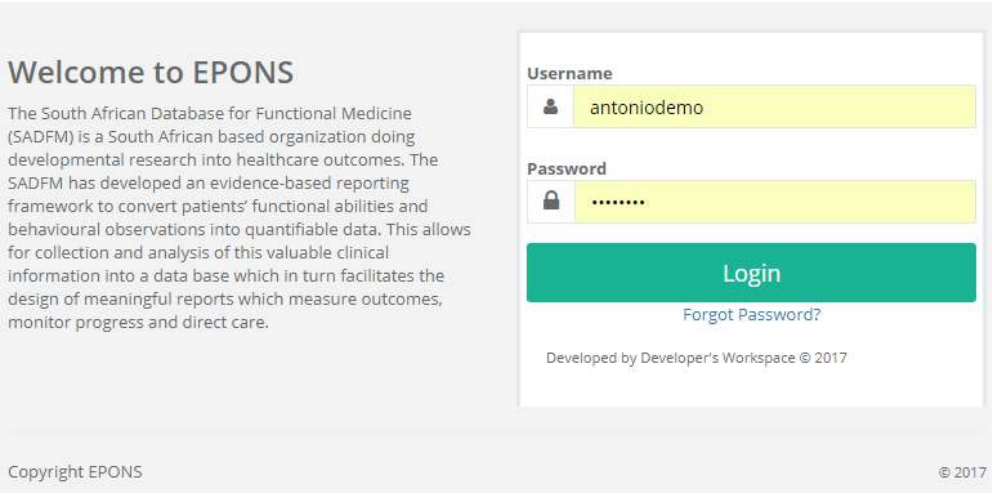
ePONS User Manual

Last Updated Ver.1

Contents

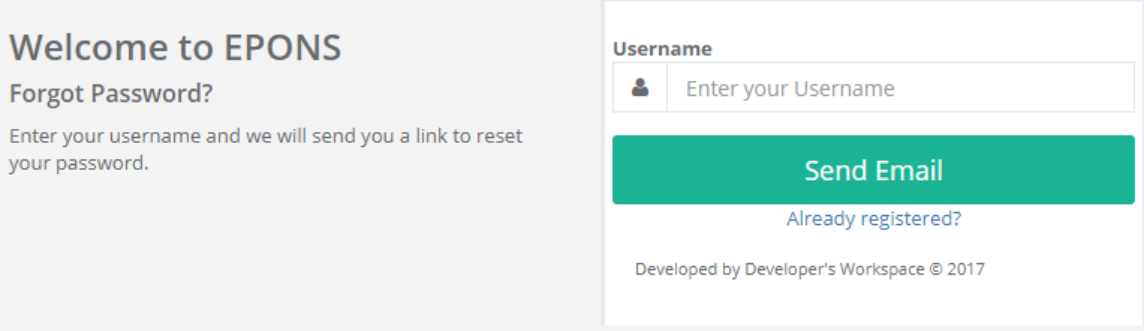
1. First Login

If you have not received an ePONS registration email yet, ask your SADFM administrator to arrange an ePONS login by contacting antonio@sadfm.co.za or skipdokter@yahoo.com. You need to provide SADFM your Name & Surname, as well as your work- or personal email address (NO shared work addresses), Profession i.e. Registered Nurse or Occupation Therapist and your role i.e. Administrator or Clinician in the Facility for this to be enabled. When you receive the email, follow the instructions to set up and finalise your Profile. This involves creating/change a password, filling in some additional personal details. You will need to remember your username and password to log in in the future.



Back to Contents

If you cannot remember your given ePONS password, click below the "**Login**" button, on the blue "**Forgot Password**?" text and you will be re-directed to a new window to enter your **Username** and Send an Email to the SADFM Administrator. *The "Already registered?" text will take you back to the Login Screen.*



Once logged in, you will get an **Notification regarding patient confidentiality** -

SADFM stores your personal details, including your name, ID number and email address for identification and communication purposes. In this application you are likely to have access to sensitive patient information.

By using this application, you agree to respect patient privacy and not reproduce or share any information, personal or medical, to any unauthorised parties.

2. General

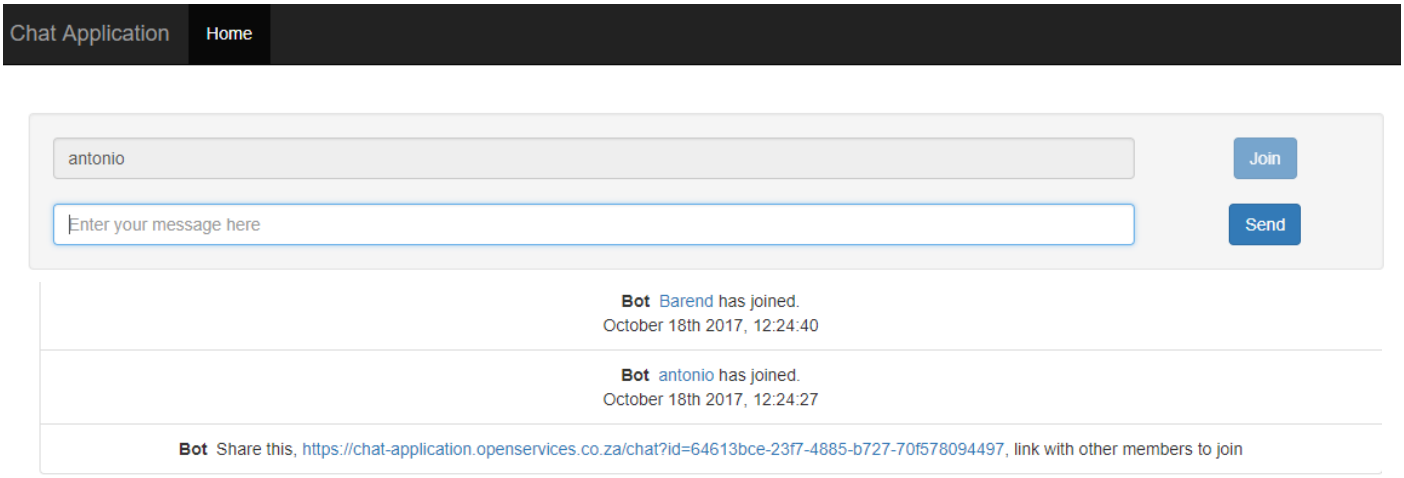
You will be logged out if you have been inactive for 10 minutes. After this you will have to log back in with your username and password if you want to carry on working on the system.

