

# CMC104: Viewing a Care Plan

<b>Intended Audience</b>	This module is designed for urgent care staff and others who will be viewing care plans on the Coordinate My Care (CMC) system.
<b>Purpose</b>	This module introduces users to the Urgent Care Summary screen and navigation menus which provide access to detailed information about the patient and the patient's care plan.
<b>Objectives</b>	By the end of this module, users will be able to: <ol style="list-style-type: none"><li>1. Find a patient's care plan.</li><li>2. Identify care plan icons.</li><li>3. Navigate to a care plan's Contacts, Medication and Emergency Treatment Plan screens.</li><li>4. Add a note to an urgent care update.</li></ol>
<b>Prerequisites</b>	<i>CMC101 Logging In to the Coordinate My Care System</i>
<b>Grading Criteria</b>	This module is not graded; quiz questions and simulations are provided for self-assessment.
<b>Duration</b>	30 minutes

## Module Outline

<b>Module Introduction</b> .....	3
<b>1 Care Plan Background</b> .....	4
1.1 The Care Plan Life Cycle.....	4
1.1.1 Introduction (text) .....	4
1.1.2 Care Plan Life Cycle (video) .....	4
1.1.3 Key Points for Urgent Care (text).....	8
<b>2 Viewing a Care Plan</b> .....	9
2.1 Viewing a Care Plan.....	9
2.1.1 Introduction (text).....	9
2.1.2 Viewing a Care Plan Demonstration (video) .....	9
2.1.3 Patient Search (text/image) .....	16
2.1.4 DNACPR (text/image).....	17
2.1.5 Viewing Documents Attached to a Care Plan (text/images).....	18
2.1.6 Medication (text/image) .....	18
2.1.7 Icon Reference List (text/image).....	19
2.1.8 Duplications (text).....	20
2.1.9 Viewing a Care Plan Simulation .....	20
2.1.10 Summary (text) .....	24
2.2 Restricted Records .....	24
2.2.1 Introduction (text).....	24
2.2.2 Restricted Records Demonstration (video).....	24
2.2.3 Summary (text) .....	28
2.3 Self-Assessment .....	28
2.3.1 Question 1 (dropdowns) .....	28
2.3.2 Question 2.....	28
2.3.3 Question 3.....	29
<b>Module Conclusion</b> .....	30
Conclusion.....	30
C.1.1 Module Conclusion .....	30

## Module Introduction

Welcome to *CMC104 Viewing a Care Plan*.

This module is designed for urgent care staff and others who will be viewing care plans on the Coordinate My Care (CMC) system.

This module:

- Demonstrates how to find a patient care plan in the CMC system.
- Describes the care plan layout and navigation.
- Explains the Urgent Care Summary and Emergency Treatment Plan screens.
- Demonstrates how to add a note in the Urgent Care Update section of a care plan.

By the end of this module, you should be able to:

1. Find a patient's care plan.
2. Identify care plan icons.
3. Navigate to a care plan's Contacts, Medication and Emergency Treatment Plan screens.
4. Add a note to an urgent care update.

# 1 Care Plan Background

## 1.1 The Care Plan Life Cycle

### 1.1.1 Introduction (text)

Because more than one person can be involved in the creation and use of a patient's care plan, it is important to understand the various steps of the care plan creation process. The video on the next page will introduce you to the care plan life cycle and highlight what actions different types of users can perform at different stages in the life cycle.

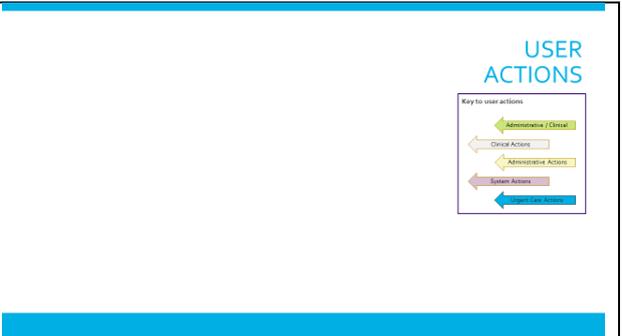
### 1.1.2 Care Plan Life Cycle (video)

Link to video [here](#).

Duration: 7:00

<p><b>Introduction</b></p> <p>In this video, we will look at the care plan life cycle, highlighting:</p> <ul style="list-style-type: none"> <li>• The actions different types of CMC users can perform.</li> <li>• The states a care plan passes through on its way from being a discussion with a patient to an electronic Coordinate My Care record available to the patient's care team.</li> <li>• The circumstances which bring the care plan life cycle to an end.</li> </ul>	
<p><b>Three Roles</b></p> <p>When logged in to the system, a Coordinate My Care user will have one of three roles: <i>Administrative, Clinical or Urgent Care.</i></p>	
<p><b>Four States</b></p> <p>A patient's care plan will always be in one of four states: <i>Draft –Needs Finalisation, Draft – Needs Approval, Published, or Published – Needs Review.</i></p>	

