Michael

Introducing Michael

Please note, the purpose of this narrative is to provide an example for interoperability. We have had the narrative reviewed by a number of HCP's* and believe it to be a realistic reflection of this scenario. However, we do understand that this may not reflect regional differences. Please focus on the requirements for patients and data, moving across a number of services, rather than specifically how these services work.

Hello, I'm Michael. I'm 58 years old and I live alone in a small flat. I don't work and I don't go out much because I suffer from anxiety attacks. Sometimes people perceive my behaviour as being aggressive. Once someone called an ambulance and in A&E the staff called the police. It was so scary it made my anxiety worse and I became more agitated, this meant that I couldn't explain what was wrong, I just needed them to know.

My mental health team understand my challenges and told me they could use their computer to share information, they called it a flag. I have agreed that information may be shared about me. The last time I had an attack a passer-by thought I was having a fit and called an ambulance. Now that flag is available, the A&E team called my mental health team. This is so important to me, I am less frightened of what happens when I have an attack and this makes me less anxious.

I am also diabetic and have a foot ulcer. A community nurse comes to see me at home twice a week. She cleans and dresses my ulcer and takes blood tests to check my sugar levels. I'm not very good with taking my insulin, sometimes I forget. The practice nurse tells me this is wrong and said I need to see her more often. I don't want to do this and hate going to the hospital clinic. That's where I saw Dr Singh he said he could see all the information from the different teams and I was putting myself at risk by not following their advice.

Now I go to the local pharmacy each week, to discuss my medication compliance so I don't have to go to the practice so often. The district nurse still comes in and she and the pharmacist share information with my GP practice and Dr Singh.

They enrolled me on a telehealth scheme. I get texts to prompt me to eat at the right time and remind me to take my medication and tick it off to say I have done it. I also have access to my health records and can see a list of all my appointments, so there's no excuse for missing any now. I'm really pleased and promised to try harder to comply with their advice.

That's what made me decide to stop drinking. I thought if everyone was helping me I should do something myself. I only drink at night and do put water in my whisky. I never told the truth to the doctors and Dr Banerjee's team. I even fell out with my family as they said it was too much, I just didn't realise how bad it was. I was fine the first two nights but then I started to sweat and felt terrible, my heart was racing and I felt disorientated. It was late so I rang out of hours.

I remember talking to the out of hours GP but then it all went black. They told me afterwards that I'd had a seizure bought on by withdrawal from alcohol, I vaguely remember being in an ambulance and then at A&E, but it was a couple of days before I was aware enough to know I was on a ward. It was a good job they had their computers as I couldn't tell them I was diabetic and was taking tablets for my anxiety.

I'm glad I gave permission to share my data, as that helped them choose the right treatment and meant that Dr Lowndes at outpatient's knew exactly what had happened in all my clinics and I didn't have to remember all the details.

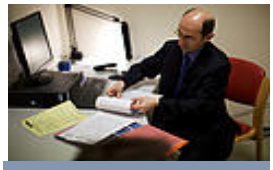
Now I'm home and feeling better, I have extra tools to help me cope. As well as the text alerts on my phone, to remind me to eat regularly and to take my medication, now I'm less anxious and alcohol free I am able to use other apps. I record my weight and blood sugars regularly. This is helping me with my diabetes and makes me feel more in control of my own health. It also means I need fewer appointments, so I worry less.

I've managed to stay off alcohol with the support of Dr Lowndes and my mental health team. I have another app on my phone which links me into the liver team and supports my recovery.

Now I order prescriptions on line and don't have to go to the GP practice. I pick them up from the local pharmacy and they all receive information I enter on the phone, I'm proud to say, shows than now I'm taking my medication properly.

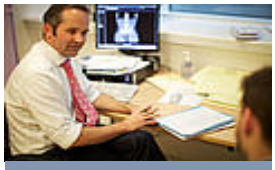
I lost touch with my family, probably because they could see how much I was drinking. Now my sister visits after work on Wednesdays and makes sure I have the right food in the house. I share my on-line records with her and, now she can see I'm not drinking, she's able to support me in staying healthy and staying out of hospital.