All **+View** buttons on all Windows, Tabs will view the Patient Details and here you can **Edit** or **Add** data and **Save** once done. **Most of the Sections where data is entered, it will be saved when clicking on the -View button again, unless otherwise, there is a Save or Save & Exit or Update button.**

Where ever you get to a field where you need to enter data and you see a "**Select an Option**" > this means this is a dropdown menu where you can select from assorted entries.

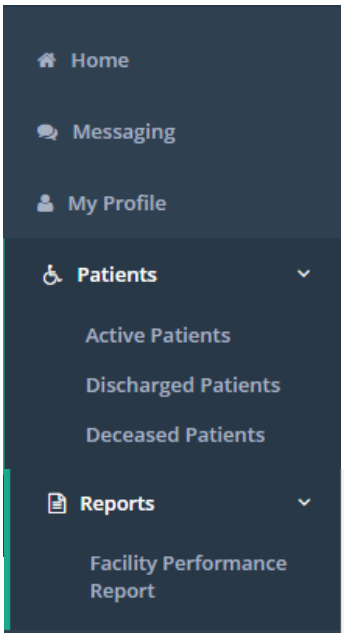
At the top right of the home screen, you will find your *username* **>** *messages received notification* (this icon will indicate with a number) **>** ***Log out*** **>** *Notifications* panel icon will open on right side of screen when clicked on **>** and a ***Live Chat Support Team*** will assist when available. After hours (after - 8am to 5pm) you can send an email to developersworkspace@gmail.com.

A preview of what the "**Live Chat with Support Team**" page will look like.



Back to Contents

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

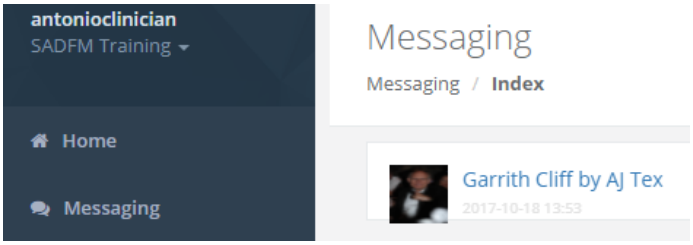


3. Home

If you click on the **Home** text on the left Menu, you will be taken to the default List of **Active Patients**.

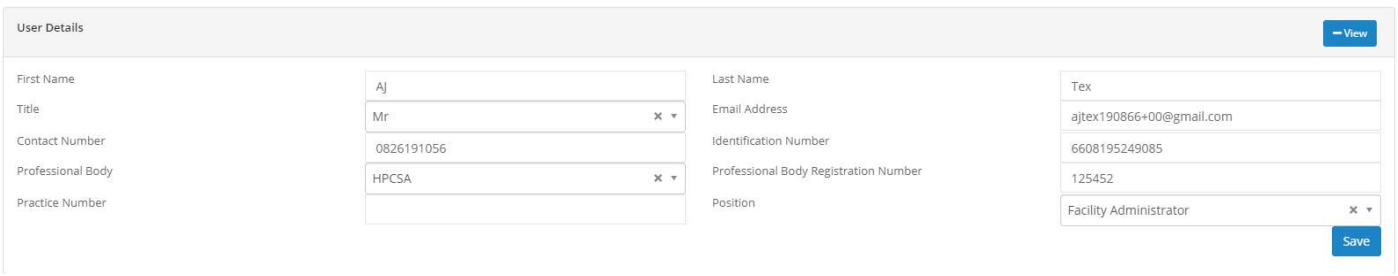
4. Messaging

This function is only when you want to view internal ePONS history messages between another Clinician **regarding a patient.** This is not a personal text message to other Clinicians. All messages written will be stored here for tracking purposes. *(Currently work in progress)*



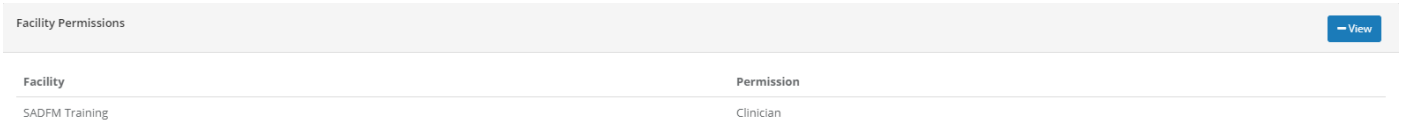
5. My Profile

Once you have setup your Profile User details, please make sure you have entered your "**Professional Body**" & "**Professional Body Registration Number**" 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.*

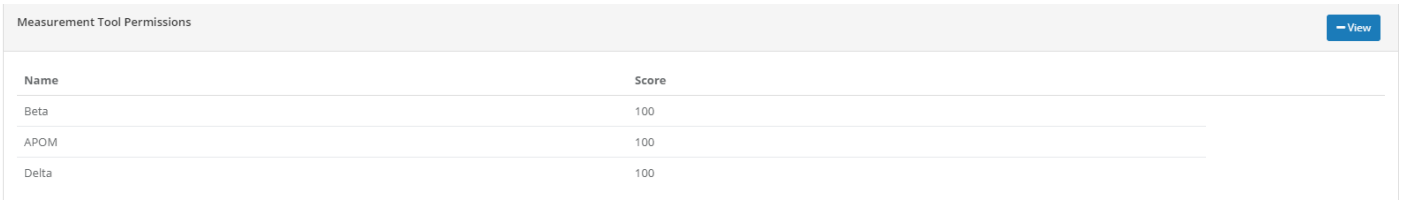


Back to Contents

If you click on Facility Permissions you will see what your permission usage is on the system. Administrator, Case Manager, Clinician and depending on your permission you have different view sets within the system as mentioned above.



