

ePONS User Manual

Last Updated 2016 JULY

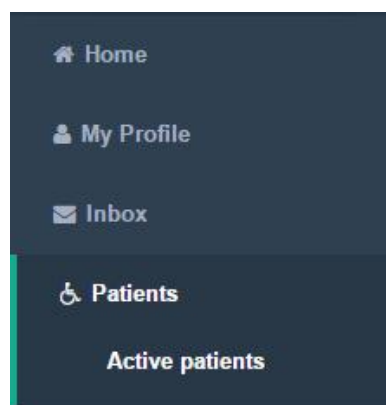
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1. First Login

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.

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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.

If you intend to claim from medical schemes for services provided, you have to complete the following fields.

I'm registered with:

☐ No Professional Body ☐ HPCSA ☐ SANC ☒ Social Worker

My registration number with this body is:

4545645

My practice number is:

Practice Number

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.

This patient exists in our database. Do **NOT** create a new file for this patient. You may create a new **CASE** if the patient presents with a new problem.

If the patient has returned due to a previous problem, do the following:

- Assign team members to the patient.
- Start adding **VISITS**.

This is a new patient

This is my patient

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

1. Personal

2. Support services at home

3. Additional info

Identity information

Enter the patient's ID or Passport number

Personal Information

Select title ▼

First Name

Surname



Date of Birth

Gender ▼

Race ▼

Contact Details

Contact number

South Africa ▼

Province ▼

City ▼

Street

Postal code

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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:

The image shows three calendar pickers side-by-side, each with a 'Birthdate' label and a calendar icon. The first picker shows 'March 2015' with a grid of days from 22 to 28. The second picker shows '2010' with a grid of months from Jan to Dec. The third picker shows '2010-2019' with a grid of years from 2009 to 2020. Each picker has navigation arrows (left and right) and a top bar with the current selection.

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

The image shows a form with three tabs: '1. Personal', '2. Support services at home', and '3. Additional info'. The '2. Support services at home' tab is active. It contains a list of services with checkboxes next to them:

- Assisted Living Services available? ☐
- Palliative/End of Life services available? ☐
- Family/Friends support available? ☐
- Frail care services available? ☐
- GP available? ☐
- Home based nursing care available? ☐
- Paramedic services available? ☐
- Sharing with other people? ☐

Fill in the additional info, and click on Save:


The image shows a form with three tabs: '1. Personal', '2. Support services at home', and '3. Additional info'. The '3. Additional info' tab is active. It contains three sections:

- Medical Scheme**: A dropdown menu for 'Medical Scheme' and a text input for 'Membership number'.
- Patient Information**: A dropdown menu for 'Residential environment' and a dropdown menu for 'Admit from'.
- Next of Kin**: A series of text inputs for 'Name', 'Contact number', 'Email address', and 'Relationship (e.g.: child, mother, husband, etc)'.

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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.

Case details	
ICD 10	Unknown
Impairment Group *Optional	Select impairment group ▼
Admission Status	Admission status ▼
Referring doctor	
Referring doctor contact	
Referring doctor email	
Referring doctor practice number	

Onset Date  Onset Date


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.

Select Provider

×

SADFM Training ▼

Allocation date

 08 Apr 2016

Select a Team Member
(You may select more than one team member)

Team Member

[Show Advanced Options](#)

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.

+



Jane Fonda Age 47, Female, White

[Home](#) / [Patient](#) / [Details](#)

Click on a + to view detail

Personal details

Firstname	Jane
Title	Ms ▼
Gender	Female ▼
Contact number	0851112236
Country	South Africa ▼
City	Bloemfontein ▼
Residential Enviroment	Private home ▼
Next of kin name	
Next of kin Email	
Medical Scheme	De Beers Benefit Society ▼
Admit from	Home ▼

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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 details

ICD 10	Unknown		
Impairment Group	1 4 - Strokes - No Paresis		
Onset Date		29 Mar 2016	
End date		End date	
Admission Status	Voluntary		
Referring doctor			Treating doctor
Referring doctor contact			Treating doctor contact
Referring doctor email			Treating doctor email
Referring doctor practice number			Treating doctor practice number

Multi-Disciplinary Team (MDT)

10 records per page

Case	Provider	Team Member	Roles	Allocation date
Unknown	SADFM Training	Ruby-Lynn Hugo	Occupational therapist	06 Apr 2016
	SADFM Training	Admin Trainor	Administrator, Occupational therapist	06 Apr 2016

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

Add a Scale 

Select scale



Select frequency

Cancel

Add

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.

Select Provider

Allocation date		06 Apr 2016
Discharge date		Discharge date

Cancel

Save

c. Multi-Disciplinary Team (MDT)

Add a MDT member to allocate to a patient's care.

Allocate a Team Member to Andre Brink

Select case (optional)

Select provider

Allocation date

20 July 2016

Select a Team Member

Team Member

(You may select more than one team member)

Show Advanced Options

Cancel

Add

d. 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.

Case

Select a case (optional)

Date

08 April 2016

16:20

Notes

Vital Signs

Beta

Save & Exit

Daily Notes

(Notes you enter here will **not** be included in the Patient Progress Report for the Case Manager)

This note is visible to all clinicians.

B

I

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11

A

TI

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.

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Patient Progress Notes

(Notes you enter here will be used to compile the formal Patient Progress Report for the Case Manager)

B

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11 ▾

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Tl ▾

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.

Notes

Gamma

Meal Preparation	1	2	3	4	5	6	7
Household Chores			3	4	5	6	7

Direct help with tasks required - Subject does “nothing” within the definition.

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.