Mrs. Banerjee
Mental Health



Dr Singh
Diabetes MDT

Jacky
Ward Manager



Dr Lowndes
Liver Specialist

Meet the team

Hello, I'm **Mrs Banerjee, I am the lead CPN**, working with Dr James our Community Mental Health Team Psychiatrist. We've been working with Michael since he was a teenager, helping him to understand and manage his anxiety attacks. There have been times when Michael has been drug free, however, his partner recently left him, he lost his job and the stress has exacerbated his condition. For the past four years Michael has been taking 150 MG Venlafaxine each day.

Michael's anxiety attacks often make him agitated and resulted in a visit to A&E and the police being called. We want to prevent this. With his consent, I put a flag (special patient note) on Michael's record. This flag will appear on all Michael's associated records, meaning all teams will be alerted to his mental health issues and our team's contact details.

Hello, I'm **Dr Singh, I am an endocrinologist specialising in Diabetes**, working in the hospital Out Patient Department. Working closely with the primary care team, I am able to see the data they have collected regarding Michael, along with the history from our clinics and the community pharmacy. All the data merges to give me the information I require in graph format.
I see a correlation between Michael's weight, blood sugar, insulin prescriptions and HBA1c. This visual view containing information gathered by the primary, community; secondary care and the patient is essential to me as I can see – at a glance - the impact on Michael's diabetes in relation to changes in his medication; weight or diet.
Michael needs help to conform to his medication regime. We send an electronic referral to the community pharmacy, ensuring they have access to Michael's prescribing history and the graphical view of the key indicators and know to alert us of any negative changes.
We also enrol Michael on our telehealth scheme, it is a simple, yet successful, tool which uses SMS text messaging to remind patients to eat and medicate routinely. We are also able to receive data from Michael in relation to his sugar levels and weight through the same device.

Hello, I am **Jacky, I am a ward manager on an Acute Medical Unit**. To update our consultant. I need to create a record. Michael is unable to provide answers to our questions about his history. I search to see who else in involved in this patients care and find the names of his GP; pharmacy; mental health and community teams and Dr Singh's diabetic clinic. I quickly send an alert to each of them to let them know Michael is with us and will be here for a few days.

With access to these records I am able to pull data into our system to populate the MAU record. Including demographic details and information relating to Michaels, MDT diabetes record; MHT treatment for anxiety; Data regarding today's encounter with OOH's and Michaels seizure; Details of examination and investigations in A&E.

When the consultant arrives I'm able to tell him that Michael is a 58-year-old man, who lives alone, has poorly managed diabetes and is taking insulin. His HBA1c has recently improved due to MDT intervention. He suffers from anxiety and took 150 mg of Venlafaxine 8 hours ago. He stopped drinking suddenly, and is showing signs of alcohol withdrawal. In A&E he had a CT scan which shows no sign of stroke. Fully informed the consultant is able to implement our protocol.

Hello, I am **Dr Lowndes, I'm a Liver disease specialist**. I see from his inpatient records that, Michael had a psychiatric review. I call up who else is involved in this patient's care and see that Michael is a patient of Mrs Banerjee. I send a task to ensure my team engage with the community mental health team to support us in keeping Michael alcohol free.

I also see that that MHT have been prescribing 150 MG Venlafaxine and that Michael is a diabetic. Once I have assessed him I may need Michael to see our comorbidity medicines management team, our system will alert all the other teams about my prescribing choices.

I pull up Michaels investigations report. This gives me a correlated view of his tests and results from primary; community and acute care. I am particularly interested in his LFT's and Serum levels. Michael has had regular FBC's because of his diabetes and I'm able to see this data integrated with the recent tests run in A&E and on the MAU.

As it's a month since he was in MAU and Michael assures me he has stopped drinking, I re-run a number of the tests and request an ultrasound scan. I will see Michael again in a month to review. My nurse works with Michael to create a care plan, which will be shared with his GP; Diabetic and Mental Health teams. We also enrol Michael on our telehealth scheme to enable him to more effectively manage and monitor his health and to alert us if there are any changes.

*References: - The story has been validated by 10 GP's, two Consultant Psychiatrists, a Ward Manager with experience of alcohol withdrawal and a Chief Information Officer.