ePONS User Manual

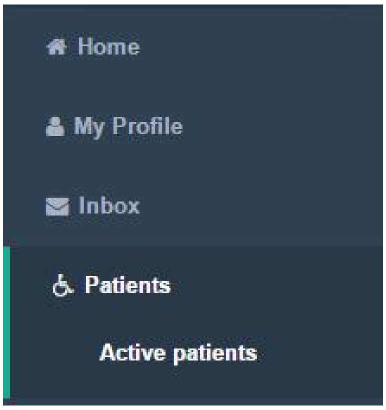
Last Updated 2016 JUNE

Contents

1. First Login

If you have not received an SADFM registration email yet, ask your administrator to arrange an SADFM login. You need to give them your Moodle (Online Credentialing Examination Software) username, as well as your work- or personal email address, Name & Surname and Profession and your role in the Facility in order for this to be enabled. When you receive the email, follow the instructions to set up your Profile. This involves creating a password, setting up a security question in case you get locked out of the system, and filling in some additional personal details. You will need to remember your username and password to log in in the future.

Once logged in, you will see various menu options on the left of your screen, depending on the permissions you have been set up with.

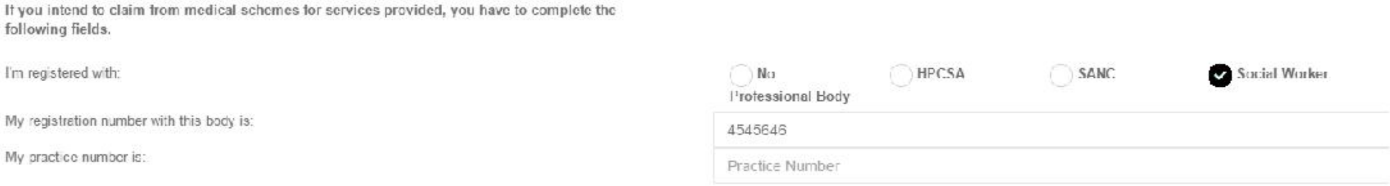


2. General

You will be logged out if you have been inactive for 10 minutes. After this you will have to log back in with your username and password if you want to carry on working on the system.

3. My Profile

Once you have setup your Profile details, please make sure you have entered your "**Professional Body**" details (i.e. HSPCA or SANC), as this will allow you to have access to enter Notes / Comments on the Visit page. (Depending on your Role and permissions) If this is left open you will not be able to enter any Notes / Comments for the Patient Progress Reports.



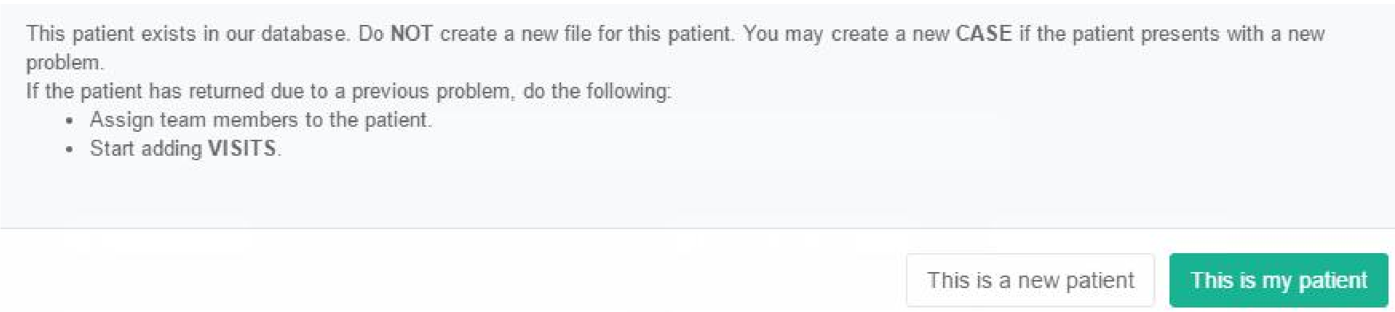
4. Patients

Here you can find existing patients by searching on various fields. Double click on a patient to view their file and perform various functions.

