

Design principles core concepts, consistency and standardisation for the WCP, DHCW eForms and related software

Use these standards to build consistent user interfaces and present information clearly.

Each standard in this document has been finalised and is ready for use.

More standards will be added over time.

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Introduction

Use this document to improve consistency across all NHS Wales procured, supplied and developed software, including the WCP (Welsh Clinical Portal) and WNCR (Welsh Nursing Care Record).

This document will be updated frequently to reflect new ideas, including DHCW and stakeholder input. Do not download the document as it may become out of date. Instead, visit the [UI Standards Teams channel](#) for the latest version.

The concepts and principles apply firstly to DHCW eForms, then the WCP, then other DHCW products. This document should be included or referenced in future procurement specifications.

The final authority for design issues for the WCP, DHCW eForms and related software is the DHCW clinical and technical design team.

The standards for eforms in this document are focussed on desktop applications, we do not yet have a standardised design for eforms on mobile.

Core concepts / Principles

These are concepts or rules that have been agreed by DHCW or have emerged during the evolution DHCW owned systems. All colleagues must be aware of these concepts and rules and apply them in their work to avoid repeating past errors. Core concepts and rules usually override individual requirements, and this should be communicated to stakeholders.

Anything that happens to a patient or is done to a patient in a health care context must be recorded by a permanent entry in the medical record. This is visible to those people who have a legitimate right to view that record. Entries must be dated, time stamped and attributed, whether this is the complete document or to individual sections.

An electronic medical record must be able to display a timeline of events for the patient.

The principles and rules in this document are applicable to all WCRS documents.

This document should be read by all PMs, BAs, designers and devs (including third parties), before doing any design (terminology, language, abbreviations, user interface conventions and guidelines, regulatory rules).

Core Concepts / Principles

A WCP/Wales Care Records Service (WCRS) document or form typically represents a single event, attributable to a single person, on a patient's timeline. A single version of a document has an event date, a document date and a single author.

Where applicable, documents can be edited to create a new version of the document, and, where identified, revised or additional sections can be attributed to a different author.

Mapping of forms and clinical processes to documents can be difficult. A common error is combining what should be two or more documents or processes into a single form.

This aspect of a form's design should be reviewed by the clinical and technical design team before detailed design and technical work starts, to avoid any re-work.

There is consensus that it would not be pragmatic to apply the above to existing forms or forms that are currently work in progress, but that these should be applied to new forms and as forms are updated.

If you have any queries, comments or suggestions please email WCPAndUIStandards@nhs.wales.uk

Examples of events which should be represented by a single document include:

- A consultation or assessment by a nurse or other health care profession, for example an Outpatient medical note.
- A hospital inpatient episode – for example a Discharge advice letter.
- A test request.
- A result sign off.
- Recording action taken as a result of looking at a test request.
- Transcribing medications.

The principles are based on, in approximate order of importance:

- Consistency.
- Clinical and professional rules, standards and conventions.
- Industry and academic rules, standards and conventions.
- NHS Wales and DHCW precedents and existing practice.

Introduction

Working Practices

All colleagues involved in stakeholder engagement and WCP design and development are expected to follow these practices:

- Read this document.
- When the document is updated, read the updates - the different versions will reference the changes made.
- Feedback any omissions or suggestions for improvement.
- Plan to make your outputs consistent with the principles in this document.

When engaging with stakeholders and creating designs or associated documentation:

- Stick to the principles in this document.
- Copy wording and diagrams from this document and adapt them, this document will be updated to include stock diagrams.
- If necessary, work with the clinical design team to come up with new concepts, wording and diagrams consistent with those in this document, which will be included in future versions.

Explicitly reference, for example:

- (a specific version of) this document
- "standard DHCW date format"
- "standard DHCW form layout"
- "standard DHCW author section"
- "standard DHCW date control"

When developing software or forms:

- Apply the principles in this document
- For a given user interface construct (form, patient banner, section or question), use the same HTML, CSS and Javascript
- If a design element is not covered by this document, work with the clinical design team to come up with a solution - this document will be updated to include the new solution
- If a design element seems unachievable, work with the clinical design team to come up with an alternative which is consistent with the principles in this document - this document will be updated to include the alternative.

Accept that compromise, care and attention to details may be necessary

Consistency

Consistency should apply to core concepts, business rules, the underlying data model, user interactions, presentation of information and the user interface.

Consistency can be achieved in many ways across NHS Wales procured, supplied and developed software, including the WCP and WNCR, for example a group of radio buttons or checkboxes.

The benefits of consistency with software include:

- Being easier to learn, remember and use
- Fewer surprises
- Fewer mental hurdles
- Better user experience and fewer user errors
- Easier, faster stakeholder engagement process
- Easier, faster design process and development, resulting in a shorter “time to market”
- Better, more reliable interoperability between software components and third-party software
- Easier to check and test
- Fewer bugs, resulting in fewer bug reports and service calls
- Improved performance
- Reduced training needs
- Better reputation and data
- Fewer risks and better outcomes for patients

NHS number

The NHS number must be:

- Separated into number groups of 3, 3, 4
- There must be a space after the third and sixth numbers

Good Example:

123 456 7890

Bad Example:

1234567890

Give space

Give space

123 456 7890

3

3

4

Non NHS Wales

When a form requires a user to search for any location or site that is outside Wales, or where it might be inside Wales but is a non NHS site,

please use the field label of "Non NHS Wales" rather than "Non-NHS Wales". No hyphen is used.

GPs are technically not employed by the NHS, but for the purposes of our forms they are included as NHS Wales.

When this field is used, include this hover text on the field label: "**NHS Wales includes both primary and secondary care**", i.e. you would not use this field if you were searching for a GP based in Wales.

Note, hover text is only available currently on desktop applications and not mobile.

Presentation of information

Sentence case

All text should be in sentence case. For example, Senior responsible clinician, **not** Senior Responsible Clinician.

Display of users' names

A clinician's name should be followed by their job role and speciality.

An exception can be made when the speciality is already present, or there is no room for it, for example:

Outpatient medical note

Event Date: 07 Dec 2021

Specialty: **Rheumatology**

Senior responsible clinician: LAWSON, Thomas M, Mr (GMC:3489251)

Whilst it is acceptable to display a GMC or PRN number, or a NADEX, it is never acceptable to display a PIN number for a registered nurse.

Right sentence case:

Senior responsible clinician

Wrong sentence case:

Senior Responsible Clinician

For example:

HURLE, Rhidian A, Mr (GMC:2567890), Consultant, Urology

PRICE, Lucy C, Mrs (PRN: DT11782), Dietitian

DAVIES, Anne, Mrs (NADEX:AD202399), Medical Secretary

1. Name & GMC

3. Speciality

HURLE, Rhidian A, Mr (GMC:2567890), Consultant, Urology

2. Job role

Presentation of information

Drop down menu

An arrow  must be used as the symbol on all dropdown menus. This should be consistent across all forms.

You must not use a  triangle.

For example:

Send results to: *  Unknown or not recorded 

Not:

Send results to: *  Unknown or not recorded 

Abbreviations

Avoid using abbreviations. They are known to cause clinical errors.

Do not put full stops  between letters when you use an abbreviation or acronym, for example:

say ECG **not** -E.C.G.

If you cannot avoid using an abbreviation, for example due to limited space, you should use a tooltip that shows the word in full. Use a dashed underline  on the abbreviation to make it clear there is a full explanation if you hover over it.

There are a small number of **acceptable abbreviations**:

Titles, for example: **Dr, Mr, Mrs**

Units of measurement, for example: **cm** and **kg**

You can say **mg instead of milligrams**.

However, you must say micrograms in full to avoid confusion.

Example:

To come in
 TCI

Presentation of information

Apostrophes and contractions

Avoid using apostrophes and contractions where possible, for example 'it's' and 'can't'.

Using the **full words is clearer for users** and helps to prevent incorrect apostrophe usage, which can create a poor impression.

If an apostrophe is essential but you're unsure if it is being used correctly, seek advice.

Ampersand

Use the word '**and**' rather than an ampersand **(&)** unless it is part of a brand name.

Forward slash

Use the word '**or**' rather than a forward slash **(/)**.

Default values

Use default values where possible. This helps to save clinicians' time and improves usability.

Be clear in user stories when a data item has a default value, rather than "Unknown or not recorded" or "Not recorded"

Standard DHCW **date of birth** format

Display the date of birth followed by the age in brackets.

Use the following abbreviations: **For example:**

Minutes - display **min**

Hours - display **h**

Days - display **d** 12-Oct-2019 **(1d)**

Weeks - display **w** 12-Sep-2019 **(4w)**

Months - display **m** 12-Apr-2019 **(6m)**

Years - display **y** 12-Oct-2018 **(1y)**

If the person is:

over 18 years, display years

2 years up to 18 years, display years and months

12 months up to 2 years, display months and days

4 weeks up to 12 months, display weeks and days

2 days up to 4 weeks, display days

2 hours up to 2 days, display hours

less than 2 hours, display minutes

Chronologies of events

The default order for chronologies of events should be displaying the oldest record first, but there are exceptions to this rule which are currently being reviewed: 2 of which are currently the list of documents and the list of test results, both of which show the latest at the top.

Where possible, a user should be able to sort on a list, to change the order.

If the list presents with a vertical scroll bar, it is advisable that the latest entry is at the top.

An exception can be made when the chronology of events needs to match an existing process.

For example,

If you need to change the order but there is no existing process to match, it should be approved and discussed with the 'Design authority' group (currently in the process of being set up). In the meantime, for any changes email WCPAndUIStandards@nhs.wales.uk

Example:

Date Received/Scheduled	Time Received	Test(s)
		x
14-Dec-2021	12:58	CRP,FBC,UUER [Request]
10-Dec-2021	15:32	Sialogram parotid Lt [Request]

Tables are presented with items in chronological order with the most recent first. However, users should be able to sort any column (when applicable).

An arrow at the top of these columns will indicate which columns can be sorted. This is a feature currently available in the WCP and WNCR.

Presentation of information

Toolips and explanatory text

Diagnosis

Last updated or confirmed 14-Jan-2021 @ 16:30 by EVENS, Ceri,

No diagnosis

Provisional diagnosis

Definitive diagnosis

Confirm s

Often used for disease reporting and statistics. Should usually have been agreed by an appropriate senior responsible clinician or MDT before it is recorded here. Should NOT be based solely on a biopsy report.

Close

- Do not use an information icon.

Medications

The NPSA guidance contains a wealth of information and recommendations to be followed when recording and viewing medicine information.

There is too much information to display here in the UI standards document, so please familiarise yourself with this guidance when creating any eforms that involve medications.

[View the NPSA guidance](#)

- Use tooltips if you need to give more information to a user to help them complete a field.
- The user should see the tooltip automatically when they hover over the field, or when the question has keyboard focus.
- The tooltip should not hide any part of the question that it relates to.
- The tooltip should still be displayed if you click in a field to enter text. If the user no longer wants to see the tooltip, then "Close" can be selected. However, if the focus is moved away from this field, the tooltip will be removed automatically, but will appear again if the focus is returned to this field

Examples of how to list medications include:

Erythromycin - gastro-resistant

DOSE 500 mg - oral - four times a day

Latanoprost - 50 micrograms per mL - eye drops

DOSE 1 drop - ocurrar- both eyes - once a day at night

Warfarin

DOSE dependent on INR - oral - once a day at 18:00

Digoxin

DOSE 250 micrograms - oral - once a day in the morning

Form design, font sizes and spacing

Standard WCP design is based on best practice guidelines for usability.

The aim is to create standard templates for each form type, for example electronic test requesting (ETR).

Check Shades of Pale for existing templates and best practice.

[**Found here**](#) username and password can be requested from Steve Shering.

Fonts

Specify a relative font size to allow users to zoom in and change the resolution. A font size of 1, or 1REM would be the standard 12 point font. A font which is slightly bigger is classed 1.2, and one that is smaller is 0.8.

View all [**design**](#), [**font sizes**](#), [**spacing**](#) and [**colours**](#) in the appendix.

Line spacing

The blue bars with the white writing has good contrast, so the text is easy to read. The spacing between the text and the edge of the blue bar ensures the best possible legibility.