If you click on the **Measurement Tool Permissions** > this will view the measurement tools you have been trained in to evaluate patients on and will view your final examination mark. You must have an 80% or higher final mark to use any of the SADFM tools on the system.

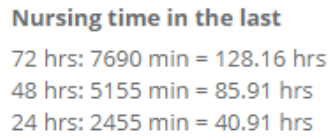


To change your password, click on the **+View** button on the right and enter your desired password and click **Save**.

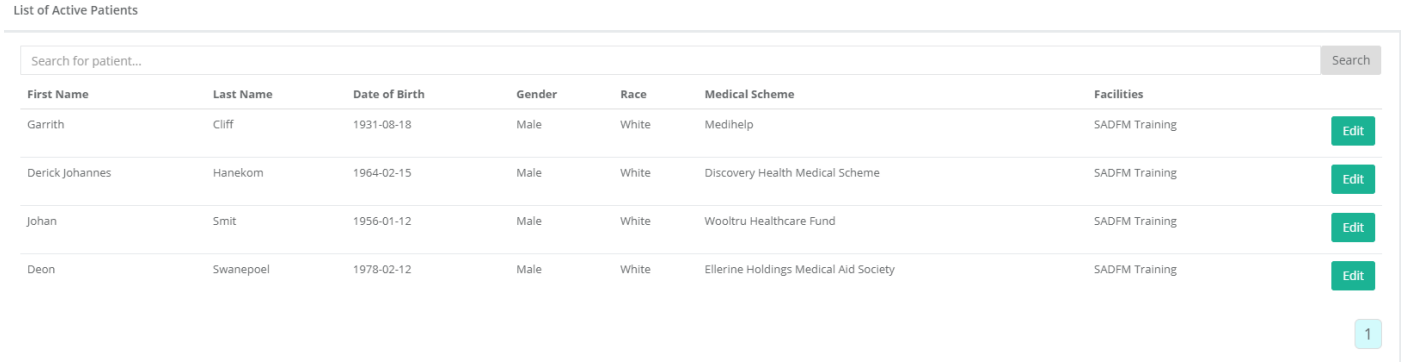
6. Patients

Just below, the top right menu on home screen, 

you will see the "**Nursing time in the last**" hours within the facility. This can help the clinician to see how many hours it will take to nurse the current active patients in the facility.



You will see a list of patients in your **Active Patient** list as soon as a patient(s) has been allocated to your care by the Case Manager or an Administrator. If no patients viewed in your Active list, it means that no patients have been allocated to you. There will be a maximum of 10 patient files viewed on your patient list and thereafter it will view on following pages. i.e. 



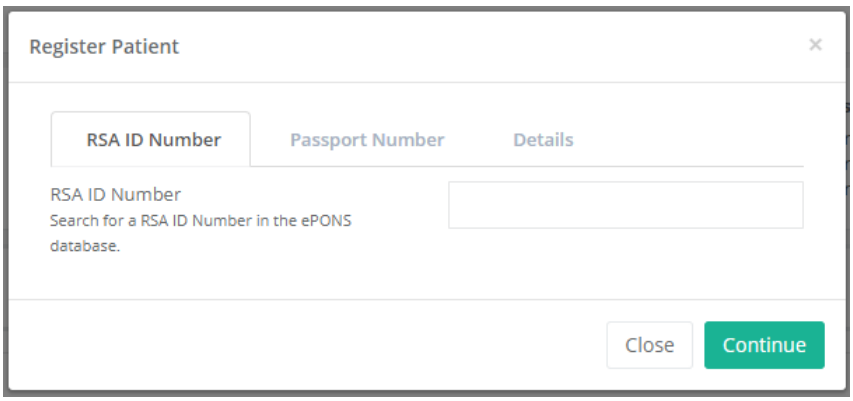
Back to Contents

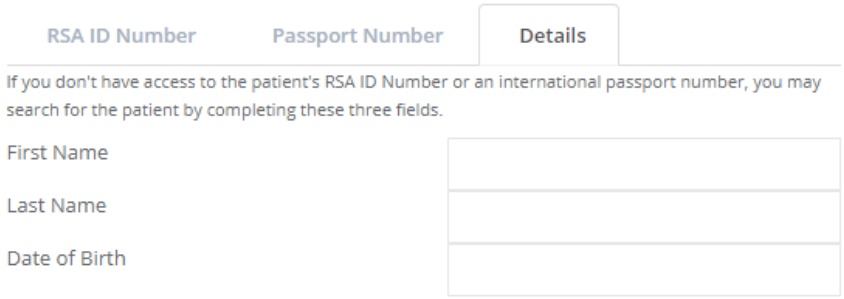
Here you can find existing **Active patients** by searching on various fields. Click on the "**Edit**" button on the right, to view a patient's file and perform various functions. Within the Patients Menu (left blue panel), you will also find **Discharged Patients** as well as **Deceased Patients**. Patients that has been discharged by the Admin Clerk (Receptionist) or Case Manager, will be stored in the Discharged and/or Deceased Patient lists.

a. Register (Admit) Patient Details

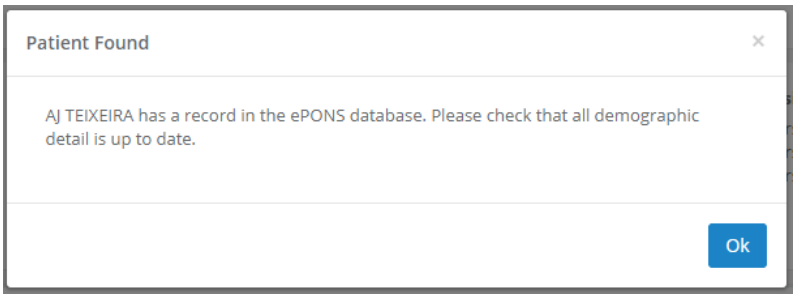
This function is available to Case Managers and Administrators (Receptionists) only.