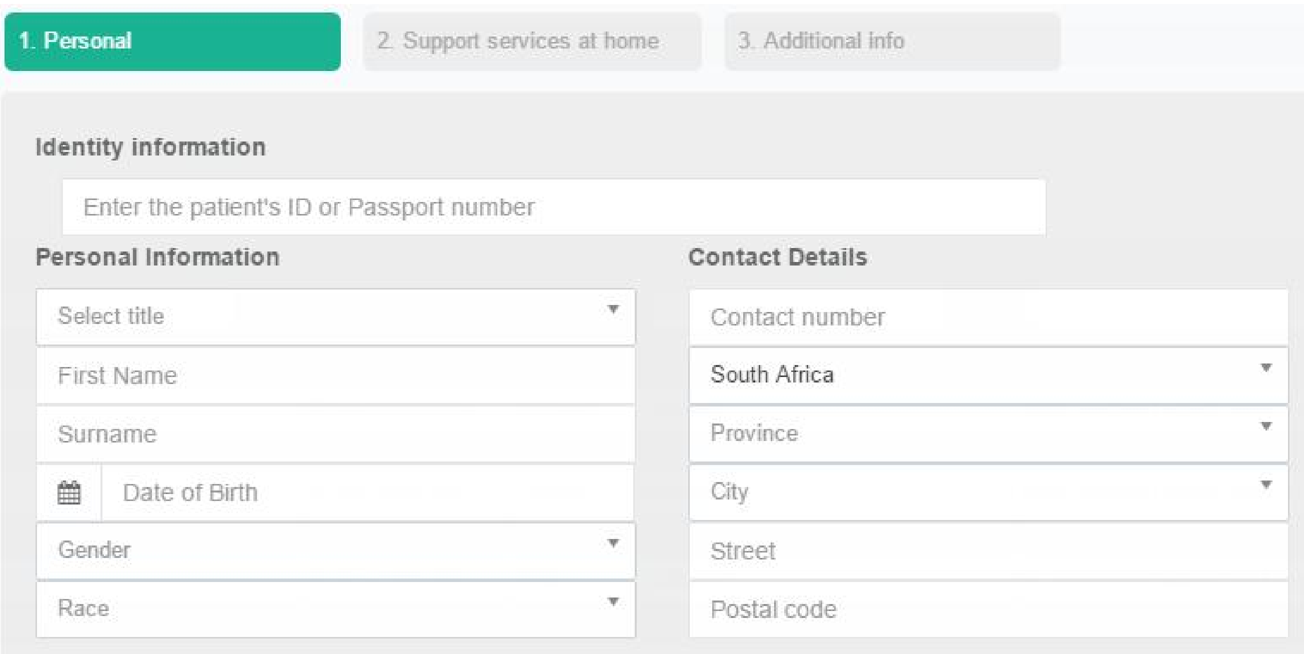
a. Add Patient

This function is available to Case Managers and Administrators only.

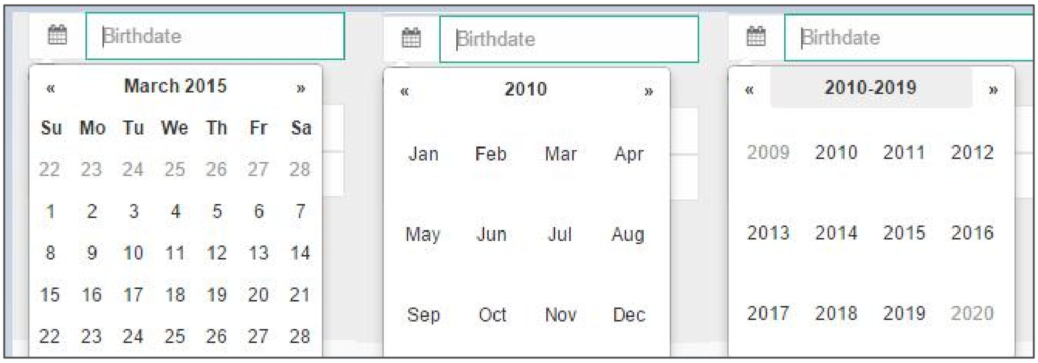
Go to Patients > **Active Patients** and click on ***Add a New Patient***. First, enter their ID or Passport Number and tab or click into the next field. If this patient already exists in the system, you will be given the option to open their record. Add a case if they don't have existing cases that are relevant to your treatment plan.



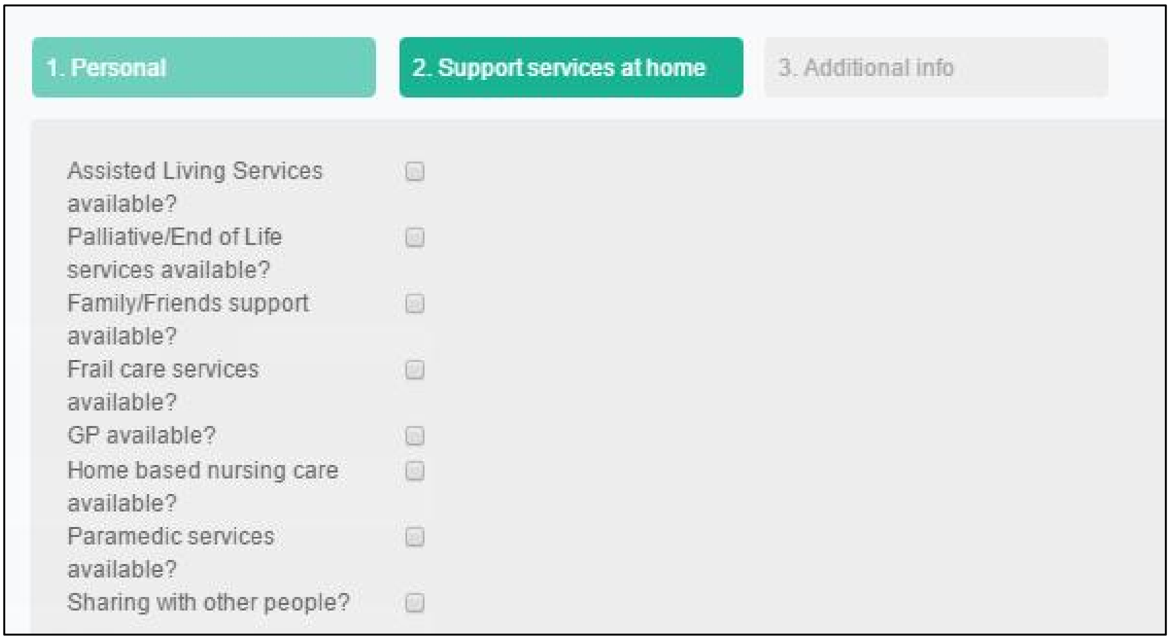
If the patient does not exist in the system yet, you can fill in their details to create a patient record.