In the Read only view, the content of the field becomes larger than its heading to add emphasis. It is important that the spacing between the heading and the content is smaller than the space between the content and any other heading below it.

This is an example of good spacing:	This is an example of bad spacing.
Host organisation University Hospital of Wales	Host organisation University Hospital of Wales
New or follow-up Follow-up	New or follow-up Follow-up
Meeting date 15-May-2021	Meeting date 15-May-2021
<p>The spaces are all even and it is more difficult to read:</p>	

Table option 1

This standard table is to be used in most cases. This table type:

Is suitable to be added to over time, possibly by more than one user

Allows a user to select a button that opens a new screen to enter in the data

Has a burger menu on the far right to edit or delete an entry

Has rows that can be reordered - a decision should be made during its design about which columns need a sort arrow

Should display struckthrough entries in the date order they were added, not the date they were struckthrough

Performance status

Date	WHO performance status	ASA classification	Clinical frailty score	Lansky performance scale	Authored by
15-Jun-2018	1	1	1		JONES, Connor M, Mr (GMC:236789), Consultant Surgeon, 17-Jul-2018
16-Aug-2018	1	1	1		PETERS, Clare M, Ms (NADEX:cp123987), MDT Coordinator, 16-Aug-2018
01-Jan-2021	1	1	1	90	PETERS, Clare M, Ms (NADEX:cp123987), MDT Coordinator, 16-Aug-2021

Add performance status

← Selecting 'Add performance status' opens up a separate screen to add in the data.

Burger Menu

Add performance status

Date*

dd-Mmm-yyyy

WHO performance status

ASA classification

Clinical frailty score

Lansky performance scale

Add another

Ok

Cancel

Tables

2 table types can be used:

Table option 2

This table type:

Is suitable for when more than 1 entry needs to be added at the same time, for example adding entries for a treatment plan.

Is slightly quicker than option 1, and does not have the attribution for each user. The attribution statement under the section heading will display the last user who updated this table.

Is editable 'in situ', without having to click an edit option.

Has no sort order arrows in the column headings, the rows can be sorted using the arrows in column.

Treatment plan options

Option	Order	Modality	Intent	Intent	Completed	Data completed
⚡	▼	▼	▼	▼	<input type="checkbox"/>	dd-Mmm-yyyy <input type="button" value="x"/> 
⚡	▼	▼	▼	▼	<input type="checkbox"/>	dd-Mmm-yyyy <input type="button" value="x"/> 
⚡	▼	▼	▼	▼	<input type="checkbox"/>	dd-Mmm-yyyy <input type="button" value="x"/> 

Add treatment row

Try to **avoid** having an attributed table and other data in the same section.

If just a attributed table exists in a section, there is no requirement to have an Attribution statement

Status badges

There are several Status badges that are used to identify the status of forms and PDFs.

These are used in place of watermarks.

These status badges will be the size required to fit the text and will not all be the same size.

When more than one status badge is displayed on a document, they will be listed in alphabetical order.

Forms

The following status badges will appear, where applicable, at the top left-hand side of the eForms in a red box with white text, above the Document title.

Draft Countersignature required

Highly sensitive Not checked by author

Forms - An example of their placement is as follows:

Highly sensitive
Document title
Site: Hospital site, healthboard or hospital site
Event date: dd-Mmm-yyyy
Specialty:
Senior responsible clinician: SURNAME, Forename Middle Initial, Title (PRN:####), Role of main specialty
Author:
Version:
 General practitioner C DAVIES WILLOWBROOK SURGERY STRATHY ROAD SAINT MELLONS
 123 456 7890 CRN A000001A
DUCK, Donald 13-Feb-1986
10 Heol Creigau Sex not specified
Pontypridd
Cardiff
Rhondda Cynon Taf, XX12 3XX

Presentation of information

Status badges

Draft

As well as a “Draft” status badge appearing on the actual document and the PDF, a “Draft” status badge will appear in the metadata, when a form requires finalising.

PDFs

The following status badges will appear, when applicable, at the top left-hand side of the PDFs, in a black box with white text, directly above the Document title.

Countersignature required **Draft** **Superseded**

Highly sensitive **Misfiled** **Potentially misfiled**

Not checked by author

Note: Misfiled, Potentially misfiled and Superseded status badges will not display on the forms as the forms are not editable when they have these statuses.

Outpatient medical note

Event Date: **11 May 2022**

Draft

(v1)

Specialty: **Cardiology**

Senior responsible clinician: **AVERY, Philip G, Dr (GMC:2837176)**

Author: **PRITCHARD, Patricia, (GMC:), Business Analyst, Dermatology**

Site: **Amman Valley Hospital**

[Edit](#)



PDF - An example of their placement is as follows:

Highly sensitive

Document title

Site: Hospital site, healthboard of hospital site

Date: dd-Mmm-yyyy

Specialty:

Senior responsible clinician: SURNAME, Forename Middle Initial, Title (PRN:####), Role of main

Author:

Version:

When a status badge is present, this must be displayed on every page of the PDF

Presentation of information

Mutually exclusive options

Where there is only one possible option for the user to select, consider the following:

- 2-5 options: use a radio button group, this minimises mouse clicks and mouse movement.
- 6-15 options: use a simple drop-down list, that displays all the options.
- Greater than 15 options: use a dropdown list with fuzzy matching.

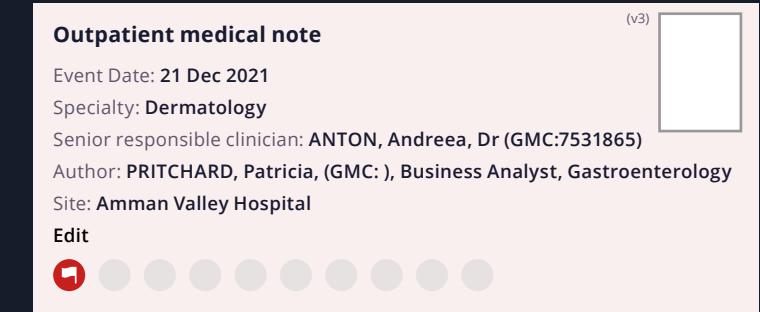
Read more information about [fuzzy matching](#)

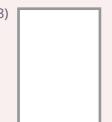
Viewing Highly Sensitive information

When a document is marked as "Highly sensitive" the document tile will show the following:

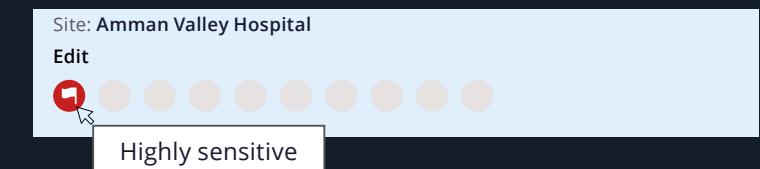
- The background will be pale pink, and turns blue when hovered over
- The highly sensitive icon will appear, which is a white flag on a red circle
- Hovering over the icon will show a tooltip that reads "Highly sensitive"

Document overview example:



Outpatient medical note
(v3) 
Event Date: 21 Dec 2021
Specialty: Dermatology
Senior responsible clinician: ANTON, Andreea, Dr (GMC:7531865)
Author: PRITCHARD, Patricia, (GMC:), Business Analyst, Gastroenterology
Site: Amman Valley Hospital
[Edit](#)

Hovered over example:



Site: Amman Valley Hospital
[Edit](#) 


Highly sensitive

Presentation of information

Patient banner

The patient banner will appear when a patient is selected. It is split into three sections.

Left hand section:

This is the red box containing adverse reactions and patient warnings.

Middle section:

This is contained with a grey border and has the following details:

- If the patient is an inpatient, the Ward and SRC will be displayed, with the Ward name and SRC information in bold text.
- Hovering over the SRC will display the Speciality.

- Icon for Welsh language if this has been recorded as the patient's preferred method of spoken communication.

- Orange warning triangle icon if the patient has other hospitals IDs within the same health board.
- Print icon, to print out a set of patient labels.
- If the patient is deceased, the words "Patient deceased" with the date of death will be underneath the icons,

with white text and a burgundy background.

- Link to "Advanced care plan".

Right hand section:

Patient addressograph label.



The screenshot shows the Patient Banner interface with three main sections:

- Adverse reactions:** Last updated by CHURCHILL 17-Mar-2021 15:57. Contains entries for Peanut: Anaphylaxis, Benzylpenicillloyl polylysine: Anaphylaxis, and Erythromycin: Nausea. Buttons for 'Confirm/Edit' and 'Hide' are present.
- Warnings:** Last updated by PYE 14-Apr-2021 14:21. Contains 5 warnings. Buttons for 'Confirm/Edit' and 'Hide' are present.
- Patient Details:** Shows the patient's Ward (RGH AMU Ward 4), Doctor (Dr JONES, Andrew W. (GMC:645347), Consultant Cardiologist), and the date of death (Patient deceased 19-Nov-2020). It also displays the advance care plan status (Advanced care plan discussed).

At the bottom, there is a message: "Highly Sensitive information is DISPLAYED. [HIDE](#) for this patient. * 1 active user(s) [Show](#) * Add to watch list: 0 notifications, [click here to see first](#). * All available tests are displayed (not just PIT3 DRS Environment)."

A close icon, which will close the current patient.

Presentation of information

Radio buttons

You should use a radio button when users are only required to select 1 option. If you use 6 or more radio buttons a drop-down list may be more suitable, but this should be reviewed on an individual basis.

'Yes / no' radio buttons

'Yes / No' radio buttons are an exception to the alphabetical rule. You must always add a third option of 'Unknown or not recorded' as this allows the user to deselect 'Yes' or 'No' if they were selected by mistake. This option should always appear at the end of the list.

The radio buttons should appear in this order:

- Yes
- No
- Unknown or not recorded

If an option for 'Other' is also needed, this should be placed before 'Unknown or not recorded', or as the last option if 'Unknown or not recorded' is not present.

The 'Other' option should open a non-mandatory free text box, but only when the radio button is selected to avoid cluttering the screen. The free text box should appear to the right of the list if possible.

Radio buttons must:

- Have a heading label above them
- Be aligned to the left
- Be displayed in one column
- Have individual labels to the right of each radio button
- Be in alphabetical order where possible. If another order is needed this should be documented in the design specification

All options should be in alphabetical order unless explicitly stated in the design documentation, or where there is a standard set of answers which have been designed to follow a specific order.

Presentation of information

Checkboxes

Use a checkbox when users can select more than one item from a list

Checkboxes should:

- Have a heading label above each group
- Be aligned to the left
- Have labels on the right
- Be in a single column, unless there is a large number of options – you may want to consider a design change in this instance as checkboxes may not be the right format to record the data
- Be in alphabetical order

If you include an 'Other' checkbox option, it should be at the end of the list. A free text box will appear once ticked, and it should be decided on a case by case basis as to whether this free text box is mandatory

Example:

Reason for discussion

- Make treatment plan
- Post-mortem case review
- Review imaging
- Review other pathology
- Review post-operative pathology
- Review treatment plan
- Second opinion
- Other

Single checkboxes

You can use a single checkbox to confirm that a user has read or checked information. You can also use one to show or hide information.

For **Yes or No** questions,
use a radio button group instead.

All options should be in alphabetical order unless explicitly stated in the design documentation, or where there is a standard set of answers which have been designed to follow a specific order.

Functionality

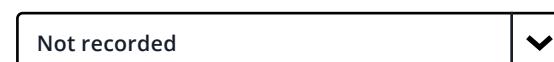
Dropdown lists

The default value for a dropdown, before the user selects an option, should usually be "Unknown or not recorded".



Where the question is based on a pre-existing standard or specification where one of the options is "Unknown", then the dropdown option of "Unknown or not recorded" must be split into two separate options of "Unknown" and "Not recorded". "Not recorded" will then be the default value.

This allows the option of "Unknown" to be selected where it is important to record that a particular value was not known at the time of recording.



All options should be in alphabetical order unless explicitly stated in the design documentation, or where there is a standard set of answers which have been designed to follow a specific order.

The default value should never be blank.