Go to Patients > **Active Patients** and click on ***Register Patient***. First, enter their RSA ID Number or Passport Number on the tabs or click on the **Continue** field. You **MUST** enter an **ID or Passport number** to be able to save the patient record, otherwise you will lose the rest of the patient info you have captured. If this patient already exists in the system, you will be given the option to open their record.

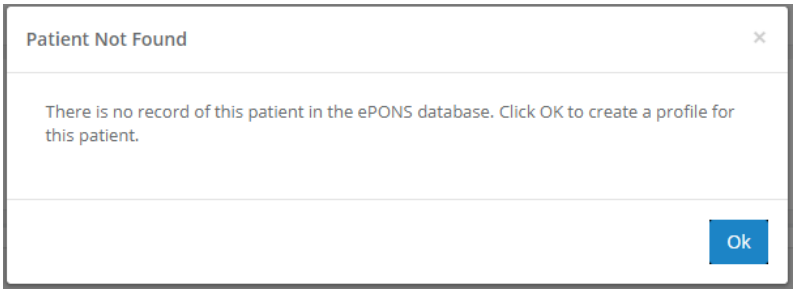




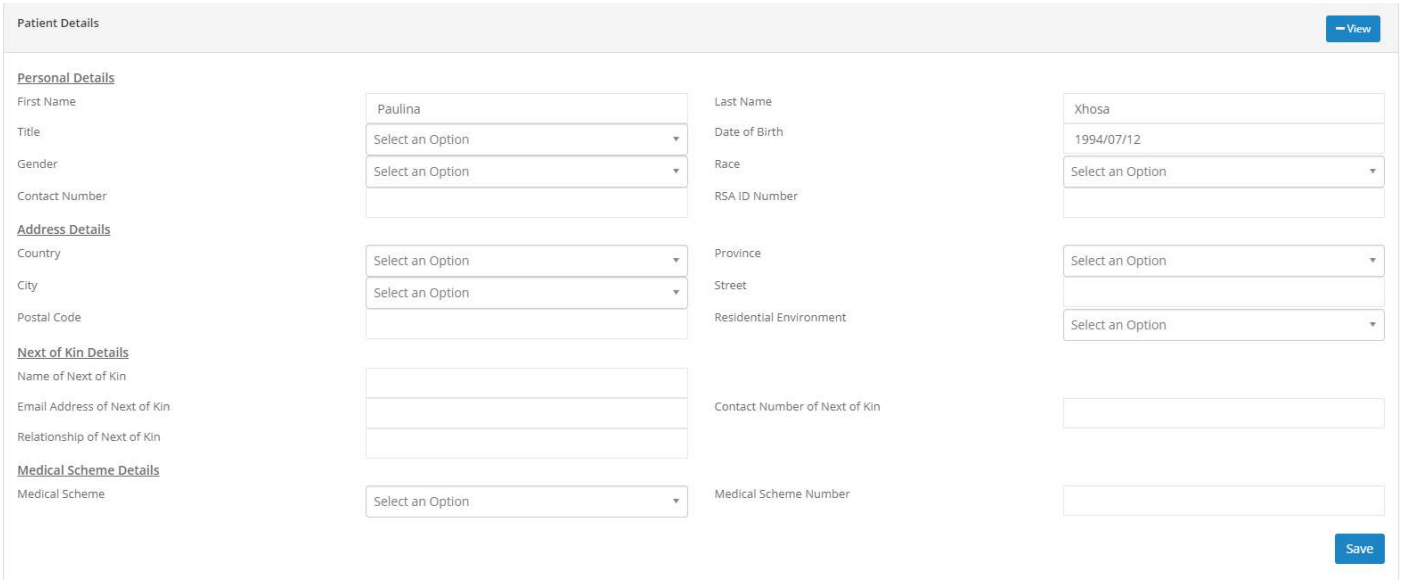
You will get a notification if the Patient already exists in the system and if so, click on the **Ok** button to continue.



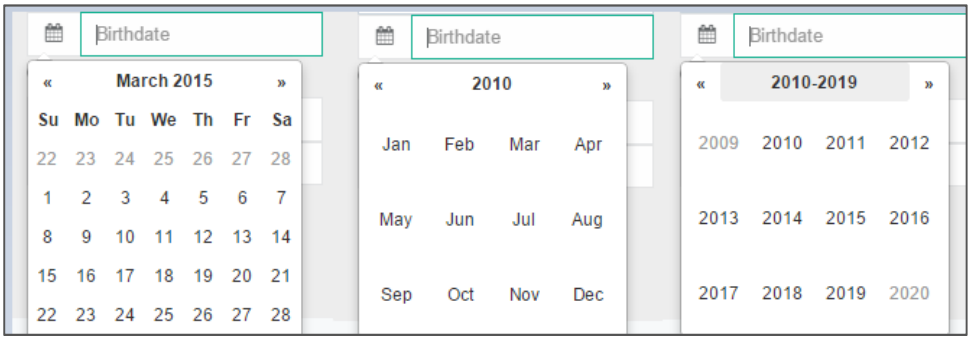
If the patient does not exist in the system yet, you can fill in their details to create a patient record. **Don't forget to enter the ID or Passport number.**



Back to Contents



Tip: *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:*



Once you get to the "**Country**" field, you have a dropdown to select from.

You ***must*** select the **Country** first for the system to generate the **Province** and **City** accordingly. This means that if you select *South Africa*, only South African provinces will view in the dropdown and if you select *Western Cape,* then only Western Cape cities & towns i.e. *Bellville* will view in the dropdown.

The following window will appear and from here you can **+View** / **Edit** existing Patient detail – If you click on any **+View** button, you can *Edit* existing Patient Data or add entries.

To add a Patient Photo to identify the patient file, double-click on the patient logo as seen below. Select from a folder on your computer and once selected, click **Open**.