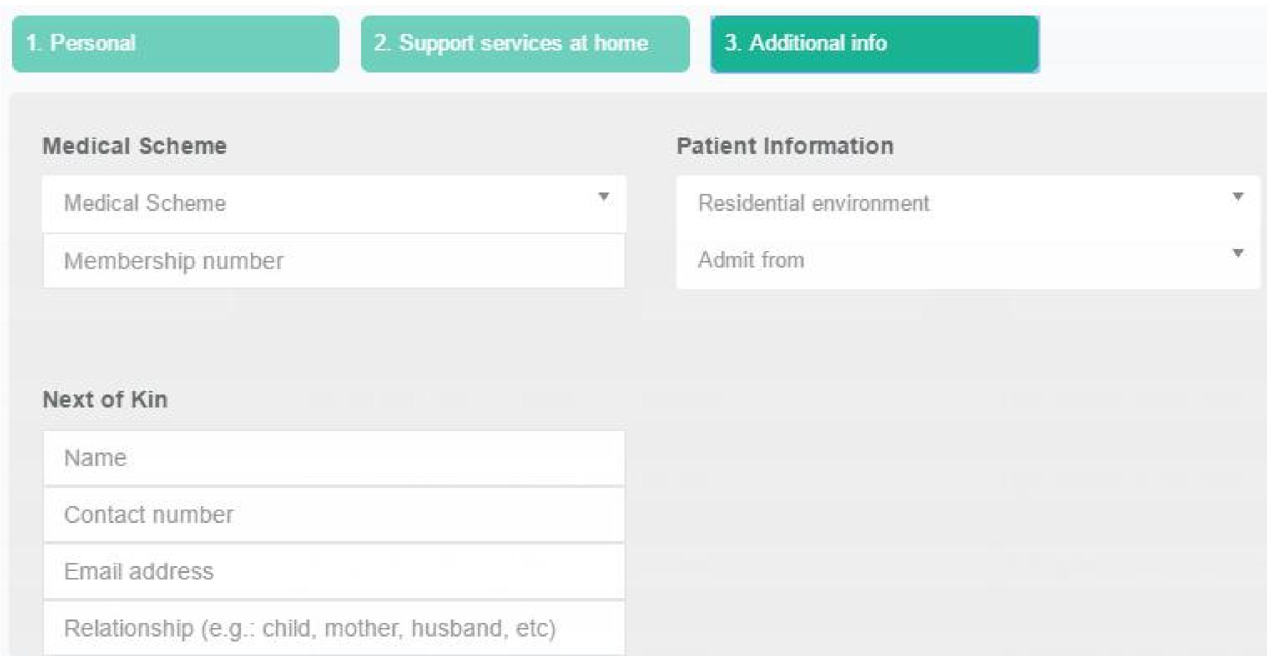
Tip: In order to go back in time on the calendar picker, click on the top bar to zoom out from month > year > decade, and click on the left arrows to go further back in time:



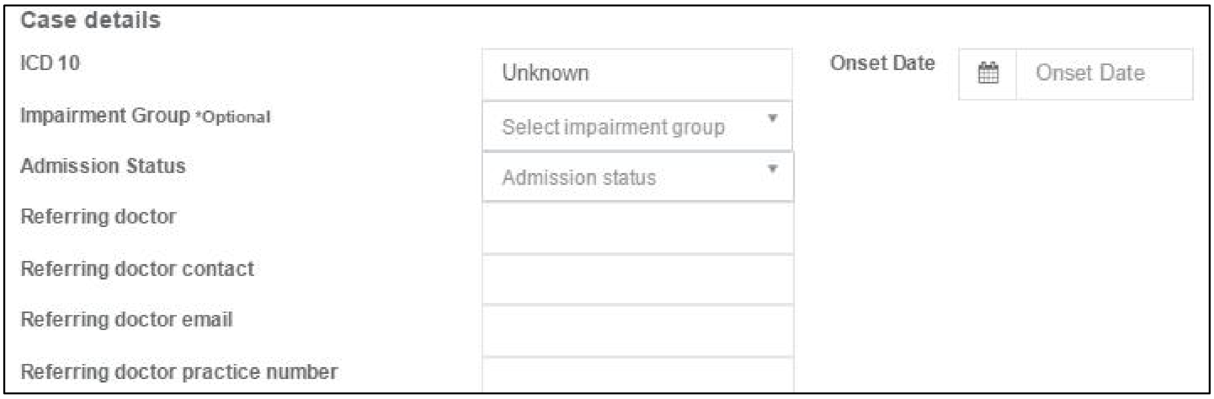
Click on ***Next*** to fill in the Support Services at home details