When counting completion of mandatory fields, "Unknown or not recorded" or "Not recorded" must count as not completed.

In WCP forms, if a dropdown is mandatory and "Unknown or not recorded" or "Not recorded" still remain as a value, then the form cannot be marked as final and the "Final" or "Final/Send" checkbox will be inactive.

In the case of forms that do not have a "Final" or "Final/Send" checkbox, the user will not be able to save and close the document until these dropdowns have been changed and they will receive the standard red label against the relevant field that still needs completing.

In PDFs where dropdowns have not been completed, for example still have the "Unknown or not recorded" or "Not recorded" options, these will not be included in the PDF unless explicitly requested in the design specification.

The rationale for not having dropdowns blank by default is:

- Blank is ambiguous and could mean "Unknown", "Not recorded", "Not applicable", "Error in the save data.. Should "save" also read "Saved"?," "Error in the form implementation"
- "Unknown or not recorded" is more likely to encourage users to make a selection than a blank value

Functionality

Auto learning users' favourites

Users may benefit from being presented with items that they select the most when they click on a field.

When designing the form, consider:

- The number of items that a user should be presented with
- Allowing a user to remove items from the list that they no longer consider to be a favourite, and still type into the search field to find other tests

For example, in the Radiology request form, when a user clicks into the “Add test” field, a list of up to 30 of their most selected tests can be viewed before they have even typed in any search criteria. The small cross on the left-hand side allows the user to remove this item from the list.

Add test

Search for tests...	<div style="border: 1px solid #ccc; padding: 5px; margin-bottom: 5px;"> × XR Ankle Both + </div> <div style="border: 1px solid #ccc; padding: 5px; margin-bottom: 5px;"> × MRA Neck + </div> <div style="border: 1px solid #ccc; padding: 5px; margin-bottom: 5px;"> × CT Head + </div>
---------------------	---

Dates

The date **should have**:

- 1 or 2 numbers for the day - for example 8 or 22. However, when the date is displayed in a field like the **date picker**, it must have a leading zero: **02-Oct-2021**
- 3 letters for the month, starting with a capital letter
- 4 numbers for the year
- Each component is separated by a dash (-)

Good Example:

2-Oct-2021

02-Oct-2021

2-Oct-2021

2-Oct-2021

2-Oct-2021

Bad Example:

2/OCTO/21

2-OCTO-2021

2-Oct-21

2/OCT/2021

Time format

Time fields should always be in the 24 hour clock format

12:58

Functionality

Date/time picker

The **date picker** should:

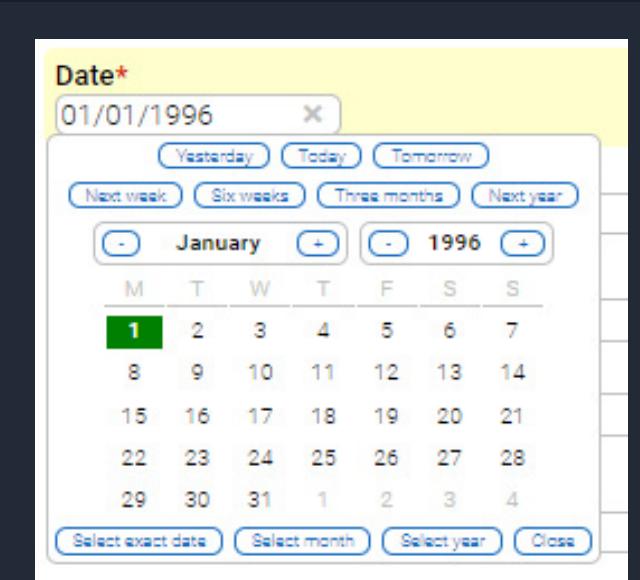
- Launch when the date field or icon  is clicked.
- Allow users to manually type in the date, not just click the date.
- Show dates in the field with a leading 0, for example **06-Dec-2021**.
- Contain buttons for the user to be able to nudge the calendar backwards or forwards by month and year.

Within the **date picker**:

- Today's date should be highlighted as a red square and bold white number.
- Selected date should be highlighted as a blue square and bold white number.
- Hovering over a date is highlighted as an orange square and plain black number.

The **date picker can be customised**. Before displaying it, make sure that all options are relevant to your users.

For example,
some date pickers will not need the "Six weeks" button.



This screenshot is a comprehensive date picker showing all possible functionality.

Functionality

Date/time picker

There are a variety of potential additional requirements for the customisation of date pickers, which should be specified in the design documentation, such as:

- Allowing partial dates, for example clicking on "Select month" should insert the current month and year into the date field, and "Select year" should insert the current year – this is useful for recording things like start dates for adverse reactions
- whether the date and time picker will be limited to past dates and times, or future dates and times, or both; e.g., an estimated date of discharge should only allow entry of a future date/time, appreciating that as time passes this may become a past date.
- Shortcut buttons for the most common dates, e.g., yesterday, today and tomorrow.
- Shortcut buttons for +1 week, +6 weeks, +three months and +one year.
- Shortcut buttons for -1 week, -6 weeks, -three months and -one year.

Manually entering dates

As well as using the date picker, the date can also be entered manually. The date field is to contain greyed out text displaying dd-MmmYYYY If the user manually enters a date other than the format of dd-mmm-yyyy, eg, using forward slashes instead of dashes as in 01/01/1996, then the calendar will convert this and the relevant date will be highlighted in the calendar, the user will need to select the date to confirm that this is the correct one.

When a user is tabbing through the form, the focus should be at the beginning of the field so that the date can be typed, if necessary, without having to click into the field. There should also be a ~~x~~ at the right-hand side to delete an incorrect date. If a user does type in say 12-04-2022, this is automatically converted to 12-Apr-2022.

Horizontal scroll bars

Horizontal scroll bars should only be used in clearly defined exceptional circumstances, where there is no chance that the user will miss vital information.

Such examples where it is acceptable is in the Observations recording where the eform is similar to a paper chart and the recordings are placed horizontally next to each other. Another example is the Bowel Assessment Chart in the WNCR.

Functionality

Copy and paste

Copy, cut and paste options are potential sources of clinical error. Currently, there is nothing in the WCP to stop a user from copying data from one place to another.

However, the following principles have been agreed by the DHCW patient safety team. Some of the items are already in place, others are aspirational and will hopefully form part of future development.

General rules

Copying from a non-DHCW application and pasting into a DHCW application is allowed without restriction or logging.

However, copying from one patient record and pasting into a different patient record is NEVER ALLOWED.

Current functionality

- Users can copy and paste patient identifiers from one application into another.
- When editing a document, users can cut, copy and paste information from one part of a document into another part of the same document without any restriction.
- When editing a document, users can cut or delete information from that document, but the document should be saved with a new attributed version.
- Where possible, use links to pull data into forms. For example, when doing a cardiology referral, you can copy a test result from the test results list into the form. In Welsh Nursing Care Record (WNCR), when doing a measurement, you can link this to a form - there is a link icon to indicate this.

Functionality

Copy and paste

Aspirational/future development

All documents, including tests results and requests, should have a "Copy link" option which can be copied and pasted anywhere, even outside of the WCP.

If you are then viewing this document outside of WCP and a user clicks the link, the user is taken to the WCP log in screen and then to the specific document - **with break glass, patient banner, header, document status display, document attribution.**

When documents are created from another document, for example, Repeat test, the document should be labelled "**This document/letter/request was created by copying document X**". The label is just underneath the document title. This link is to the other document.

A user can copy and paste from one WCP document into another WCP document without restriction. However, if a user copies more than 6 words or more than 1 line from a document at once, they are shown the prompt "Consider using 'Copy link'". This is easier and safer.

Editing timeframe

The default cooling off period after a user clicks on 'Final' or 'Final/Send' is 4 hours. **No more edits are allowed once that deadline has been reached.**

Exceptions to this timeframe may be acceptable, but the reasons should be documented and explained in the design documentation.

Tab order

When tabbing through the fields in a form, the tab order should be:

- Left to right
- Then top to bottom

Autofill

Autofill of free text boxes should be disabled.

Autofill is still enabled by default in some browsers, but this can cause server errors.

Functionality

Use of SNOMED search fields

SNOMED fields are usually mandated by a business or data requirement.

SNOMED CT controls must always allow free text. This is because there is the possibility that SNOMED does not contain the data that needs to be added, and if it does, the user may not be able to find it.

Icons on SNOMED search fields

Substance

Raspberry jelly ✖ !

Medication

Product containing paracetamol (medicinal product) ✖ ✓

Manifestation

Type here to start SNOMED ICT search ✖

ICONS:

⚠ Orange warning triangle: the entry is free text

✓ Green tick: the entry is SNOMED coded

No icon: nothing entered



The tooltip for the warning triangle will display the words "**Not coded**"



The tooltip for green tick will display the SNOMED CT code

SNOMED CT search screen

Diagnosis

gastro ✖ !

Gastropathy
Gastromenia
Agastria
Microgastria
Gastropotosis
Gastritis
Gastroschisis
Gastromalacia
Gastroparesis
Dextrogastria
Gastrorrhagia
Gastrinoma
Stroke
Gastric erosion
Gastroenteritis

Parent concepts

Disorder of upper gastrointestinal tract, Disorder of abdomen, Disorder of digestive organ (disorder), Stomach finding

Concept

Disorder of stomach (disorder)

Synonyms

Disorder of stomach, Gastropathy

Child concepts

Jejunogastric intussusception (disorder)
Gastroesophageal reflux disease (disorder)
Gastric fistula (disorder)
Gastroparesis (disorder)
Gastric necrosis
Gastric anastomotic leak

Functionality

Free text boxes

A Single line:

- Is used when it is certain that data will be no more than 2 or 3 words
- Has a maximum field width of no more than 75% of the form.
- The amount of text allowed should match that of the width, so that the user is not allowed to enter more text than will be visible

A Multi line:

- Should be used for most free text data items
- Should be two lines high to differentiate from single line boxes
- Should automatically resize to accommodate typed or pasted content (or deleted content)
- Has no vertical scroll bar, users should be able to see all the data they have entered at a glance
- Has a maximum field width of 75% of the form, not the full width of the screen
- Has no character limit by default, but if one is needed a countdown should be included

Watermarks

Watermarks should not be used.

They are easy to miss and difficult to implement reliably. They can also create inconsistency between on screen views and paper printouts.

Anything that is currently represented as a watermark should be replaced by a status badge in the top left hand corner of the form. ▼

Highly sensitive

Clinical note

Site: Hospital site, healthboard or hospital site
Date: dd-Mmm-yyyy

Read '[Presentation of information - Status badge to identify status of documents](#)' for more information.

Functionality

Mandatory fields

Mandatory fields are indicated in 2 ways:

- With a red asterisk to the right of the field label.
- Section heading labels will indicate the number of mandatory fields to be completed in that section, indicated by a number in an orange background. As the mandatory fields are completed, the number decreases. Once all mandatory fields have been completed, the number changes to a tick with a green background - see example below.

For dropdown lists, these have a greyed-out default value of "Unknown or not recorded" or "Not recorded". The count of mandatory fields will indicate that these need completing.

A user could actually select the value of "Unknown or not recorded" or "Unknown" and when they do so, the mandatory count reduces accordingly.

Acute oncology	4
Laboratory results	4
Author and transcriber	✓

A red asterisk  must be used after the label of a mandatory field.

Example:

Enter review type *

Telephone consultation

Functionality

Fuzzy matching

When designing a form, consider whether a 'standard' dropdown list is appropriate (where a user just selects from a list), or whether fuzzy matching should be used instead.

Fuzzy matching allows the user to type a string of letters (1 or more) into the field and all data items that contain that string are returned. This is recommended for dropdown lists with more than 15 options.

Read more information in [Mutually exclusive options](#).

Patient location: * 

Nothing selected ▼

pat

CATEGORY II PATIENT (OUT PATIENT)

ENT OUT PATIENTS

EYE OUT PATIENT DEPT

Links

Links should work in a standard way, and must:

- Be presented as blue, underlined text - unlinked text can appear in blue, but it should not be underlined.
- Be intended for navigation from document to document.
- Work with a Back button.