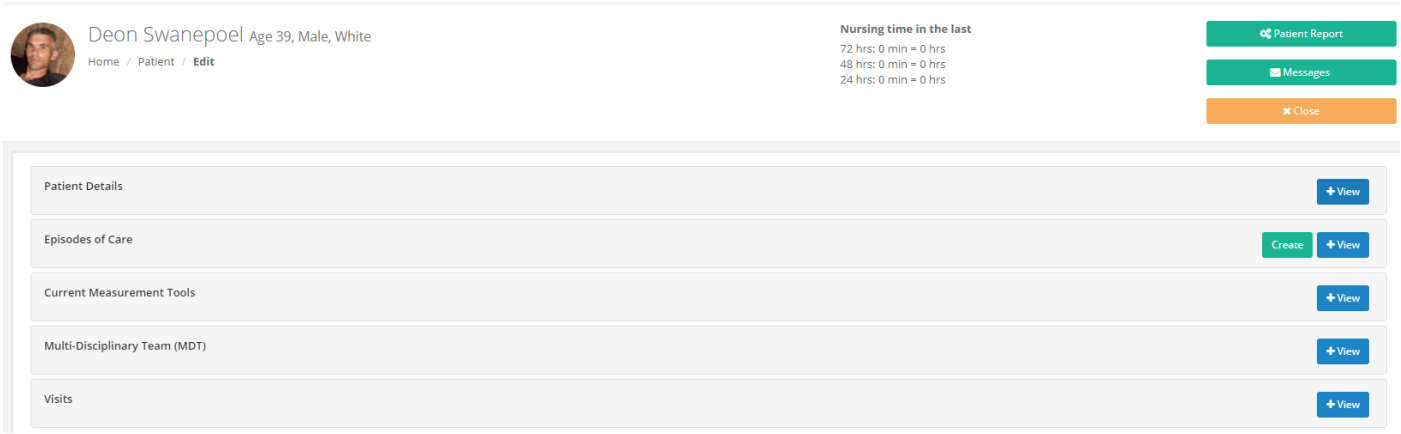
Once all Patient Demographics / Info, to the bottom end **Medical Scheme Number** has been saved you may view and edit when necessary.

Back to Contents

Click on ***+View*** on the ***Patient Details*** tab **Support Services** at home. Fill in the additional info, and click on **Save** button on bottom right of that section:

You can click on the next tab below the Patient Details & **Create** an **Episode of Care.**

(Case Managers & Administrators permission only)



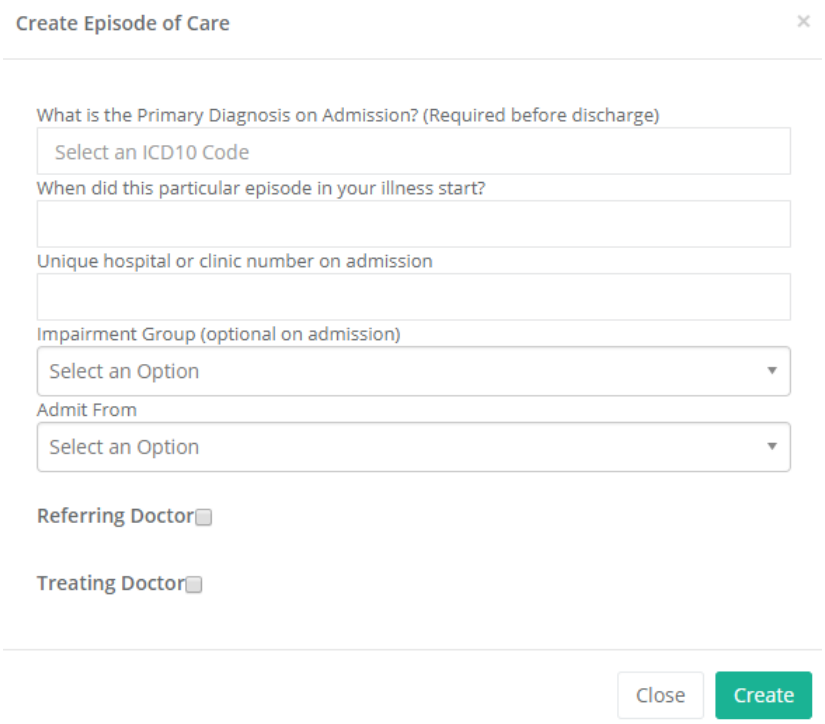
b. Episode of Care

Here you can fill in the admission details: What is the Primary Diagnosis - ICD10 code, if known, on Admission? (Required before discharge), and "**When did this particular episode in your illness start**"? (Onset Date of illness or accident), the "**unique Hospital (Facility) Patient Number**" – all the other fields are optional on Admission. You can keyword search for the Impairment Group & ICD-10 code or description, and the results will appear.

If you're a Case Manager or Administrator you can **create** an **Episode of Care**. Fill in the Impairment Group Code, where the patient has been admitted from, Referring Doctor, Treating Doctor by ticking in the tick-boxes etc.

An **Episode of Care** = documenting a patient in a facility from Admission to Discharge. An Episode of Care (patient case / admission) includes many visits.

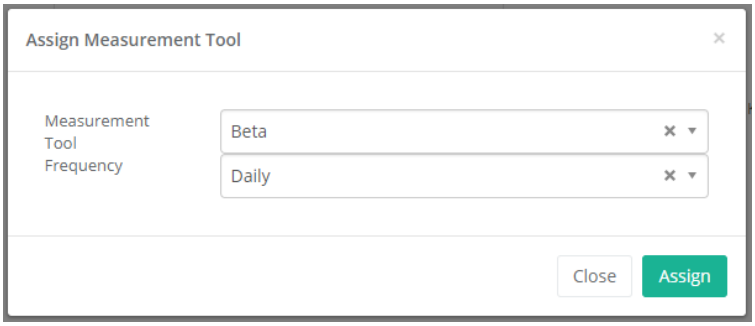
Back to Contents



c. Current Measurement Tools

And once you created an **Episode of Care**, you will be able to **Assign Measurement Tools**,

Click on the **Assign Measurement Tool** button and select from the dropdown menu a Measurement Tool i.e. Beta and the Frequency i.e. Daily or Weekly etc.