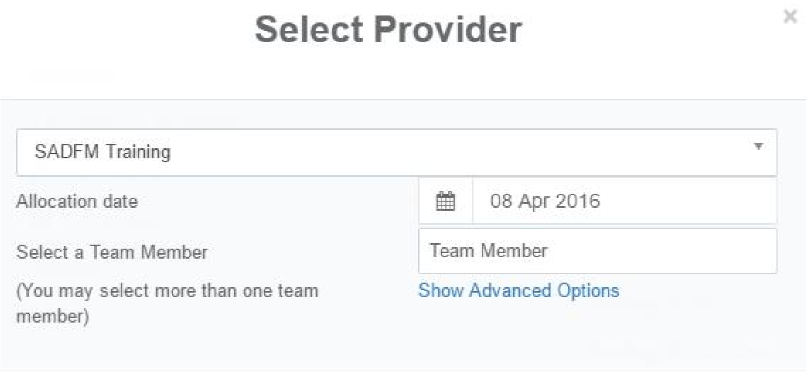
Fill in the additional info, and click on Save:



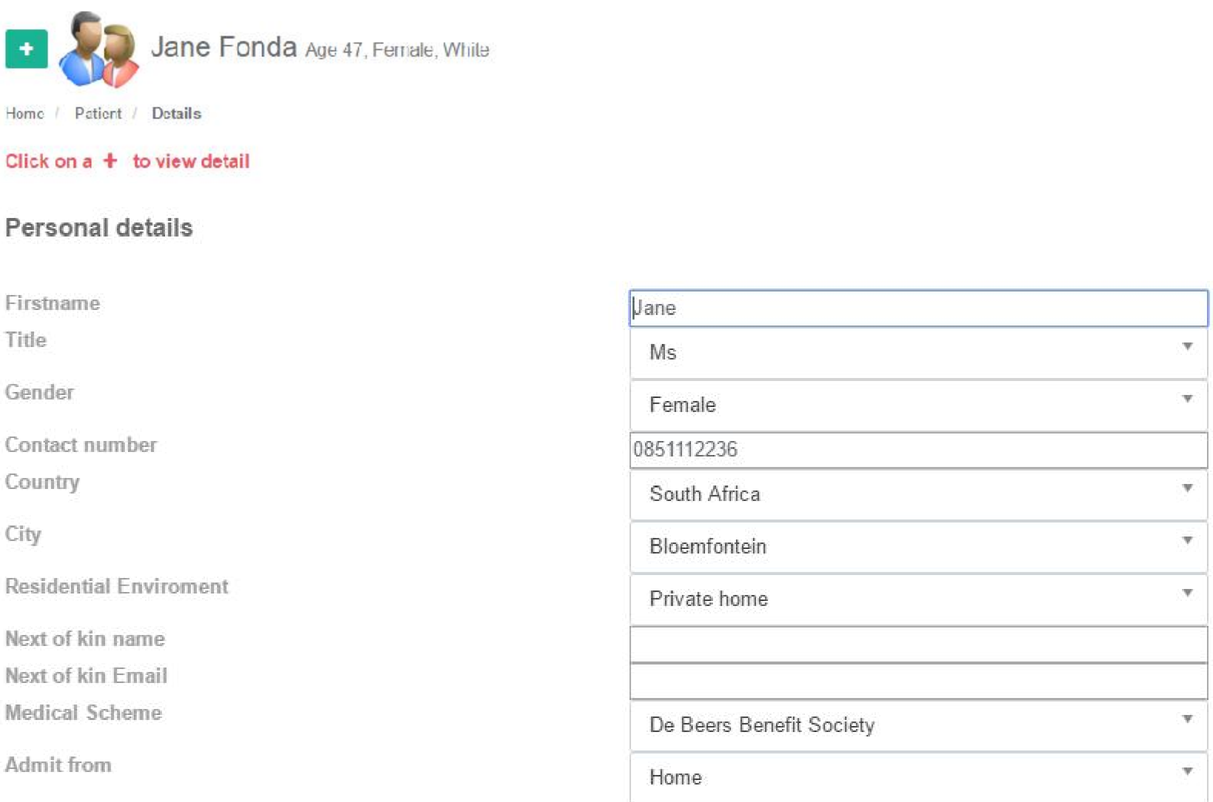
Fill in the Case details: ICD-10 if known, and **Onset Date** – all the other fields are optional. You can keyword search for the ICD-10 code or description, and the results will appear. If you're a Case Manager you can add the recommended scales, Administrators cannot perform this function as it requires medical expertise.



You can now assign the case to a specific individual. To add it to more individuals, select the Add button next to the Multi-Disciplinary Team (MDT) section on the next screen.