The following rules should be followed:

- Links are acceptable for changing full-page views within the WCP.
- **Links are not acceptable for:**
 - Actions which change data.
 - Toggling hidden items, you must instead use a check box. Example of incorrect use: Adverse reactions form.
 - Reset buttons. Example of incorrect use: WCP referrals prioritisation.
- When a link is used, there needs to be an owner of that link (usually a specialist for that area) who can check to ensure that the accuracy of that link is maintained.
- Where a link is to a result, then it should always be to the most recent one in the supersession set.
- Consider using a hover over the link "This link is to the most recent version of the target document, which could have changed since the link was created". This not be possible if the hover over automatically shows the URL.

Functionality

Access to information or functionality

Access to information or functionality should not be restricted, other than by username, password or break glass. Any exceptions should be reviewed by the clinical and technical design team and documents.

Instead, information should be displayed clearly and completely. This includes recording and displaying attribution, and warning users.

Once saved, data is almost immediately visible to all users (subject to break glass), as it would be in the paper record and in line with regulators' rules.

Access to create and edit documents is controlled by role-based access control (RBAC). Please consider this when creating forms.

The need for RBAC should always be reviewed very carefully by DHCW and should not be delegated to a project or design team.

Editing

Documents can be edited until the "Final" or "Final/Send" checkbox has been ticked. After this they are only editable during the cooling off period, which is 4 hours.

Anyone can edit anyone else's document, subject to role-based access control (RBAC). This supports documents that are written incrementally by several different people, and documents that have several contributors (the other relevant mechanism is attribution of a document section).

It supports a document being typed by an administrator and signed by a consultant, or a form being filled in by a student nurse and signed off by a registered nurse. It also helps when staff are unavailable as it reduces the loss of "once only" information, which is a concern to stakeholders. If the WCP thinks that someone should not be updating a document, a strong warning could be displayed, but the action should be allowed.

All edits are reflected in the document version history.

Functionality

Autosave

There must not be an autosave within any form or section of the WCP, under any circumstances.

- Adding an autosave would have design, performance, information governance and data security implications: The WCP doesn't store any information on users' PCs or mobile devices. This makes compliance with data security and information governance rules possible.
- The WCP requires users to authenticate when changes are saved. This helps integrity of and confidence in the electronic record.
- Once something is written about a patient on a scrap of paper in a hospital, it becomes part of the patient's permanent medical record, becomes the property of the secretary of state and must be shown to patients, lawyers, and courts on demand.

Autosave would break all these rules.

Each document has a time period where the document will be closed if there is a period of inactivity, although a warning message is given to the user.

If the screen is locked during this period of document inactivity, when the user logs back in, the form content should still be displayed if still within that document locking timeframe. When designing a form, it is important to indicate what the timeout should be for that form.

Document types

There are 3 types of document that can be designed in the WCP:

1. Forms with a "Final" or "Final/Send" checkbox. These can be edited multiple times until the "Final" or "Final/Send" checkbox is ticked. Once this is ticked and the document saved, a cooling off period begins and the document can be edited in "Draft" status. Once the cooling off period ends, the document will be "Final"; the "Draft" status is removed and no more editing is permitted, unless under exceptional circumstances.
2. Forms which are designed to be completed in one iteration, such as a pathology request form. These forms do not have a "Final" or "Final/Send" checkbox. Once completed, saved and closed, they are deemed to be "Final" and no edits are permitted
3. Forms which are designed to be completed over a longer period, do not have a "Final" or "Final/Send" checkbox and will permanently be in draft, for example cancer dataset forms.

When designing your form please ensure that it fits one of the 3 options above.

See the [Signature section](#) for more information about the various checkboxes and buttons that are available on these 3 types of forms.

Misfiling a document

Misfiling should **only** be used when a document has been created for the wrong patient. There have been occasions where a document has been misfiled when there is content error - in this case any incorrect information should be struckthrough. DHCW will be reviewing the ability to misfile a complete document for the reason of content error, and this UI PDF document will be updated when that functionality is available.

When creating a new eform, it needs to be made clear in the design specification whether this document can be subject to a misfile.

A document can be misfiled even if it has been sent to a recipient, for example a GP or Community Pharmacist. At the time of writing, it is technically difficult to send electronic notification of a misfile to a recipient. Therefore, whoever is responsible for misfiling a document is responsible for managing notifications to the recipient to inform them of the misfile.

At the point of misfile, a message is presented stating: "This document has already been sent to xxx, you should inform the recipient that the document has been misfiled".

At the time of writing, the following WCP documents can be misfiled:

- Discharge Advice Letter
- Clinical Note
- Advance Care Plan Notification
- Hepatitis C Consultation Note
- Outpatient Continuation Sheet
- Outpatient Continuation Sheet v2
- Outpatient Medical Note
- Ad-Hoc Outpatient Review

The following documents cannot be misfiled:

- COVID-19 Mortality Surveillance
- Diabetes Consultation Note
- Hospital Referral
- Inpatient Clinical Notes
- Lung Audit
- MDT Report
- Medicines Reminder
- Pharmacy Care Plan
- Referral Letter (WAP)
- Referral Supplementary (WAP)
- Patient preferences – cannot misfile the complete form, but can misfile sections

Functionality

Misfiling a document

There are **two steps** for the process of misfiling:

Step 1 - Document is recorded as "Potentially misfiled". The document is no longer editable in this state.

Step 2 - The "Potentially misfiled" document is then reviewed and is updated in one of two ways

- 1.** Document is moved to a full "Misfile". Once this happens the document becomes permanently uneditable and cannot be reactivated.

- 2.** The "Potentially misfiled" status is rejected, the form is re-activated and becomes editable.

When a Potential misfile has been rejected, and the document is within its cooling off period, then the cooling off period is reset.

Potentially misfiled

When a document is potentially misfiled, this is indicated in **3 ways**

1. The document metadata background is coloured pink and shows "Potentially misfiled" in red across the metadata

Outpatient medical note

Event Date: 21 Dec 2021

Specialty: Dermatology

Senior responsible clinician: ANTON, Andreea, Dr (GMC:7531865)

Author: PRITCHARD, Patricia, (GMC:), Business Analyst, Gastroenterology

Site: Amman Valley Hospital

!Review Misfiled

(v3) 

...

2. A "Potentially misfiled" status badge appears in the top left-hand corner of the form, with red background and white writing. A hover over will display "This document may be in the wrong patient record"

Potentially misfiled

3. The PDF will show a status badge with black background and white writing

Potentially misfiled

There should be **no** "Potentially Misfiled" status badge at the bottom of the screen underneath the PDF.

 Potentially misfiled

Misfiled

When a document is fully misfiled, this is indicated in **3 ways**

1. The document metadata background is coloured pink and shows "misfiled" in red across the metadata

Outpatient medical note

Event Date: 10 Dec 2021

Specialty: General Medicine

Senior responsible clinician: ALI, MOHAMMAD F, Dr (GMC:4115638)

Author: PRITCHARD, Patricia, (GMC:), Business Analyst, Gastroenterology

Site: 7A2F5

✓ Misfile Confirmed

(v3) 

2. A "Misfiled" status badge appears in the top left-hand corner of the form, with red background and white writing. A hover over will display "This document is in the wrong patient record"

Misfiled

3. A "Misfiled" status badge appears in the top left-hand corner of the PDF

Misfiled

There should be **no** "Misfiled" status badge at the bottom of the screen underneath the PDF.

 Misfiled

Icons

These icons are being reviewed and subject to change, as DHCW attempt to ensure that icons are consistent across both desktop and mobile applications.

Where icons are used, a description or explanation should usually be displayed next to it, or in hover text.

In the WCP and eForms the following actions (button labels) must currently be **displayed in words, not using icons**:

- | | |
|-------------------------|-----------------|
| - Open patient's record | - Close |
| - Add | - Ok |
| - Add another | - Cancel |
| - Save | - Back |
| - Save and close | - Clear filters |

The following actions, when associated with a sequence of documents, should be represented by icons.

- | | |
|------------|---------------------------------|
| - First | - Last |
| - Previous | - Back (exit from the sequence) |
| - Next | |

An orange triangle can be used to indicate a warning. The nature of the warning must be displayed in words using a hover over.

- No other icons are allowed.

The following actions will continue to be displayed using icons:

- Print
- Print labels

The following actions, when associated with a list or table, should be represented by icons:

- Refresh

The following actions, when associated with a list or table item, should be represented by icons. This document will be updated to include the agreed icons:

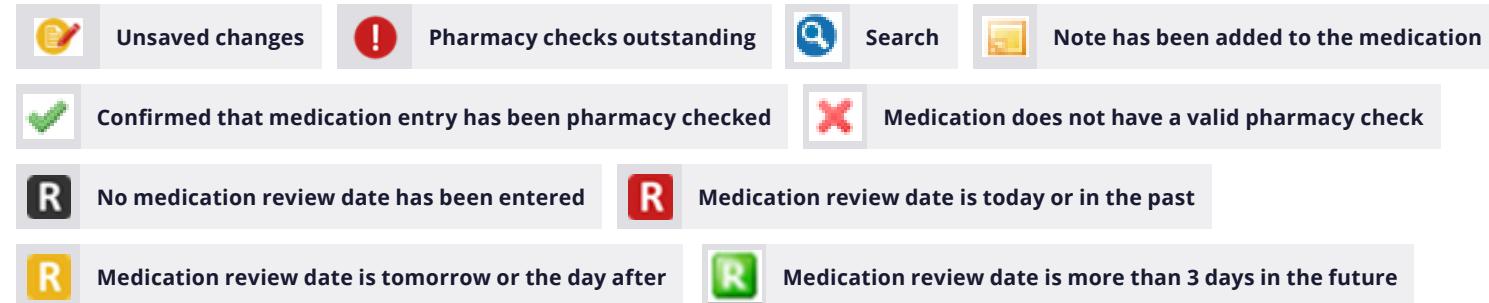
- | | |
|---------------------------------------|-------------|
| - Open document or expand for viewing | - Move up |
| - Edit | - Move down |
| - Delete | |

The following statuses of a task should be represented by an icon which appears before the name or description of the task. This document will be updated to include the agreed icon:

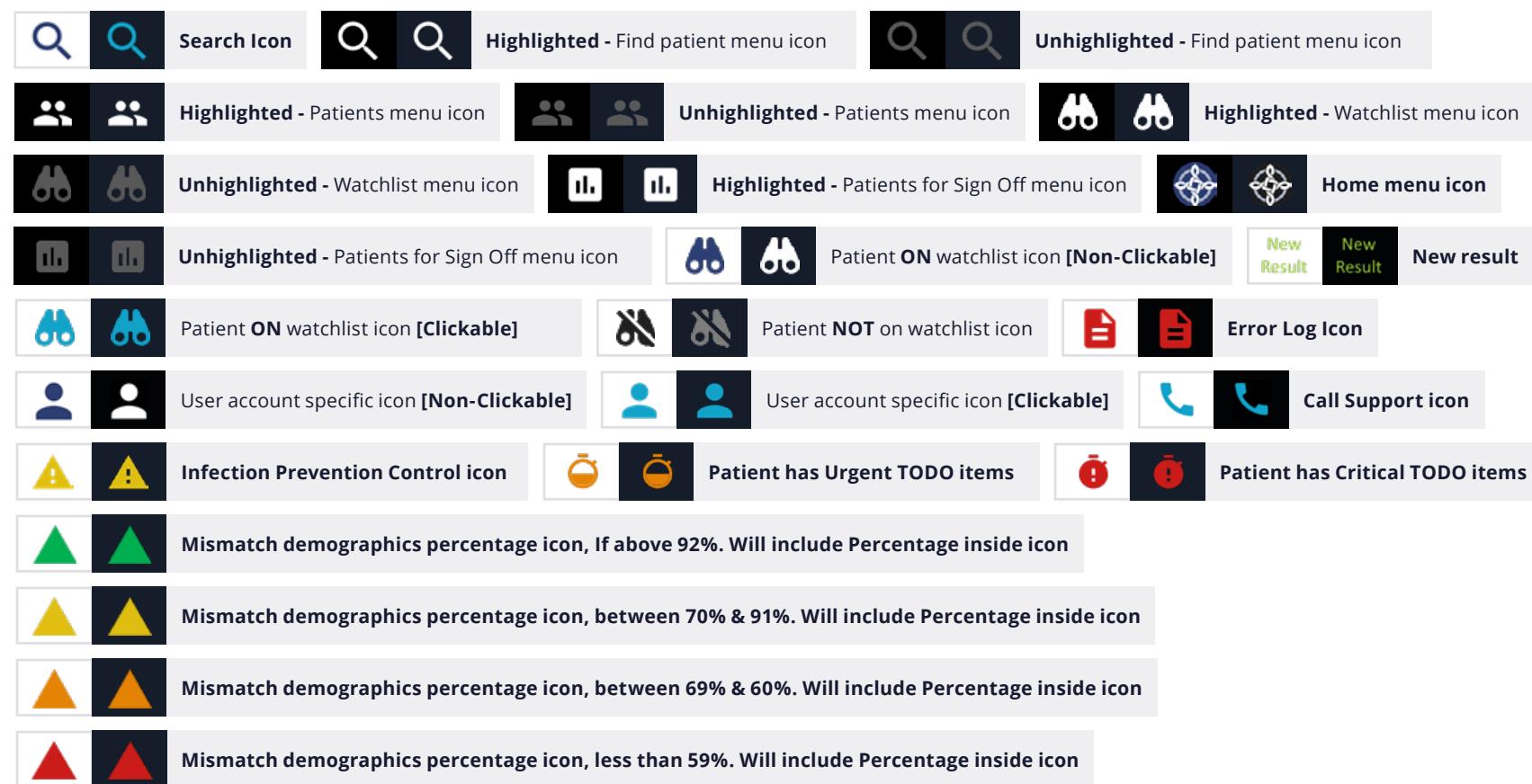
- Task outstanding or due: Red or orange asterisk
- Task done: Green tick

