N	I	A	T	L	A	M
P	C	P	A	P	T	E	S	T	R	R
E	V	E	N	T	A	R	A	V	G	A
A	G	T	D	F	L	U	R	K	E	H
E	M	E	R	G	E	N	C	Y	M	P

- Seretide belongs on the (10) list on a Shared Health Summary
- Upload a new _____(6) health summary when a new medication is added
- My Health Record is managed by the Australian _____(7) Health Agency
- A form of cancer screening for women _____(7)
- Documents uploaded by hospitals, _____(9) summary
- _____(7) Care Plan
- Patient _____(9) and reactions need to be updated. These will be uploaded on a Shared Health Summary
- _____(5) Summary
- _____(6) is a respiratory illness
- A common vaccination for the elderly ____(3)
- A break _____(8)
- This place will appreciate the information included in a Shared Health Summary _____(9)
- Where to get additional information about digital health ___(3)
- Health professionals which dispense medications _____(8)
- Advance care plans need to be uploaded in this format ___(3)
- Incentive payment ____(4)
- Security certificate ____(4)
- Registered Nurse and Doctors regulation authority _____(5)

REFERENCES:

- Australian Digital Health Agency, (2016). *The Health Care Home*. Retrieved from https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/news-016
- Australian Digital Health Agency, (2016). *My Wishes, My Plan. Advance Care Planning.* Retrieved from https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/acp
- Department of Health, (2016). *Essential Information.* Department of Health: Sydney.
- Johnson, C., Singer, R., Masso, M., Sellars, M., & Silvester, W., (2015). Palliative Care Health Professionals' Experience of Caring for Patients with Advance Care Directives. *Australian Health Review.* 39(2): 154-159.
- Lam, M., (2012). Vital Choices: Making Advance Care Directives. *Law Society Journal.* 50(5): 16-19.
- My Health Record, (2017). *Frequently Asked Questions.* Retrieved from https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/find-out-more?OpenDocument&cat=Managing your My Health Record
- NSW Health, (2004). *Using Advance Care Directives NSW.* Department of Health: Sydney.
- RACGP, (2012). *Position Statement: Advance Care Planning Should be Integrated into Routine General Practice.* Sydney: Royal Australian College of General Practitioners.
- RACGP, (2017). *Advance Care Planning.* Retrieved from http://www.racgp.org.au/your-practice/business/tools/support/acp./

Task responses

Task 1:

_____

_____

_____

_____

_____

_____

_____

Task 2:

Does not need to be submitted.

Task 3:

_____

_____

_____

_____

Task 4: Please take a screen shot of the Shared Health Summary and email to mhr@nbmphn.com.au with the subject line 'Task 5'. An email will be sent back to you to confirm receipt of the task.

Task 5: Please take a screen shot of the Event Summary and email to mhr@nbmphn.com.au with the subject line 'Task 6'. An email will be sent back to you to confirm receipt of the task.

Task 6:
Draw a line to match the appropriate visit to the correct digital health document.

Health Assessment	
Flu vaccination	**Event Summary**
Broken leg	
Stroke	**Shared Health Summary**
COPD	
Asthma cycle of care	
Cancer screening	

Task 7:

Who are the health professionals that you would call upon to assist in the care of a patient?

_____

_____

How does a well-connected community benefit the health of the patient?

_____

_____

_____

_____

Task 8:

1. Patient:

   _____

   _____

2. General Practitioner:

   _____

   _____

3. Practice Nurse:

_____

_____

4. Specialists:

_____

_____

Task 9:

- An Enrolled Nurse can create a Shared Health Summary.

  True or False.

- You should upload a new Shared Health Summary when a vaccination is given.

  True or False.

- A patient can be billed for uploading a Shared Health Summary as long as the patient is also receiving a clinical service.

  True or False.

- You need to have access to clinical software to upload an Event Summary or Shared Health Summary.

  True or False.

- You are able to upload a Summary through the online provider portal access.

  True or False.

- A coded diagnosis is a secret message to your patient.

  True or False.

- If a patient doesn't have a Medicare number, they can still get a My Health Record.

  True or False.