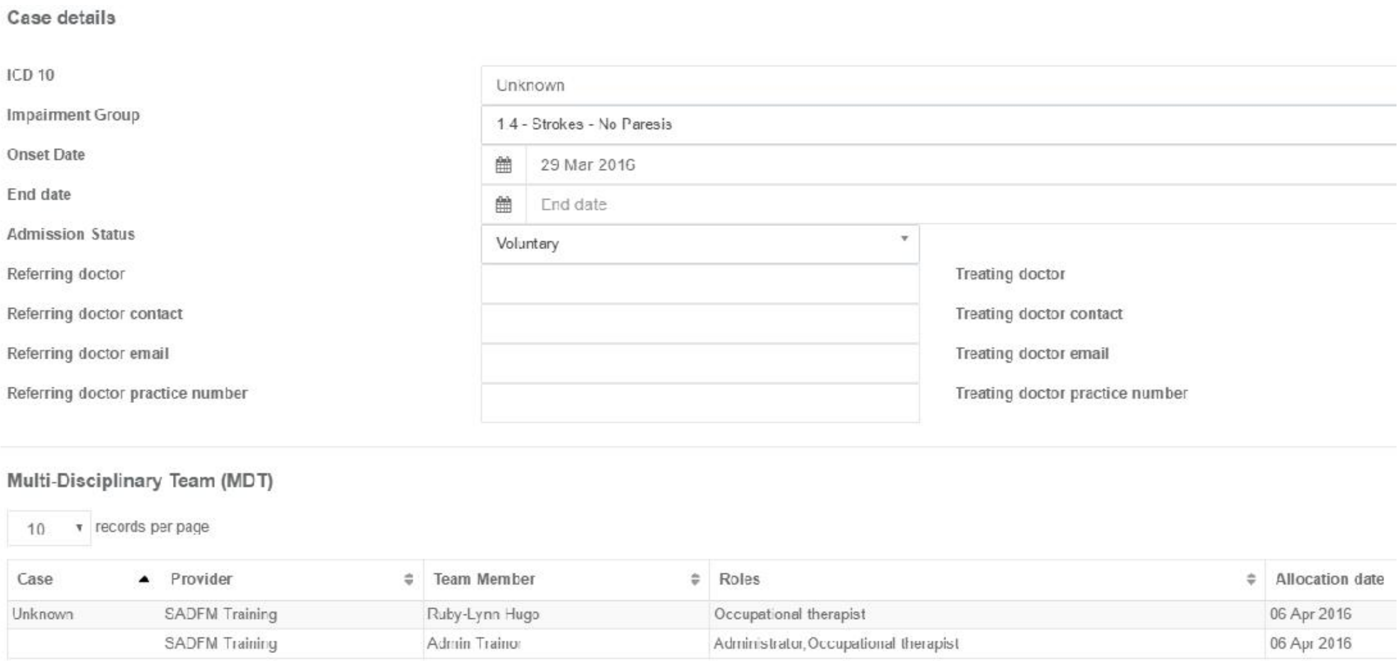


Once all Patient Demographics / Info has been saved you may view and edit when necessary by clicking on the top left next to the Menu.

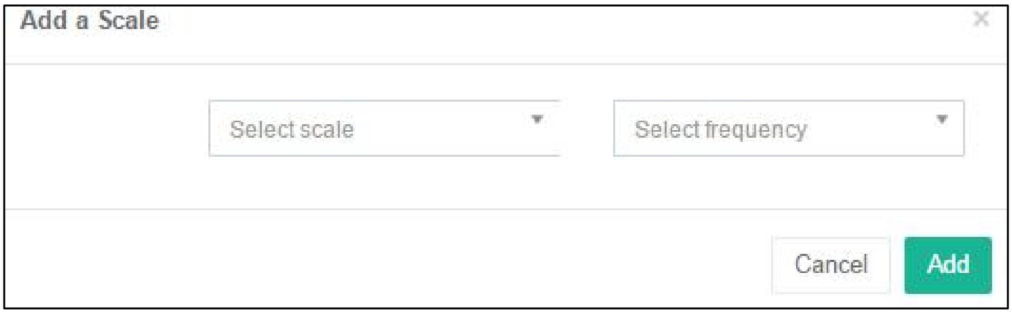


b. Cases

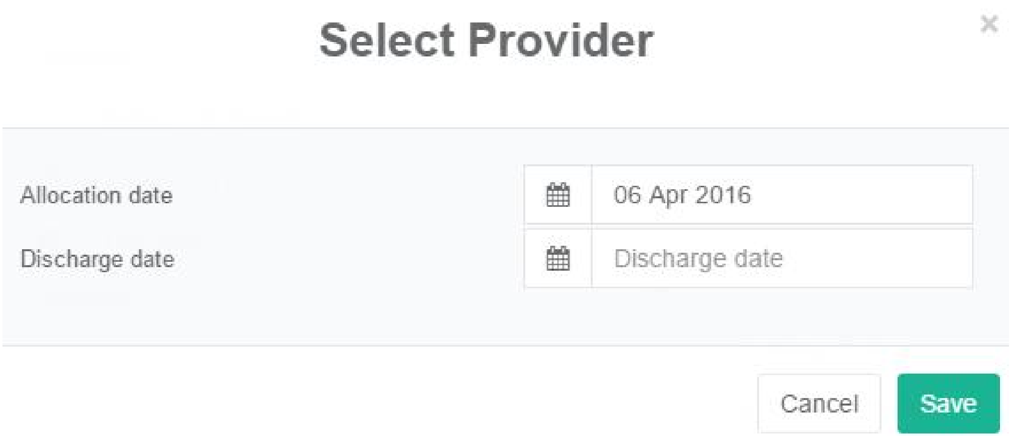
Double click into a case for more details. To edit the details, click on Edit, make your changes and click on Save.