Note: There is a significant issue with icon use in MTED. Some icons have been given non-standard meanings, these will be reviewed.

Icon	Description
	WCP
	Home
	Preferences
	Messages
	Settings
	Quick actions
	Open/Expand non displayed section (for example documents list)
	Close record
	Close
	Information icon
	Hide displayed section (for example documents list/history of adverse reactions)
	Quick reference guides, what's new and video tutorials
	Error, Invalid NHS Number, Highly Sensitive, Document sent to GP, Pharmacy checks outstanding
	Overdue to do item
	Logout
	Message Received, Additional Information received on referral, Information request received
	Message Sent, Information request sent
	Current session locked
	Unsaved changes – text goes behind
	DAL sent to GP
	DAL in the process of being sent to GP – 4 hours
	Paused, On hold
	Add, Add Item to List
	Shrink content of a displayed section
	Expand content of a displayed section
	Remove, Remove Item from List
	Calendar
	Outstanding notifications exist for this patient
	Notification, Alert, Alternate Hospital Numbers
	Patient demographics not accurately matched
	Patient demographics 100.00% accurately matched
	Personal notification
	Comments
	Results in the sign-off basket
	Copy NHS number
	Print
	Highly Sensitive Document
	Print patient demographic labels on pt homepage And printing pdfs when viewing in document history
	Graph
	Table
	Search for a patient using the NHS number
	Close window
	Minimise window
	Maximise window
	Used on Medications Reminder document
	Expand, View result
	Expand, View result
	View result
	View selected page in a new tab
	Mark page as default
	Page selected as default
	Viewable by all staff (Quick Note)
	Viewable by me only (Quick Note)



WCP Mobile icons - Light mode & Dark mode



 	Mismatch demographics percentage icon, If above 92%	 	Back Navigation	 	Expand Selection Item
 	Mismatch demographics percentage icon, between 70% & 91%	 	Expand section	 	Collapse section
 	Mismatch demographics percentage icon, between 69% & 60%	 	TODO list item	 	Filter list icon
 	Mismatch demographics percentage icon, less than 59%	 	Test Request is sensitive icon		
 	Hamburger menu icon, opens side menu	 	Patient signed off icon	 	Long picker selection removal icon
 	Long picker selection confirmation icon	 	Activate barcode reader, located on header		

Functionality

Re-use / carry forward information

When a new document is created, it can be partly pre-filled with information copied from a previous instance of that document. Copy forward rules are specific for each document type and should be written up in the design specification. The following default generic rules should be followed.

Any deviations from these defaults should be discussed, agreed, approved and clearly documented in the design specification.

General rules

Any section that pulls through data from a previous form should have the attribution data added.

Copied forward information should be whole sections or table rows.

By default, the information should be copied forward from the most recent instance of that document, by event date, that contains that information and always from the last version of that instance. However, where appropriate, information can be pulled from earlier documents. eg, for an outpatient consultation record it would be expected that a problem list would be copied forward from the previous consultation for that clinician and/or specialty, rather than the last consultation record which may have taken place with a different clinician and/or specialty where the problem list would not be relevant.

It may be relevant for the user to select which form the information is to be copied from, as in the Palliative care form. In this case, when a user selects to create a new form, they will be presented with a list of recent forms, and they can make the appropriate selection. If no relevant document is listed, then a blank new form should be able to be created which does not pull any information through from any other form.

Information should be able to be pulled from documents created in other Health boards; please specify in any design document if this is the case.

When deciding what information is to be brought forward, please check if there are any restrictions. At the time of writing, it has been deemed those questions around pregnancy, for example, cannot be brought forward and should be asked on each iteration of the form.

Pulling data from Finalised forms

When pulling information through from finalised forms, the Attribution statement will contain the details of the last user who added or updated this information. For example, if a section was filled out in form 1 and not subsequently changed or confirmed by the time that form 4 is created then that section should still be attributed to the form 1 author. If this information is updated on a subsequent form the attribution will be updated. If the "Confirm section" checkbox is ticked, then the attribution statement is also updated to the new user. This is standard attribution functionality.

Re-use / carry forward information

Pulling data from Draft forms

Copy forward should not happen from Draft forms unless there are exceptional circumstances. Example: a domiciliary visit by a palliative care physiotherapist in the morning followed by a domiciliary visit by a palliative care doctor in the afternoon, where there is no time for the HCP to finalise their form before the doctor visits.

When creating a new instance of a form and information is being pulled from a Draft form, the following warning message will be presented.

"This form will be pre-filled with information copied forward from a draft document. The copied forward information may be incomplete and may contain errors. This information will be attributed to the author of the new document."

Any information carried forward which has come from a draft form must be checked and validated by the user of the second form as the attribution statement will automatically be updated to display their details. When saving the document, if a different author to the logged in user is selected, then the attribution statement is updated to the new author.

However, if pulling information from a draft form, where information was pulled into that draft form from a previously finalised form, and that information was not changed or confirmed by the author of the draft form, then this latest form will show the original author from the previously finalised form in the attribution statement.

Pulling data from "Potentially misfiled" or "Misfiled" forms

If a form has a status of "Potentially misfiled" or "Misfiled" and a subsequent form is created, no information is pulled through, unless the misfile has been subsequently rejected. There should be no exceptions to this rule.

If sections from a form have been re-used on subsequent forms, the original form can be misfiled. At the time of writing, it is technically difficult to do anything with that re-used information on a subsequent form in this scenario.

If the information has been updated on the subsequent form, then the new author is taking responsibility for this, but if it hasn't been updated, then this carries a small risk, although the onus is on the new author to check the information is still valid and correct. However, it is also highly likely that the original form will have been misfiled before sections are re-used and the subsequent document created.

Functionality

Re-use / carry forward information

Pulling data from "Highly sensitive" forms

If the original form has been marked as highly sensitive and information is being pulled through from that form, when creating a new form, a "break glass" message will be presented, as follows:

"This form is attempting to pull through information from a previous form that was marked highly sensitive. Access to this information item will be logged and may be reported to your supervisor.

With 'Proceed' and 'Cancel' buttons

Clicking 'Proceed' pulls data into the new form and access is logged

Clicking 'Cancel' presents a new instance of the form with no data pulled through

The 'x' close button can be used to close the form once you 'Proceed', if needed at this point.

If 'Proceed' was selected, the new document will be highly sensitive by default because it contains information that has been copied forward from a highly sensitive document.

If the new document DOES NOT contain any highly sensitive information, or if all highly sensitive information is removed, the highly sensitive check box should be cleared before saving.

If the user selected 'Cancel' and a blank form is created, the 'Highly sensitive' checkbox should not be automatically ticked.

If highly sensitive data remains on the form, the checkbox needs to remain ticked when the form is saved. On any subsequent edit the normal standard 'break glass' message applies.

Carrying forward "struckthrough" information

Struckthrough information can be carried forward, although the strikethrough must also be carried forward. If the ability exists to un-do a strikeout on the original document, then the user must be able to un-strike any copied forward information on the subsequent document.

Functionality

Signature line

Available buttons/checkboxes

The following shows the available checkboxes and buttons that can appear in the signature section at the bottom of WCP forms.

Not all of these will appear on all forms; their visibility will be dependent on the type of form, its intended use, and the stage at which the form is at.

Highly sensitive

 Highly sensitive

This checkbox will display on all forms which will be listed in the Documents view when saved. Authors/transcribers will select this if the form is to be marked as highly sensitive.

If ticked, the screen will scroll automatically to the Author section and will present a mandatory free text field labelled "Reasons for highly sensitive status". This checkbox can be unticked if the document no longer contains any sensitive data.

Please see further details in "Mark as Highly sensitive" section.

Countersignature required

 Countersignature required

This checkbox will not appear on all forms, only on those where it is deemed that a countersignature clinician may be required.

If ticked, the screen will scroll automatically to the Author section and will present a mandatory free text field labelled "Countersignature required by". The checkbox can be unticked if a countersignature is no longer required and will need to be unticked when carrying out a countersignature. Until it is unticked, the "Final" or "Final/Send" checkbox is inactive.

Please see further details in "Countersignature required" section.

Username: st000319

Field showing NADEX id, will be on all forms, always.

Password:

Will only be visible when at least one change has been made on the form, ie, there is some data to save.

Functionality

Signature section

Available buttons/checkboxes

Final / Send

To be used instead of the "Final" checkbox if the form is being sent to a recipient, eg GP, therefore will not appear on every form.

Will only be active once all mandatory data has been completed. Once this checkbox is selected and the form saved, there will be a cooling off period in which the document can be edited.

By default, this cooling off period is 4 hours but, where appropriate, can be changed with the necessary approval. Documents in the cooling off period will have the status of Draft. This status will automatically be removed when the cooling period has elapsed, and the document will be deemed to be Final. At this point, the document will be sent to the recipient, eg GP.

Back

Will display when a form has been opened and no changes have been made. Allows the user to back out of the form with no messages displayed.

Once data has been entered into a form, this button will disappear and will be replaced by the "Cancel" button.

Save

Will save the form but will not close it; the form will be kept open on the screen.

Will not be available on every form, only those where it is deemed that an interim save will be of value to the user, eg on a long form

To only be used on forms that have a "Final" or "Final/ Send" checkbox

All mandatory fields do not need to be completed. A password will need to be entered to allow the form to be saved.

Send

This button will only be available on forms where there is no requirement to Finalise, the form will not be subject to a cooling off period and as soon as the user completes this form it is sent to a recipient, eg, LIMS. This will include forms such as Pathology and Radiology request forms.

Cancel

Cancels the form. Any changes made since the previous "Save" or "Save and close" will be lost.

Functionality

Signature section

Available buttons/checkboxes

Save and close

Will save the form and close it. A password will need to be entered.

If there is a “Final” or “Final/Send” checkbox:

Mandatory data does not need to be completed to save and close a document if this checkbox is present.

The “Final” or “Final/send” checkbox will be greyed out until all of the mandatory information is completed. If the “Save and close” button is selected whilst there is mandatory information to be completed the form will be saved in draft.

Once all of the mandatory information has been completed, the “Final” or “Final/send” checkbox is available for selection. If ticked, once the “Save and close” button is selected, the form will remain in draft for the specified cooling off period and will then be updated to the Final status.