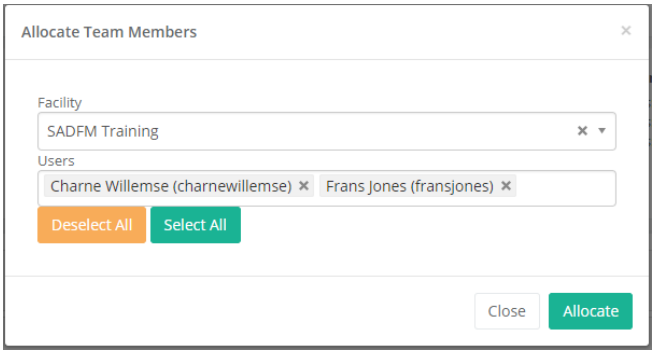


Case Managers & Administrators can also edit the **Measurement Tools** by adding /removing scales by clicking on the **Deassign** button.

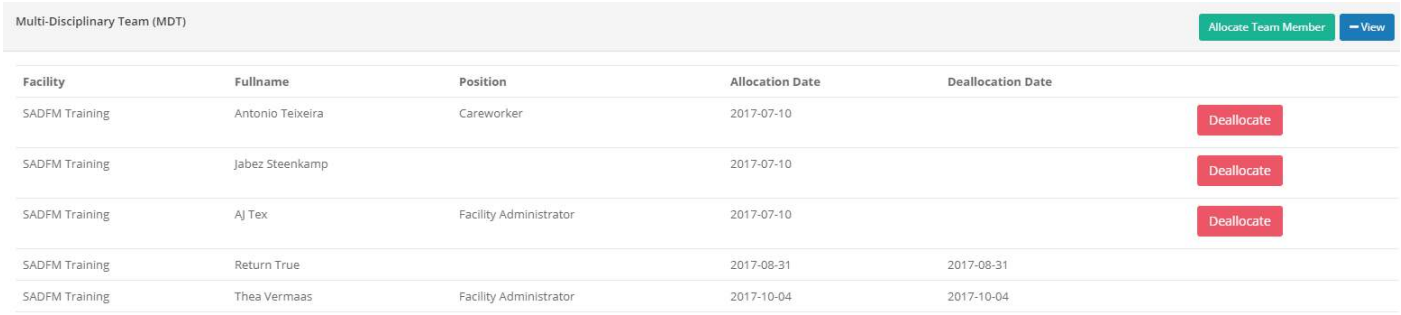
d. Multi-Disciplinary Team (MDT)

Add a MDT member to allocate to a patient's care. You can now assign the Admission / Case (Episode of Care) to a specific individual. To add the patient case to more individuals, select "**Allocate Team Members**" and then click "**Facility**" (if you have a Login for more than 1 facility) select and add the different facilities. On the **Users** field, select from the dropdown list of MDT members or to select all members, click on **Select All**. To deselect a member, click on any individual's "**x**" or you can simply **Deselect All** to start over.

Back to Contents



Case Managers, Administrators and Clinicians can also edit the MDT team members by clicking on **+View** the MDT tab. This is for Discharging a MDT member from a patient's care when your services are not required anymore.



Clinicians can only View – Patient Details, Episode of Care, Current Measurement Tools (and Deallocate themselves) in the MDT tab, by clicking on **+View**. Clinicians permission only allows to **Create & View Visits.**

e. Visits

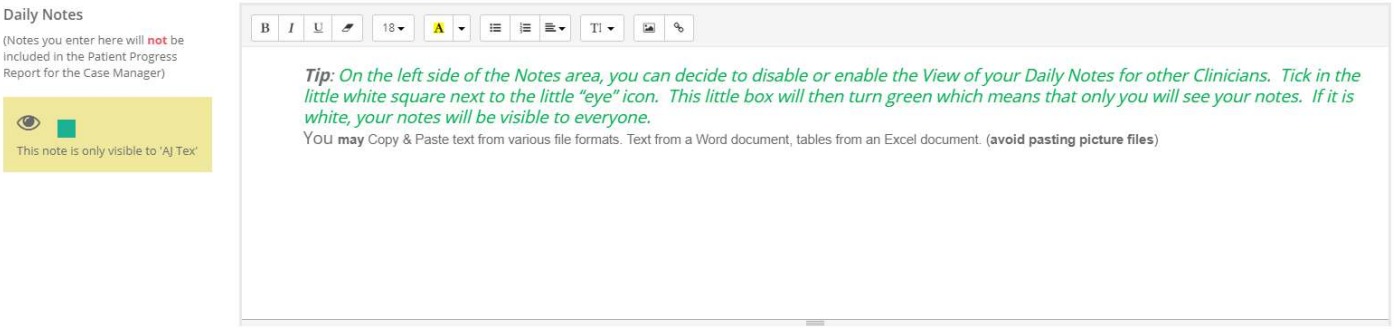
- **Create** / Add a **Visit** to capture one or more of the following observations: **Visit Details** i.e. Duration of the Visit (minutes), **Daily Patient Nursing Notes**, Case Manager **Patient Progress Notes**, Vital Signs & Measurement Tools i.e. Beta Scale (**and Attachments like photos, pdfs, and word documents for future versions*).

  When entering Visit Detail data, the Impairment Group and Primary Diagnosis (ICD10) will automatically be generated if an Episode of Care with the above mentioned has been entered and saved previously. The date and time will be automatically populated with the time you clicked on "**Create Visit**".

Back to Contents

You **MUST** enter the **Duration of the Visit (in minutes)** for every visit (Beta Assessment) performed on the patient. i.e. if a Care Worker has assessed the patient on Eating & Grooming, then the duration of the two items will +- be the time the care worker has spent with the patient to perform the tasks. It is not the time the patient took to perform the task i.e. the patient that scored a 5 for eating, the care worker must record the time it took for the care worker to supervise, cue or set-up the patient for eating, and if the grooming is scored a 4 then it is the time the care worker took to assist the patient. If the time was 8 minutes for eating and 9 minutes for grooming, then the total duration is **17 minutes**.