Case Managers can also edit the care plan here by adding /removing scales and recommended frequencies:



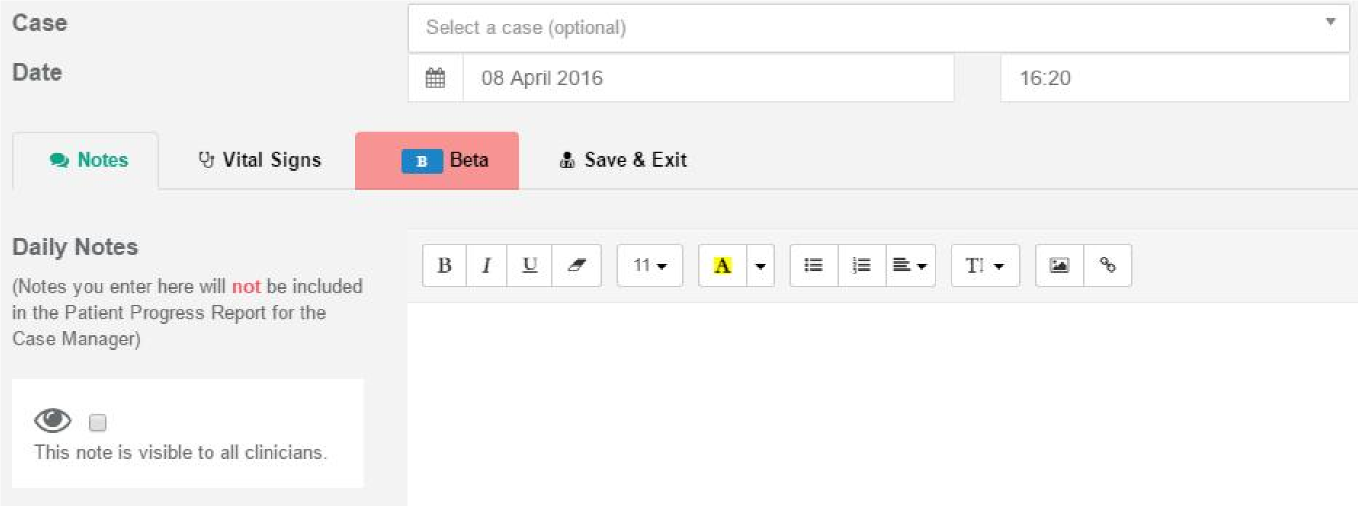
Case Managers can also edit the MDT team members by double-clicking a MDT member. This is for Discharging yourself from a patient's care when your services are not required anymore.



c. Visits

Add a Visit to capture one or more of the following observations: Notes, Scale Scores, and Attachments like photos, pdfs, and word documents.

The **Daily Notes** section will not be included in the Patient Progress Report for the Funder Case Manager.



On the left side of the Notes area, you can decide to disable or enable the View of your Daily Notes for other Clinicians. Once disabled, these notes will only be visible to you.

You may Copy & Paste text from various file formats. Text from a Word document, tables from an Excel document. (Try to avoid pasting picture files)

Instead you can attach any document format i.e. pictures files, Word, Excel and PDF.

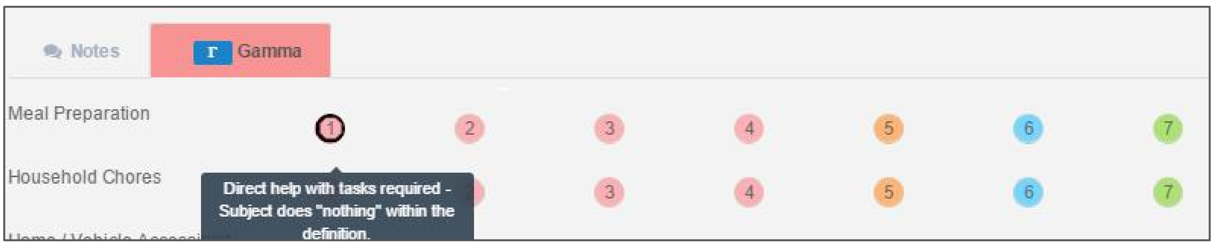
You can add your Notes for a patient on the **Patient Progress Notes** section that needs to be viewed by the Funder Case Manager.

The date and time will be automatically populated with the time you clicked on "**Add a Visit**", but you can edit it if necessary.

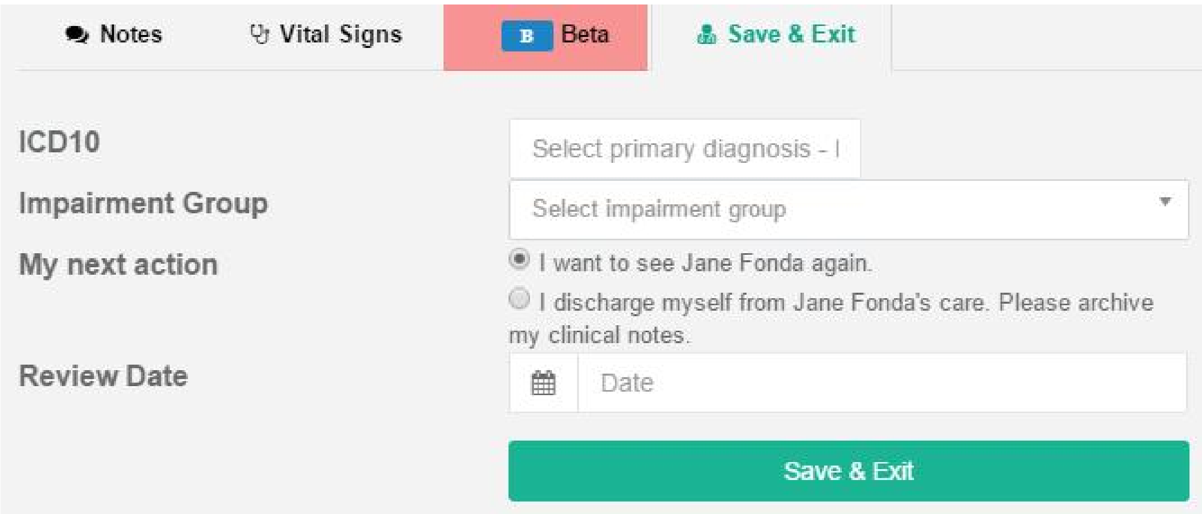
There will be a tab for each scale on the patient's care plan. If a scale needs to be added, this can be done by going into the relevant open Case, clicking on the **Edit** button, and selecting "**Add Scale**".