If there is no “Final” or “Final/Send” checkbox:

If the form is designed to be completed in one go, such as a request form, then all mandatory data must be completed before the form can be saved and closed.

There is no cooling period, ie the forms cannot be edited once saved and closed.

The form will not have a draft status.

There are other forms where there is no “Final” or “Final/Send” checkbox; these forms are designed so that information is entered on an ongoing basis. These forms can be saved and closed even if mandatory data is still required, but these forms will never be finalised; such forms include the Patient Preferences form.

For full descriptions of how the above buttons work are contained within the user stories.

Functionality

Signature section

Examples of signature bar

In all examples below, the “Highly sensitive” and “Countersignature required” checkboxes appear, but these may not be required all on forms within the WCP; their presence will depend on the form itself. All forms will always show the NADEX ID field.

Using the “Back” button

The signature row will contain the following checkboxes and button when a new form is created or where an existing form is opened and no data has been entered, and there is still mandatory data to be completed.



A screenshot of a digital form's signature row. It includes two checkboxes: "Highly sensitive" and "Countersignature required". A "Final" checkbox is greyed out. To its right is a text input field containing "Username: st000319". On the far right is a blue rectangular button labeled "Back".

- “Final” checkbox is greyed out as mandatory data is required (“Final/Send” could appear here instead), plus no data has been entered to finalise
- “Back” button, enabling the user to back out of the form as no data has yet been entered
- There is no “Save”, “Save and close” or “Cancel” buttons as no data has yet been entered to either save or cancel out of
- There is no Password field, as there is nothing to save on the form

Using the “Save” button (interim Save)

Only to be used when a form has a “Final” or “Final/Send” checkbox and will allow an interim save. Selecting this will save the data but not close the form.



A screenshot of a digital form's signature row. It includes two checkboxes: "Highly sensitive" and "Countersignature required". A "Final / Send" checkbox is greyed out. To its right is a text input field containing "Username: st000319". Next is a password input field with the placeholder "Password: [REDACTED]". On the far right are three buttons: a grey "Save" button, a green "Save and close" button, and a red "Cancel" button.

- “Final/Send” checkbox: greyed out as mandatory data is still required in this example
- “Save”: this form has an interim save – will not close the form
- “Save and close”: the form can be saved and closed. Note: Form cannot be finalised until all mandatory data has been completed
- “Cancel” button: Will cancel the form, any changes made since the previous save will be lost

Functionality

Warning messages

Different warning messages to the user will be presented under the following scenarios.

Selecting “Save and Close” – Mandatory data still required -
Form has a “Final” or “Final/Save” checkbox

The following message will be presented under the following circumstances:

- Form has a “Final” or “Final/Save” checkbox
- Mandatory data on form still to be completed (“Final” or “Final/Save” checkbox greyed out)
- User has selected “Save and close” on the form

Warning
<p>Mandatory data is still required.</p> <p>To continue to save as draft and close, click “Save as draft”</p> <p>To finalise, click “Return to form”, ensure that all relevant data is completed, including mandatory items, click the “Final” or “Final/send” checkbox, re-enter your password and click “Save and Close”</p> <p>If you have selected “Countersignature required” the form will not be finalised until that countersignature is added</p> <p>Save as draft Return to form</p>

When “Save as draft” is selected, the form is closed and will have the status of Draft. As the “Final” or “Final/Save” checkbox cannot be selected, any cooling off period has not yet commenced.

When “Return to form” is selected, the form is re-displayed, and the user can continue to complete any relevant details.

Functionality

Warning messages

Selecting “Save and Close” – All mandatory data entered -
Final or Final/Send checkbox **not ticked**

The following message will be presented under the following circumstances. Form has a “Final” or “Final/Save” checkbox

- All mandatory data has been completed
- User has not ticked the “Final” or “Final/Send” checkbox (although it is active)
- User has clicked “Save and closed”

Warning
<p><i>This form is still in draft.</i></p> <p><i>To save and close this form in draft format, click "Save and close". This form will not be sent to any recipient, if required, until finalised</i></p> <p><i>To finalise this form, and ensure that it is sent to the relevant recipient, please click "Return to form", click the "Final" or "Final/Send" checkbox and click "Save and close"</i></p> <p><i>If you have opted for a "Countersignature required", this signature will be required before the form can be finalised and/or sent</i></p>
Save and close Return to form

When “Save and close” is selected in the message below, the form is closed and will have the status of Draft. As the “Final” or “Final/Send” checkbox has not been selected, the cooling off period has not commenced.

When “Return to form” is selected in the message below, the form will be re-displayed, allowing the user to complete any further details, including ticking the “Final” or “Final/Send” checkboxes if the form is ready to be finalised.

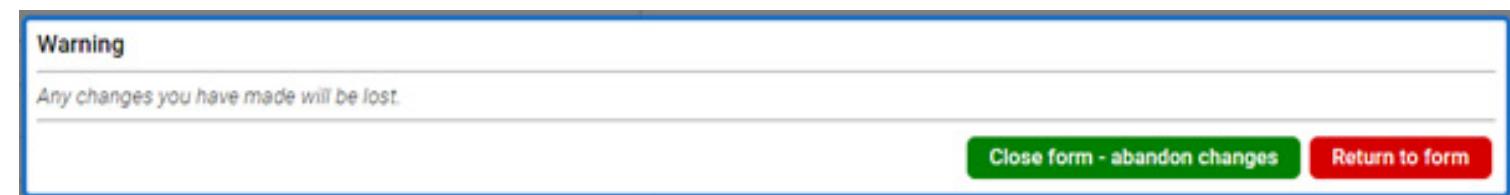
Functionality

Marking a form as highly sensitive

Warning messages

Selecting “Cancel”

When the “Cancel” button is selected on a form, the following message will be displayed.



Selecting “Save and Close” – Mandatory data still required – No “Final” or “Final/Save” checkbox is present on the form

When the form does not have a “Final” or “Final/Save” checkbox and the “Save and close” button is selected when mandatory data is still required, the user is presented with warning text in red against each mandatory field that needs to be completed. The form cannot be saved and closed until all mandatory data has been completed.

Specialty:

Nothing selected

Select a speciality

Senior responsible clinician:

Nothing selected

Select a consultant

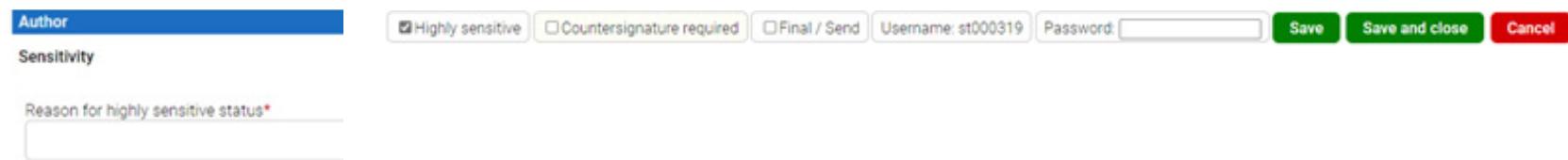
When “Close form – abandon changes” button is selected, the form is closed and any amendments made to the form since the last save are lost.

When “Return to form” is selected, the form is re-displayed. Any changes made to the form since the last save are still visible on the form.

Functionality

Marking a form as “Highly sensitive”

If the “Highly sensitive” checkbox is ticked, a mandatory free text field labelled “Reason for highly sensitive status” will appear in the ‘Author’ section. The form should automatically scroll to this field so that it is clear that there is a mandatory field to be completed.



If the form **does not** have a “Final” or “Final/Send” checkbox

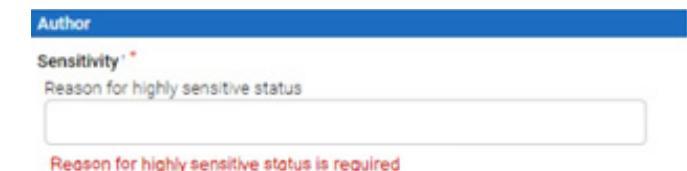
If the “Save and Close” button is selected whilst the “Reason for highly sensitive status” free text field is empty, then there will be the standard red warning against the field label. This field, along with all other mandatory data needs to be completed before the form can be saved and closed.

Any document which is marked as Highly sensitive will also have the “Highly sensitive” status badge visible in the top left hand corner of the form in white writing with a red background; on the PDF this status badge will show with white writing and a black ground in the top left hand corner.

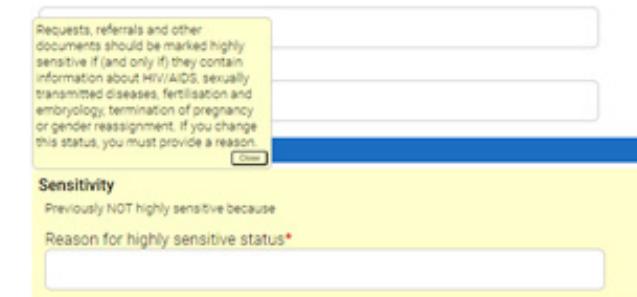
See the [Status Badge](#) section for an example how these are displayed.

If the form has a “Final” or “Final/Send” checkbox

The form can be saved and closed whilst the mandatory data is required, including the free text field for highly sensitive, but the form cannot be finalised. Once this free text field has been completed and all other mandatory data is entered, then the “Final” or “Final/Send” checkbox is available to select.



Hovering over the Sensitivity section will display the tooltip as shown below.



Functionality

Removing “Highly sensitive” status

If the tick in the highly “Highly sensitive” checkbox is removed, a mandatory free text field labelled “Reason NOT highly sensitive” will appear in the ‘Author’ section. The form should automatically scroll to this new field so that it is obvious that there is a new mandatory field that needs completing under the following scenarios.



The same rules apply as for marking highly sensitive with regards to this free text field being completed before the form can be made final, saved and closed.

Countersignature required

The “Countersignature required” checkbox would only appear on forms which have a “Final” or “Final/Send” checkbox. Any form that does not have one of these checkboxes would be completed and saved in one iteration of the form and only editable during any cooling off period.

A countersignature is required under the following **two** circumstances

- 1.** Forms being filled out by learners who cannot yet sign them off
- 2.** Forms being filled out by secretaries or other helpers who cannot sign them off

If a countersignature is required, then the user should tick the “Countersignature required” checkbox.

The form scrolls automatically to the Author section, and a mandatory free text field labelled “Countersignature required by” will now be displayed. The name of the person who should countersign this document should be entered. Until this free text field is completed, the “Final” or “Final/Send” checkbox is greyed out. Once this free text field is completed, and all other mandatory data is entered, then the “Final” or “Final/Send” checkbox is available to select.



When editing a form that requires a countersignature, the checkbox remains ticked. The “Final” or “Final/Send” checkbox will be greyed out. When a user wishes to countersign the form, the “Countersignature required” checkbox needs to be manually unticked, the “Final” or “Final/Send” checkbox ticked and the form can then be saved and closed and will be in a “Draft” status during the cooling off period.

Functionality

Draft status

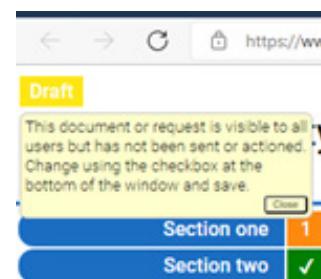
When a form has a "Final" or "Final/Send" checkbox, the status of "Draft" will be applied under the following circumstances.

- Form is being created and edited, the "Final" or "Final/Send" checkbox has not been selected
- "Final" or "Final/Send" checkbox has been ticked and the form saved. The document will have the Draft status applied during the relevant cooling off period for this document.

To indicate that a form has the status of "Draft", the status badge of "Draft" will appear in the top left-hand corner of the form.

Draft

When a user hovers over this "Draft" label, the button will turn yellow, and the following tooltip will be displayed.



The "Draft" status badge will also appear on the PDF, in the top left-hand corner, with white writing in a black background. There will be no Draft watermark on the page.

Each time a document is saved, a new attributed version is created; previous versions can be viewed in the WCP.

For forms that do not have a "Final" or "Final/Send" checkbox, as soon as the document is saved it is finalised. There is no draft status applied to these forms.