Notes

Vital Signs

Beta

Save & Exit

ICD10

Select primary diagnosis - I

Impairment Group

Select impairment group ▾

My next action

☒ I want to see Jane Fonda again.

☐ I discharge myself from Jane Fonda’s care. Please archive my clinical notes.

Review Date

Date

Save & Exit

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.

Are you sure you want to close this visit?

If you close this visit without saving, your data will be lost.
Click CANCEL to close without saving.
Click SAVE to save your data.

Cancel Save

e. 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 – on your last Visit added, on the last tab **"Save & Exit"** select the option **"I discharge myself from XXXXXXXXXXXXXXXX care. Please archive my clinical notes"**

Notes
Vital Signs
Beta
Save & Exit

ICD10
Impairment Group
My next action
Discharge Date

Select primary diagnosis - I
18.3.2.2 - Psychiatric - Major Depressive Mood Disord...
☐ I want to see Andre Brink again.
☒ I discharge myself from Andre Brink's care. Please archive my clinical notes.
20 July 2016
Save and Discharge

To Discharge a MDT member or Clinician from that patient's care, double click on a MDT member in the list and enter a Discharge date. This option is only if you haven't Discharged yourself in the Visit you added.

Allocate a Team Member to Andre Brink

Allocation date
10 February 2016
Discharge date
Discharge date

Cancel Save

To finalise a Discharged Patient from your **"Active Patient List"**, is to open the **"Cases"** and select a Case and double click on it. Then you click on the **"Edit"** button on the right. Enter the **"End Date"** and save.

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Case details

[Edit](#)

ICD 10	F20 - Schizophrenia
Impairment Group	18.3.2.2 - Psychiatric - M
Onset date	01 Feb 2016
End date	
Admission Status	Assisted
Referring doctor	Dr J J Retief
Referring doctor contact	0875556325
Referring doctor email	
Referring doctor practice number	4545646544

f. Messages

You can send out messages about the patient to colleagues.

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

A green rectangular button with a white envelope icon and the text "Messages".

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:

A dark blue rectangular button with a white envelope icon, the text "Inbox", and an orange badge with "1/3".

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

A dark blue rectangular button with a white envelope icon, the text "Inbox", and a teal badge with "0/3".

g. Graphs

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

A blue rectangular button with a white bar chart icon and the text "Graphs".

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.

Graph query

Scale

Select scale

Gamma

Show as

Select graph type

Line

Polar

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

Select dates

☐ 22 Apr 2015 14:06

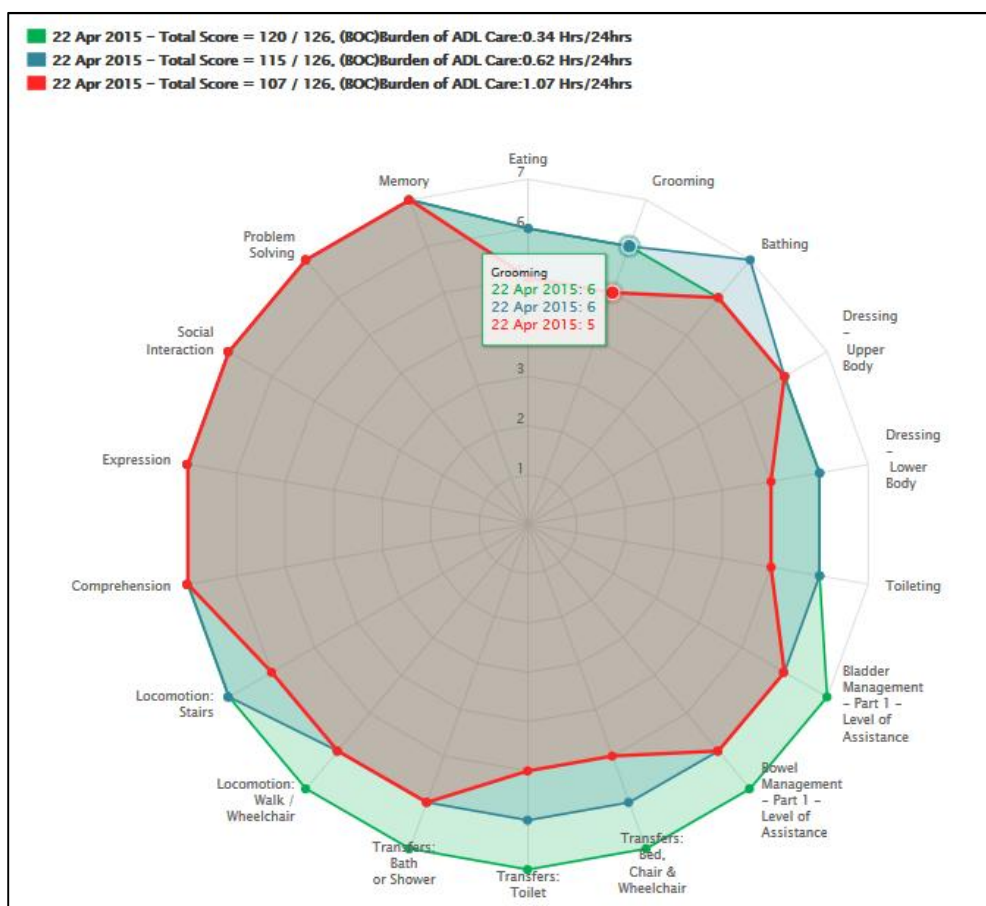
☒ 22 Apr 2015 14:09

☒ 22 Apr 2015 14:45

☒ 22 Apr 2015 15:18

Show

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.



h. PDF Patient Progress report



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

Progress Report

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.

Report filters

 01 April 2016	 08 April 2016
<input type="checkbox"/> Order by Discipline	

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

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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.