- On the next tab, click on the **+View** button **Visit Notes,** to enter Daily Notes and/or Patient Progress Notes. The top section is the Clinician Daily Notes. The **Daily Notes** section will **not be included** in the **Patient Progress Report** for the **Funder Case Manager**.



***Tip**: On the left side of the Notes area, you can decide to disable or enable the View of your Daily Notes for other Clinicians. Tick in the little white square next to the little "eye" icon. This little box will then turn green which means that only you will see your notes. If it is white, your notes will be visible to everyone.*

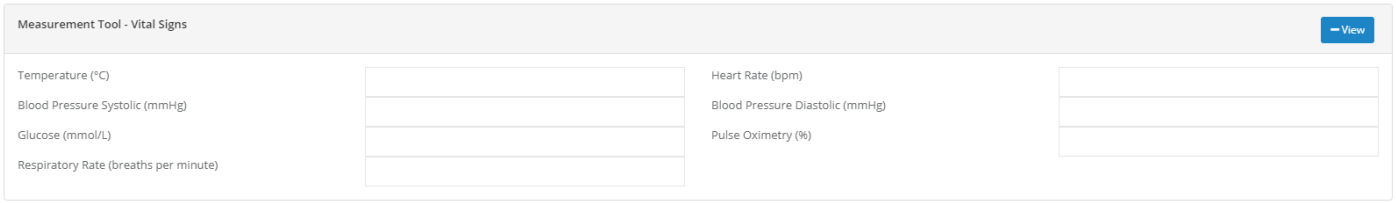
You **may** Copy & Paste text from various file formats. Text from a Word document, tables from an Excel document. (**you may paste picture files as well i.e. wound photos**)

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

- 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 (Episode of Care), clicking on the **+View** on the **Assign Measurement Tool**.

  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 assessments if you have passed your exams for that particular scale, and if your provider has subscribed to the scale***.

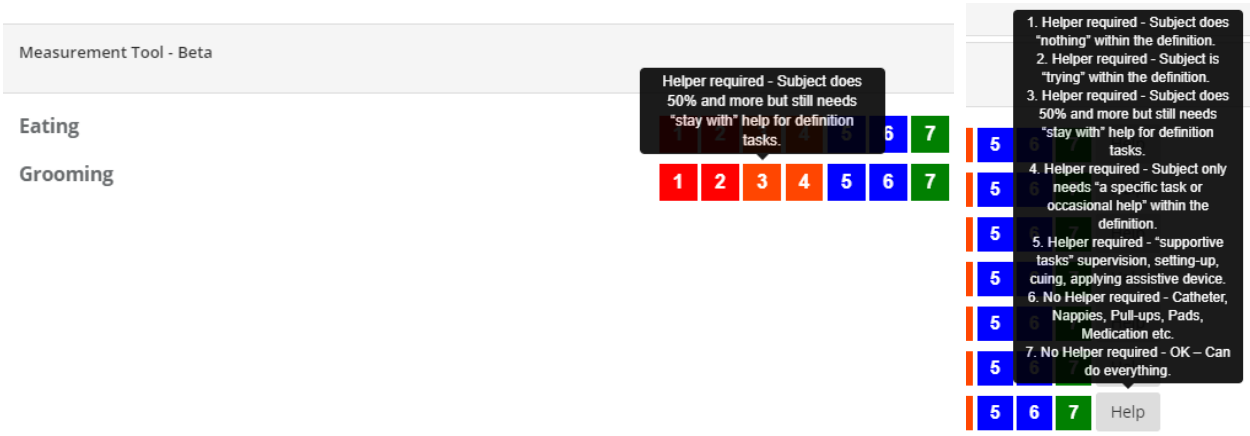
- then on the 3rd tab **Measurement Tool - Vital Signs**, click on the **+View** button and here you can enter the patient Vital Signs. Once done, click on the green "**Save & Exit**" button left of the +View button within the Visits window.



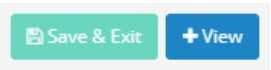
Back to Contents

- On the **Measurement Tool** tab, Click on the +View button, to enter the Scoring Scale assigned for the patient to be evaluated.

Hovering the mouse over a **score** will show a tooltip on the specific score. Hovering it over the **item** (i.e.Eating) will also show a tip. You can also hover your mouse over the **HELP** You may enter a score for all items on the scale, or complete some and create a visit later to add additional scores. A Radar (Spider) Graph will be generated **only when all items within a Scale**, is entered into the system within 24h.



To **save** the visit, **You MUST have entered the Duration of the Visit**, then either entered Notes, selected scores on the particular Scale(s) to the "**Save & Exit**".



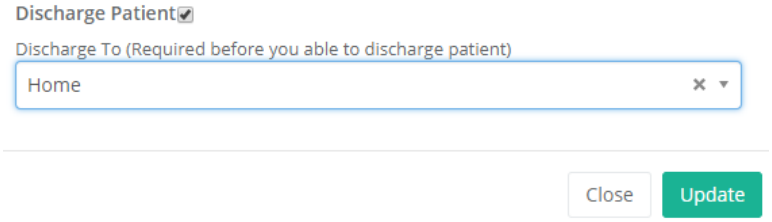
7. How to Discharge a MDT member and/or Clinician from a patient's care

When the Clinician / MDT member's care is not needed for the patient anymore, and you want to discharge yourself from the patient's care – click on the **+View** button of the **Multi-Disciplinary Team** tab and select or click on the Deallocate option.

8. How to do a final Discharge of a Patient

Once the patient has been discharged from your facility, the patient needs to be discharged from the ePONS system as well. To finalise the **Discharged Patient** from your "**Active Patient List**", go to the specific patient you need to discharge and click on green "**Edit**" button on the right, then on the **Episode of Care** tab, click on **+View** button and click on the green "**Edit**" button on the right again. If no ICD10 & Impairment Group Code was previously entered, you **MUST** enter these two fields and click on "**Update**".