If the patient is overdue an observation, the tab will be highlighted in red. But you may enter scores even if the tab isn't highlighted in red. ***You will only be allowed to enter observations if you have passed your exams for that particular scale, and if your provider has subscribed to the scale***.

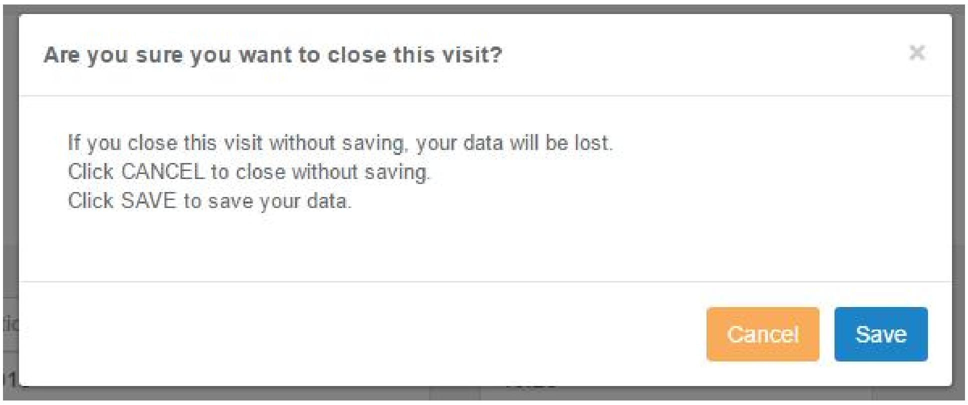
On the Scale tab, hovering the mouse over a score will show a tip on the specific score. Hovering it over the item will also show a tip. You may enter a score for all items on the scale, or complete some and create a visit later to add additional scores.



To save the visit, go to the **Save & Exit** tab, select a visit duration and a review or discharge date, and click on **Save & Exit**. If you discharge the patient, they won't appear in your patient list anymore. Instead they will appear in your **Discharged Patients** Menu.



Once clicked on the "Close" button of the Visit page, you will get a pop-up window asking you to make sure you save your data entered.



d. Messages

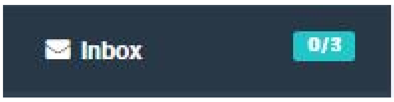
You can send out messages about the patient to colleagues.

On the patient file, click on the **Messages** button:

Click on **New Message**, select in the recipients and the message text, and send the message. These people will be informed of the message directly, but the message will also sit on the patient file, for anyone else to see.

If someone has sent you a new message, it will be shown on your Inbox:

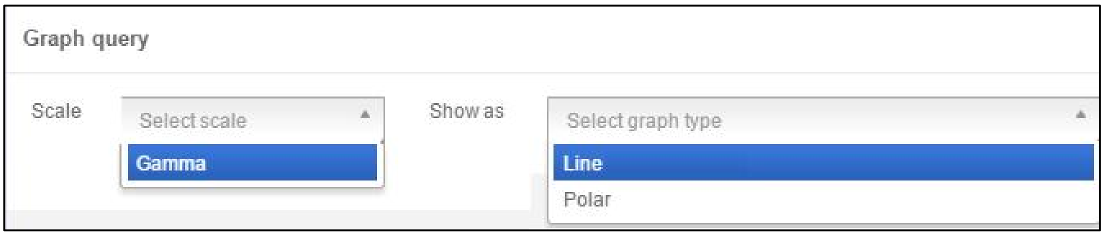
If you only have messages that you have already read, it will display as follows:



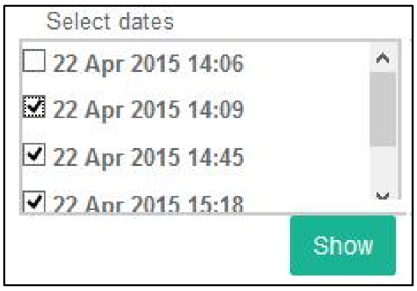
e. Graphs

On the patient file, click on the **Graphs** button: 