There is a third type of document such as the Cancer dataset forms, which are designed to be completed over a period of time. These do not have a "Final" or "Final/Send" checkbox, but can be edited over a period of time, and will always be in a Draft status. These will be subject to a "Freeze" time, but at the time of writing, this functionality is still in the planning stage.

Author

Sensitivity

Reason NOT highly sensitive

Countersignature required by*

Functionality

Finalising a document / Cooling off period

When the “Final” or “Final/Send” checkbox is ticked, a password is entered and the “Save” or “Save and close” button is selected, the document enters its cooling off period. By default the cooling off period will be 4 hours, although this can be changed on a case-by-case basis where appropriate; the reasons must be clearly documented in the design specification, and approval received.

During this cooling off period, the document still has the status of “Draft” and the relevant status badge will be displayed, both in the form and the PDF.

An “Edit” button will be visible in the document list during this cooling off period and the document can be edited. If it is edited during this timeframe, then the cooling off period is reset to 0.

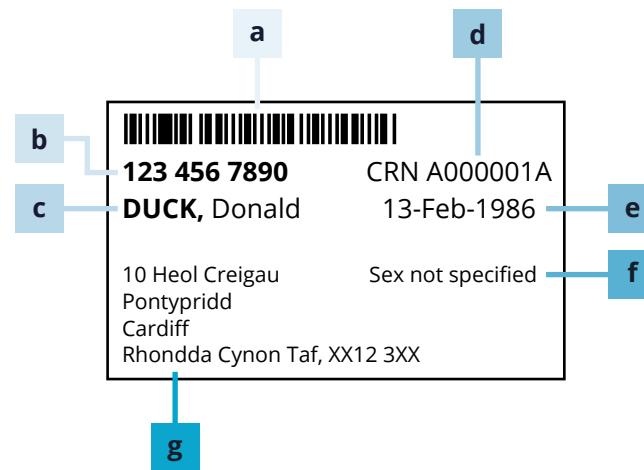
Once the cooling off period has elapsed, no further edits are allowed*, the Draft status badge will be removed automatically and the “Edit” button will be removed from the document list. If this form had a “Final/Send” checkbox, then the form is sent to the relevant recipient.

* In exceptional circumstances a document can be edited after the cooling off period has elapsed. It is important to note that if the document has been sent to a recipient, then they will need to be informed of any change.

Addressograph Label

Each addressograph label **must be:**

- On every page of the PDF
- In the top right hand corner



DSCN 2018/09, dated 12th November 2018, has been published. This gives further guidance on how to format and display the addressograph

Each addressograph label must have:

- a**: NHS Number Barcode, Code 39 format.
Barcode is for NHS number only, do not display barcode when no NHS number is present
- b**: Arial 11 Bold NHS Number in 3 3 4 Format
- c**: Arial 11 Bold Surname, Arial 11 Forenames, if field is obscured by DOB, truncate with ellipsis (...). See Label 4 of the DSCN.
- d**: [Optional] Arial 11 CRN, ensure CRN prefix is used. See Label 5 of the DSCN.
- e**: Arial 11 DOB in dd-Mmm-yyyy.
- f**: Arial 9 Values, Male; Female; Sex not specified
- g**: Arial 9 Address Line 1
Arial 9 Address Line 2
Arial 9 Address Line **Town/City**
Arial 9 Address Line **County, Postcode**

Header

- The information directly under the document title may differ depending on the document type.
- By default, the second line should read 'Event date' if the document is attached to a PAS event, for example the Outpatient medical note.
- Otherwise, the label should read 'Date of meeting' if it is an MDT form, or 'Discharge date' if it is from an inpatient stay.

Example:

Outpatient medical note

Site: Amman Valley Hospital, Hywel Dda UHB
 Event date: 20-April-2022
 Specialty: Cardiology
 Senior responsible clinician: AVERY, Philip G, Dr (GMC:2837176), Consultant
 Author: PRITCHARD, Patricia A, Mrs (Nadex: pa252675)
 Version: 2

	123 456 7890	DUCK, Donald	13-Feb-1986
10 Heol Creigau Pontypridd Cardiff Rhondda Cynon Taf, XX12 3XX	Sex not specified		

Rules for headers:

- Fields should be displayed in sentence case, with names in the standard format
- The date label in the header should never say just "Date". It needs to be clear which date is being referenced, so if the "Event date" is not appropriate, then other options can be used such as "Meeting date" in the case of an MDT form, or "Discharge date" if the form relates to an inpatient stay
- Patient label as per DSCN and to be contained within a border. The header should not be contained within a border
- A line should be used underneath the header to separate it from the main body of the form
- The header should appear on every page of the document
- A version number should appear in the header, underneath the Author (moved from the footer)
- Status badges, where applicable, will appear above the document title

PDFs

Footer

Page 1 of 1

Document author: JONES, Andrew, Mr (GMC:1234567), Registrar, Cardiology on 10-Jul-2020

Printed by: POTTS, Lucy, Miss (Nadex: lu123456) Medical Secretary on 11-Jul-2020 at 14.30

Rules for footers:

- Fields should be displayed in sentence case, with names in the standard format (Note Surnames should be in ALL CAPS)
- The footer should not be contained within a border
- A line should be displayed above the footer to separate this from the main body of the text
- No document version number (moved to the header)
- The footer should appear on every page of the document
- A status label, for example 'superseded', is no longer visible (moved to the header)

Tables

- Tables should be displayed with a horizontal line separating each row.
- The Headings will be left aligned, in italics, in the same font as the main font, but with a 0.6 rem.

Performance status					
<i>Date</i>	<i>WHO performance status</i>	<i>ASA classification</i>	<i>Clinical frailty score</i>	<i>Lansky performance scale</i>	<i>Recorded by</i>
15-Jun-2018	1	1	1		JONES, Connor M, Mr (GMC:236789), Consultant Surgeon, 17-Jul-2018
16-Aug-2018	1	1	1		PETERS, Clare M, Ms (NADEX:cp123987), MDT Coordinator, 16-Aug-2018

PDFs

Layout and presentation of fields within the form

If you are designing a form and have been asked to make the layout suitable for a window envelope, please be mindful we are attempting to reduce the number of paper documents that we send.

If it is necessary to send a paper copy using a window envelope, when designing the form please ensure that the recipient and address is displayed accurately and that no other information is visible in the window

When presenting fields on a PDF, there are several options:

- If a field has not been completed on the form, remove it from the PDF - this is the default option
- If a field has not been completed on the form, then show on the PDF but with the text "No data entered", for example for some assessments you would want to know that a particular check was not carried out
- Whether a field has or had not been completed, always remove from the printout

We are trying to move away from sending paper documents, but currently it is not possible to send all documents electronically.

PDFs

Display of questions/answers on the PDF

For each question on a form, a decision should be taken as to whether these should be displayed on the PDF.

On the PDF never display a question label on its own.

Also consider whether struckthrough information needs to be displayed. This should be decided on a case-by-case basis and specified in the design specification.

Only the following options are available:

Default options

- Completed fields should be displayed on the form
- Non-completed fields should not be displayed on the form, includes “Unknown or not recorded” or “Not recorded” responses

Acceptable alternatives

- Non-completed fields can be displayed but must contain the text “Not recorded” underneath the question. This is useful if you want to know that a particular assessment was not carried out. However, putting a large amount of these blank questions can lengthen a form, reduce the legibility and, if printed, can use additional paper and ink
- Whether a field has or has not been completed on the form - always omit from the PDF view

Multiple pages

Patient identifiers need to be displayed on every page, as well as the name of the document and dates.

The header and footer **must** appear on all pages to ensure accurate identification of the pages should they become separated.

Form sections

Section and sub section headings should have a shaded banner with black text.

Do not enclose any sections or sub sections of the document in gridlines or boxes. There is evidence that rules and lines are a barrier to understanding, especially vertical lines.

Sub-sections should be indented from both sides by 5% of the main heading.

Example of how to display sections and sub-sections:

Section 1 - Main heading

Last updated on 5-May-2022 at 1140 by SHERING, Steven G Mr (GMC123456). Consultant General Surgery

Main section Question 1

Response to Main section Question 1

Main section Question 2

Response to Main section Question 2

Sub-section 1 heading indented by 5% on both sides from main heading

Last updated on 5-May-2022 at 1140 by SHERING, Steven G Mr (GMC123456). Consultant General Surgery

Sub-section Question 1

Response to sub-section Question 1

Sub-section Question 2

Response to sub-section Question 2

Sub-section 2 heading indented by 5% on both sides from main heading

Last updated on 5-May-2022 at 1140 by SHERING, Steven G Mr (GMC123456). Consultant General Surgery

Sub-section Question 1

Response to sub-section Question 1

Sub-section Question 2

Response to sub-section Question 2

PDFs

Splitting sections

If a section is split over more than one page, the section header should be repeated at the top of the second or subsequent page with the word "Continued".

When designing forms, be mindful that if sections are long, it might push a later section over two pages where that later section should not be split.

To prevent this, consider intentionally splitting a document and have a blank page either side of the section that you need to keep on one page, for example safeguarding.

For these blank pages, use the text "This page is intentionally blank" to avoid confusion.

Highly sensitive	Superseded
Document title	
Site: Hospital site, healthboard of hospital site	
Date: dd-Mmm-yyyy	
Specialty:	
Senior responsible clinician: SURNAME, Forename Middle Initial, Title (PRN:####), Role of main specialty	
Author:	
Reason for review - continued	
Other	
This is additional text to show that when a section is split over more than 1 page, then the section header should be displayed, along with the word "continued"	

PDFs

Font

A comprehensive list of fonts, font sizes, font weights and spacing are [listed in the Appendix](#).

As an example, fonts for questions and answers:

- The main font to be used on the forms should be Roboto, with a font size of 1rem and a font weight of 300.
- Question labels should be decreased compared to the main font - use a relative size of 0.8 for the questions.
- Indent the answers slightly relative to the questions. Use a left and right padding of 0.5rem.
- Ensure that there is no blank line between the question and the answer. There should be a blank line between any answer and the next question. This makes it easier to see which response belongs to which question

Nested questions

Nested questions should be indented on the PDF. Do not place them in a single line.

Form questions that have been answered using checkboxes and/or radio buttons should be replaced by bullet points on the PDF.

For example:
Correct

Host organisation
University Hospital of Wales

New or follow-up
Follow-up

Meeting date
15-May-2021

For example:
Incorrect

Host organisation
University Hospital of Wales
New or follow-up
Follow-up
Meeting date
15-May-2021

Example:

Past medical history

Does the patient have a pacemaker or implanted device?

- **Cardiac resynchronisation therapy (CRT-P)**

Has the patient undergone any previous cardiac Surgery?

- **Yes**
- **Valve surgery**
- **Aortic valve**
- **Replacement**
- **Mechanical**

Standard questions and responses

Some questions will have standard responses; a list of these will be created over time, the first of which is "Urgency"

Urgency

The categories of 'Urgency' in order:

- Routine
- Urgent
- USC
- Emergency (Inpatient/ED)

The label **hover text** should be:

"How urgent is the test or referral? Used for prioritisation and referral to treatment monitoring"

Questions

All questions **must be** in bold.

Sub questions **do not have** to be in bold.



The label must always be '**Urgency**'.



Labels like '**Priority**' or '**Category**' **should not be used**.

Attribution statement

Consider adding an attribution statement when a section is going to be used in another form or it is important that information is checked each time the form is edited. The form user can decide if the question needs to be asked again.

The attribution statement should be:

- "Last updated or confirmed 'date' @ 'time' by 'name'"
- In italics

Where a section in a form only contains a table and this table has individual attributes on each entry, there is no requirement to have an Attribution statement for the section.

A "Confirm section" checkbox will be at the bottom of the section.