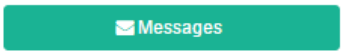
Once you have updated both fields, you can click on the Edit button again and the Select the "**Discharge**" ☐ (tick-box) and enter the **Discharge To** (Required before you are able to discharge patient) from the dropdown selection at the bottom of the screen and **Update**.



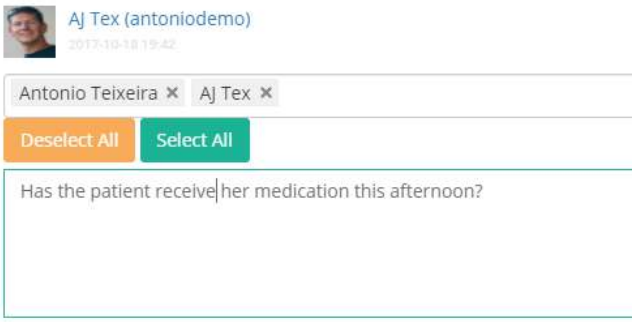
Back to Contents

9. Messages

You can send out messages about the patient to colleagues.

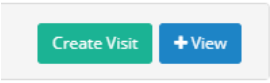
On the **patient** file, click on the **Messages** button: 

Select in the recipients, by clicking in the "**Select Users**" field and the message text, and send the message by clicking on "**Send**". These people will be informed of the message directly, but the message will also sit on the patient file, for anyone else to see.

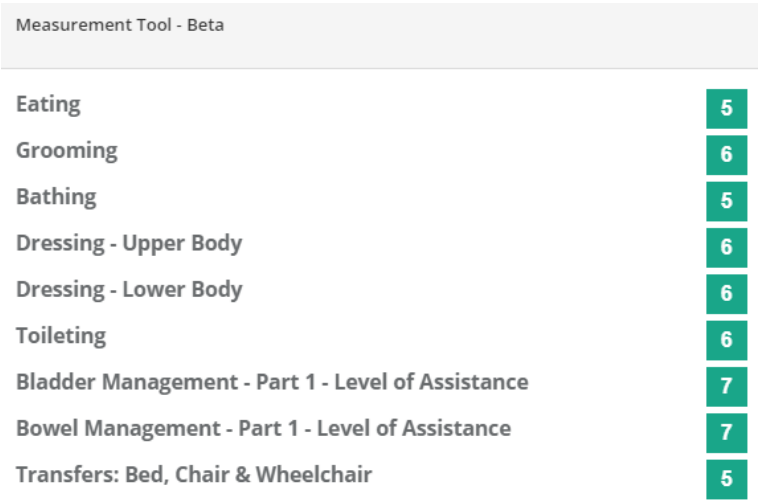


10. Visit Views

On the patient file, click on the **Visits' tab** **+View** button:

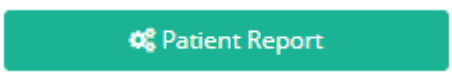


Then click on any of the Visits' done **+View** button you want to look at. Here you can view all the Visit details you have entered previously and Saved.
Below is just a sample of the Beta Scale in **View mode**:



11. Patient Report Views & Downloads

Go to a Patient file and at the top right, click on the "**Patient Report**" button.

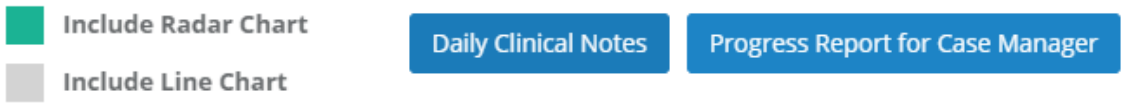


Only scales where all items have been completed at least once for the patient, will be generated in the Report.

Once you clicked on the Patient Report button, you will be presented with several options to print 2 different Reports.

Back to Contents

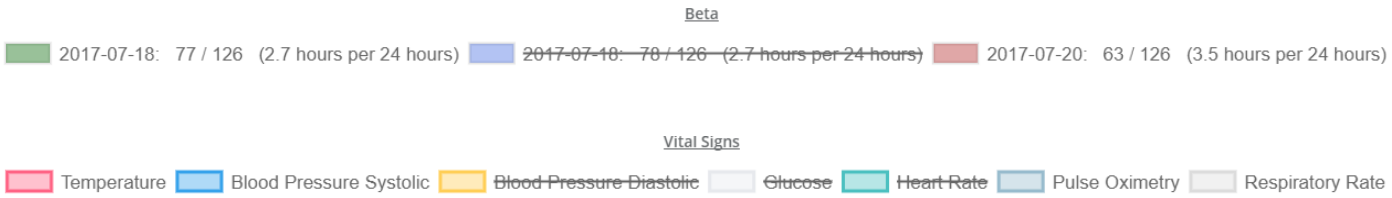
Here you can select to include either only the **Radar Graph** and/or include a **Line Chart**. (the Radar Graph is set by default).



You then make your Date selection and click on either button. You will have the option to **view / download in pdf format** both the "**Daily Clinical Notes**" or "**Progress Report for Case Manager**".

For the **Beta scale**, the **Burden of Care** will be displayed. If you hover over a data point on any graph (incl. line charts, Vital signs), you will also see the values for the different times on a pop-up box.

If you click on any of the **Visit Dates** of an Radar, Vital signs' labels or Line Graph, the specific Visit done' info on that date, will disappear on screen and if you click again, it will re-appear.



You can also click on the **Download PDF** 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).

12. Training

This function is available for users with Training permissions only. (This function will be available in future versions.)

On the left-hand menu, click on ***Training*** and then ***Training Videos*** *and/or* ***Training Scoring Manual***.

13. Administrators

These Administrators and Case Managers will have an extra heading in the Main Menu on the left for viewing **Facility Reports**. i.e. **Facility Performance Report.** ***(in future updates, there will be a Facility Dashboard Report as well).***

Back to Contents

The Following Explanations for the "Facility Performance Report" as 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 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.

Back to Contents