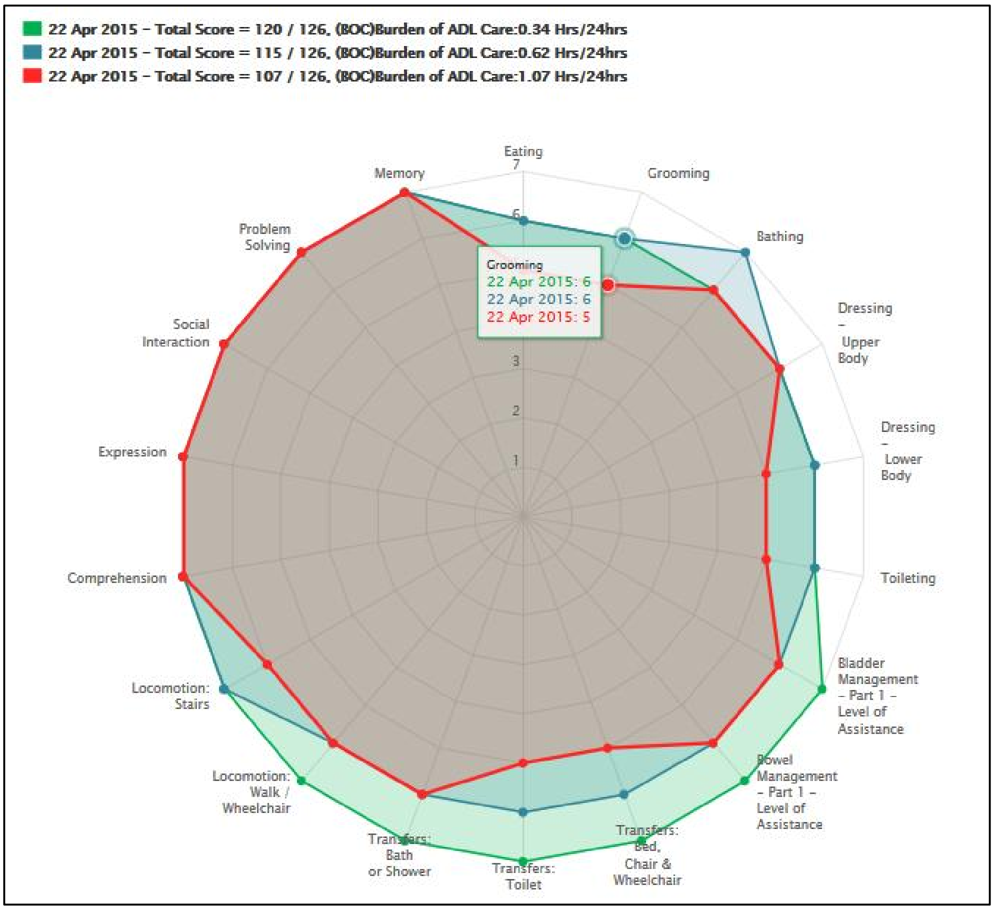
Then select the scale you want to look at, plus Line or Polar graph. Only scales where all items have been completed at least once for the patient, will be shown here.



For a **polar graph**, select up to 3 (three) dates to display on the graph. Then hit the show button.



The graph will be displayed, along with the legend at the top. For the Beta scale, the Burden of Care will be displayed. If you hover over a data point on the graph, you will also see the values for the different times on a pop-up box. If you are viewing a polar graph, you can also click on the **Download** button, which will generate a PDF of the graph, along with additional patient information.



f. PDF Patient Progress report

If you want to view and download the **Patient Progress Report**, you can click on the

button, which will generate a PDF of the graph(s), along with additional patient information and the Notes you have entered for the Visit(s).

By selecting the Dates for the Progress Report and you can also view the Report by putting a tick in the **Order by Discipline or not.**

5. Training

This function is available for users with Training permissions only.

On the left-hand menu, click on ***Reports*** and then ***Training Report*** to view details of your team's training progress.

6. Administrators

These Administrators will have an extra heading in the Main Menu on the left for viewing Facility Reports.

The Following *Explanations* for some of the "**Facility Volume Report**" and the "**Service Performance Report**" are set out below:

Some Definitions of words used within the manual to guide you in this section.

% = the percentage of the total of Admissions for that specific impairment.

ALOS = Average Length of Stay for that impairment.

Onset Days = the amount of days from date of onset (injury, beginning of illness, surgery) to the day of admission into sub-acute.

Admission Score = the average admission scores for that impairment.

Discharge Score = the average discharge scores for that impairment.

Gain = functional gain between admission score and discharge score.

LOS = amount of days between admission date and discharge date.

Efficiency = functional gain divided by the LOS i.e. 10/10

Calculating the Burden of Care (BOC) Only the Beta Scale

The **Burden** of care of any patient at any stage can easily be calculated to evaluate and plan for the patient's care and treatment plan.

It must be understood that BOC only refers to help rendered to the patient's activities of daily living e.g. eating, bathing, transfers,

bladder and bowel management, help with cognitive items such as comprehension, expression, problem solving, memory etc.

From this it is clear that a BOC is not a once off period but rather the sum total of the time spends with a patient over a 24-hour period.

If all the patients in a sub-acute facilities Beta scores are available, the unit can easily calculate the collective caregiver BOC required for the facility over a 24-hour period.

Please note:

- **BOC does not include professional nursing such as wound care, intra venous and intra muscular therapy, patient management.**
- **BOC does not include professional therapeutic services.**
  The psychiatric patient's BOC cannot be calculated with this formula.