Example:

Section heading	
Last updated or confirmed	→ Last updated or confirmed 9-Aug-2021 @ 16:30 by SHERING, Stephen G, Mr (GMC:3202142), Consultant, General Surgery ← In Italics
<input type="checkbox"/> Checkbox option	
Sub-section heading	
<input type="checkbox"/> Option 1	
<input type="checkbox"/> Option 2	
<input type="checkbox"/> Option 3	
<input type="checkbox"/> Confirm section	
↑ Confirm section	

eForms

eForm heading, including addressograph label

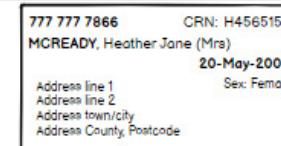
Headings

Sometimes it is difficult to pull all the information into the heading, for example an event date for the anticoagulation forms would be the discharge date, which would be impractical to pull through whilst the patient is still on a ward.

This guidelines should be applied on a case by case basis.

Outpatient medical note

Site: Amman Valley Hospital, Hywel Dda UHB
Event date: 20-April-2022
Specialty: Cardiology
Senior responsible clinician: AVERY, Philip G, Dr (GMC:2837176), Consultant
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Version: 2



Label

Patient Labels should be aligned to the right of the heading, as in the screenshot.

Consider the following:

- If the patient does not have an NHS number, do not put the name of the patient on the first line. Leave the name on line 2 to make it clearer that there is no NHS number
- The second column of data should be right aligned, as per the DSCN.
- Hovering over any of the data items should display a label, for example hovering over "Cook" in the example should show a label containing "Surname". This helps when some people have similar surnames and forenames.

Headings should:

- Display heading details on left hand side of label, left aligned
- Include a heading name in a larger font than the rest of the text

Include the following data:

- Site: include the hospital but if this is not possible, include the health board
- "The date label in the header should never say just "Date". It needs to be clear which date is being referenced, so if the "Event date" is not appropriate, then other options can be used such as "Meeting date" in the case of an MDT form, or "Discharge date" if the form relates to an inpatient stay
- Specialty: include the relevant specialty for the activity being recorded
- Senior responsible clinician: the SRC for the patient in that specialty
- Author: the author of the document
- The title should be displayed in brackets after the forename. This is a departure from the DSCN but necessary to enable the patient to be addressed correctly.
- No bar codes are necessary on the eForms. These will only display on the PDF versions of the eForm.

 CORRECT	 INCORRECT	 NOTES
- Adverse reactions	- Allergies - Allergies and intolerance - Patient warnings	Patient warnings are now recorded separately and are not part of adverse reactions.
- Automatic monitoring	- NIIAS	
- Patient warnings	- Alerts	
- Addressograph - Patient identifiers - Patient contact information	- Demographics	
- Countersign	- Authorise - Validate - Sign off	'Countersign' should only be used when a second signatory is required. See 'sign off' below.
- Sign off	- Authorise - Validate	'Sign off' is used in relation to a result, letter, or document.
- GMC number	- GMC code	
- Inpatient clinical notes	- Patient journal	A patient journal is a document written by the patient, like a diary.
- Lab test	- Pathology test	For many front-line clinicians, 'pathology' includes: - Autopsy - Gross pathology on resected specimens - Histopathology

[Continued on next page]

 CORRECT	 INCORRECT	 NOTES
[Continued from previous page]		<ul style="list-style-type: none"> - Cytology - and variants such as immunohistochemistry and fluorescent insitu hybridisation <p>But not lab haematology, clinical biochemistry, microbiology or immunology.</p> <p>There is an exception for the 'Pathology test request' WCP form.</p>
<ul style="list-style-type: none"> - Medication(s) - Med(s) 	<ul style="list-style-type: none"> - Drug(s) 	For many people, 'drug' means something that is addictive or misused.
<ul style="list-style-type: none"> - NHS Wales master patient index 	<ul style="list-style-type: none"> - eMPI - MPO 	
<ul style="list-style-type: none"> - NHS Wales user database and authentication system 	<ul style="list-style-type: none"> - NADEX 	
<ul style="list-style-type: none"> - Request 	<ul style="list-style-type: none"> - Order 	In relation to a test.
<ul style="list-style-type: none"> - Prioritise 	<ul style="list-style-type: none"> - Grade 	In relation to a referral.
<ul style="list-style-type: none"> - Professional registration number 	<ul style="list-style-type: none"> - GMC number - GMC code - NMC pin and RCN 	This is more inclusive of all users.
<ul style="list-style-type: none"> - Repeat test - Create similar document - Create follow-on document 	<ul style="list-style-type: none"> - Clone document 	'Clone' has a very specific meaning in biology and medicine.

 CORRECT	 INCORRECT	 NOTES
- Result notifications	- Alerts and notifications	'Alert' has a specific meaning in user interfaces, it is the highest level of warning and must be acknowledged before the user can do anything else.
- Senior responsible clinician	- Consultant	The senior responsible clinician could be a GP or a nurse.
- Test	- Investigation - Examination	This includes all endoscopy, endoscopic retrograde cholangiopancreatography (ERCP), and radiological angioplasty. Even though these are procedures, from the perspective of most frontline clinicians, they are usually requested and dealt with in the same way as lab tests. 'Examination' is used by some radiographers and radiologists, but this is unacceptable. For most doctors and nurses, it means looking at the patient with their own eyes, palpating their abdomen, and auscultating with a stethoscope.
- Test request	- Order - Message	In the UK, clinicians request tests from colleagues, rather than ordering them. In DHCW, 'message' is often a technical term when information is passed between IT systems
- Warning	- Attention - Notice - Danger - Please be aware	Warning is applied to the title and text of pop-up warning messages
- Speciality	- Specialty	Speciality and specialty have virtually the same meaning. Speciality is the commoner form in British English, specialty in American English.

Blue // background of section title bars, add buttons

#1B6EC2

Black // most text

CSS "black"

Light blue // background of record headings

#8CD2E7

White // most backgrounds

CSS "white"

Green // background of Save button, section complete tick

#008000

Silver // most lines

CSS "silver"

Light yellow // background of tooltips, hovered questions, hovered buttons

#FEE715

Dark yellow // background of hovered radio button or check box

#F4D03F

Orange // background of incomplete field counter, warning icons

#FD8A10

Red // background of badges like Draft and Cancel buttons, delete icons

#D50000

Link blue // text colour for hyperlinks

#337AB7

Pink // background colour to highlight errors - this might change or be removed

#FFC0C7



```
<link href="https://fonts.googleapis.com/  
css?family=Roboto:300,300i,500," rel="stylesheet">
```

Main font

```
font-family: 'Roboto';  
font-size: 1rem;  
font-weight: 300;  
letter-spacing: 0.01em;  
line-height: 1.2;  
color: black;
```

Bold font - same as **Main font** but

```
font-weight: 500;
```

Form title - same as **Main font** but

```
font-size: 2rem;  
font-weight: 500;
```

Form subtitle - same as **Main font** but

```
font-size: 0.8rem;  
font-weight: 500;
```

Form "metadata" (site, date, etc) - same as **Main font** but

```
font-size: 0.8rem;
```

Column headings - same as **Main font** but

```
font-size: 0.6rem;  
font-style: italic;
```

Patient label - different, matches DSCN // **Bold**

```
font-family: Arial;  
font-size: 11pt;  
font-weight: bold;
```

Patient label - different, matches DSCN // **Not bold**

```
font-family: Arial;  
font-size: 11pt;
```

small // (for address and Sex: Male) (the "small" is not in the DSCN but it improves appearance and layout)

```
font-family: Arial;  
font-size: 9pt;
```



Other

Most CSS **margins, borders and padding**

None

Box borders and corners
(most elements do NOT have borders)

padding: 0.4rem;
border: 0.1rem solid silver;
border-radius: 0.4rem; (0.8rem for left corners of
section tabs)

Most lines

border: 0.1rem solid silver;

Most transitions

transition: background-color 0.5s ease-out;

Specific elements

Top title bar and patient label area

width: 100%;
margin-bottom: 0.2rem;
border-bottom: 0.2rem solid blue;
border-bottom-color: (cBlue); (see red above)
padding: 0.2rem;

Patient label

padding: 0.4rem;
border: 0.1rem solid silver;
border-radius: 0.4rem;
background-color: white;

Badges (like Draft)

font-weight: 500;
color: white;
background-color: cRed; (see red above)
padding: 0.2rem 0.5rem 0.2rem 0.5rem;
border-top: 2px solid white;
border-bottom: 2px solid white;

Navigation panel // there is a table for layout with

border-collapse: 0.4rem;
border-spacing: 0.15rem;



Section tab in nav panel

```
display: table-cell;  
margin: 0.1rem;  
padding: 0.1rem;  
padding-left: 0.6rem;  
padding-right: 0.6rem;  
border: 0.2rem solid transparent;  
border-top-left-radius: 0.8rem;  
border-bottom-left-radius: 0.8rem;  
text-align: right;  
white-space: nowrap;  
background-color: #1b6ec2; //hcBlue  
color: white;
```

Missing info counter in nav panel

```
display: table-cell;  
width: 1rem;  
margin-left: 1rem;  
padding-left: 0.6rem;  
padding-right: 0.6rem;  
font-weight: 500;  
text-align: center;  
background-color: #1b6ec2; //hcBlue  
color: white;
```

Section title

```
padding: 0.2rem;  
padding-left: 0.4rem;  
font-weight: 500;  
text-align: left;  
color: white;  
background-color: cBlue;
```

Section content

```
margin-top: 0.4rem;
```

Section attribution statement and filter lines

```
padding: 0.2rem;  
padding-bottom: 0.1rem solid blue;  
border-bottom-color: cBlue;  
font-size: 0.8rem;  
font-weight: 300;  
font-style: italic;  
color: black;  
background-color: white;
```

Record list

```
padding-bottom: 2px solid blue;  
border-bottom-color: cLightBlue;  
margin-left: 2%;  
margin-right: 2%;
```



Record title bar

```
background-color: cLightBlue;  
font-weight: 500;  
padding: 0.2rem;  
padding-left: 0.4rem;
```

Record attribution statement

```
padding: 0.2rem;  
padding-bottom: 0.1rem solid blue;  
border-bottom-color: cBlue;  
font-size: 0.8rem;  
font-weight: 300;  
font-style: italic;  
color: black;  
background-color: white;
```

Record content area

```
margin-top: 0.4rem;
```

Main button

```
display: inline-block;  
height: 2rem;  
margin: 0.2rem;  
border: 0.1rem solid (color);  
border-color: (color);  
border-radius: 0.4rem;  
padding-left: 1rem;  
padding-right: 1rem;  
text-align: center;  
text-decoration: none;  
white-space : nowrap;  
color: white;  
background-color: (color);  
cursor: pointer;  
transition: background-color 0.5s ease-out;
```



Add button

```
display: inline-block;  
height: 1.6rem;  
margin: 0.2rem;  
border: 0.1rem solid purple;  
border-color: (color);  
border-radius: 0.4rem;  
padding: 0 0.6rem;  
text-align: center;  
font-size: 0.8rem;  
text-decoration: none;  
white-space: nowrap;  
color: (color);  
background-color: white;  
cursor: pointer;  
transition: background-color 0.5s ease-out;
```

Boxed control at bottom of form, like Final checkbox

```
border: 0.1rem solid silver;  
border-radius: 0.4rem;  
display: inline-block;  
height: 2rem;  
line-height: 2rem;  
margin-left: 0.2rem;  
padding: 0 0.5rem;
```

Row of buttons at bottom of form

```
border-top: 0.2rem solid (cBlue);  
padding-bottom: 2px;
```

Single line text input

```
max-width: 35rem;  
margin: 0;  
border: 0.1rem solid silver;  
border-radius: 0.4rem;  
font-size: 1rem;  
font-weight: 300;
```

Radio button group, most question types (including label)

```
padding: 0.4rem;  
border-radius: 0.4rem;  
border-width: 0;  
margin: 0;
```

Grid cells, grid rows (for layout of questions)

```
border: none;  
margin: 0;  
padding: 0;
```



Tables (for tabular data) enclosing div (*includes table title*)

```
padding: 0.4rem;
```

Table cells

```
border-bottom: 1px solid silver;  
padding-left: 0.3rem;  
padding-right: 0.3rem;  
font-weight: 300;  
vertical-align: top;
```

other

```
border: none;  
margin: 0;  
padding: 0;
```

WCP

Welsh Clinical Portal

WNCR

Welsh Nursing Care Records

WCRS

Welsh Care Records Service