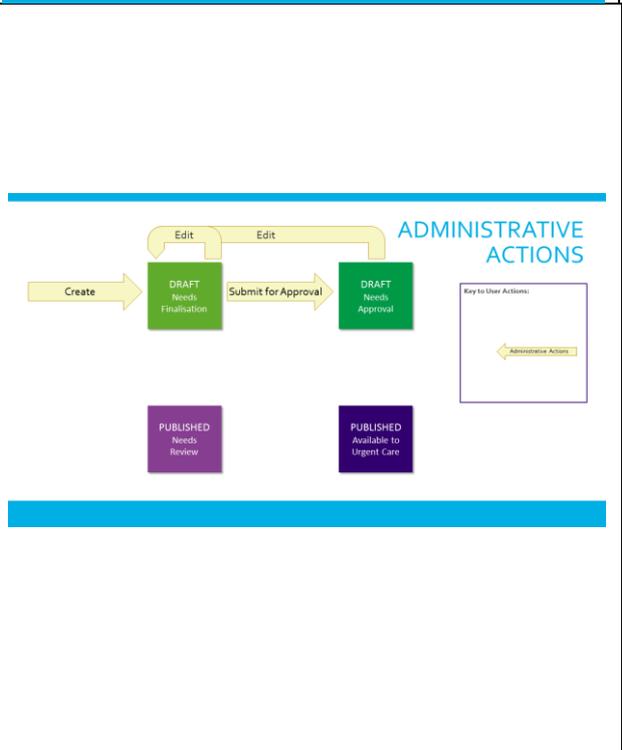
**User Actions**  
 Urgent care staff can only view care plans in one of the published states, so let's look at what actions a CMC user with a particular role can take to progress a care plan through the life cycle to a published state.



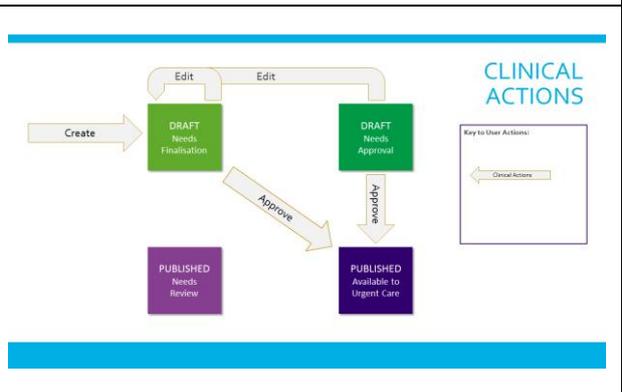
**Administrative Actions**  
 We'll begin by looking at what actions are available to users with the administrative role.

Administrative users have the ability to create a new care plan record on behalf of a clinical colleague. They can also edit the record, adding or removing information at the request of a clinical colleague.

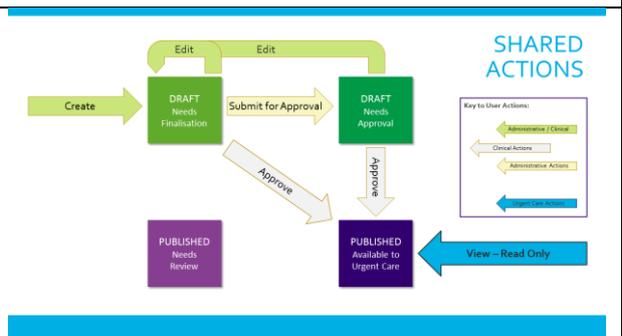
The care plan will remain in the state *Draft – Needs Finalisation* until the user believes that the information in the record is complete and submits the care plan for approval, usually by the clinical user who requested the care plan be created or edited. However, even with the care plan in the *Draft – Needs Approval* state, an administrative user can continue to make updates and re-submit the care plan as many times as necessary. Care plans in the draft states can be viewed by an administrative or clinical user, but not by urgent care users.



**Clinical Actions**  
 Users with a clinical role can also create new care plans and edit existing care plans that are in either of the two draft states. In addition, they have the ability to approve care plans created by themselves or others. When a care plan is approved, it is published by the system and becomes available for urgent care users to view. Notice that clinical users can approve care plans directly from the *Draft – Needs Finalisation* state.



**Shared Actions**  
 Together the two sets of actions look like this, and we can see how administrative and clinical users can work together to create and publish a care plan.

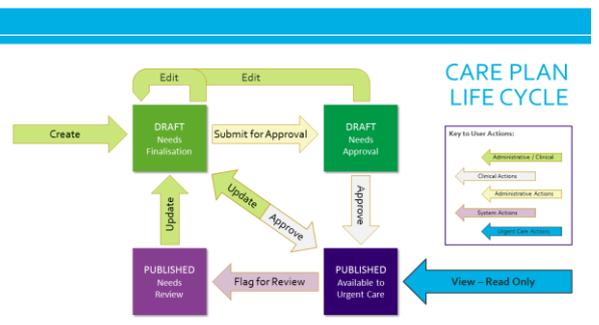
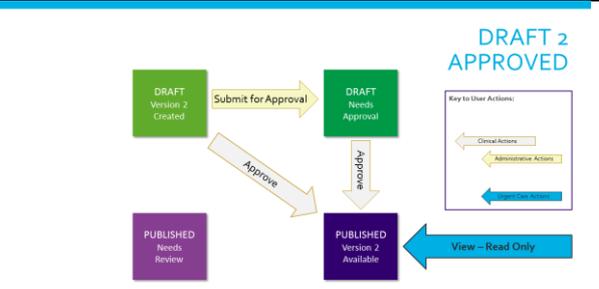


<p><b>Urgent Care View</b></p> <p>As mentioned previously, urgent care users can only view care plans once the care plan has been published – in other words, only after a clinical user has approved the care plan.</p>	
<p><b>Automatic Actions</b></p> <p>Care plans are reviewed periodically to ensure they continue to be relevant based on the patient's current state of health. At the time the care plan is approved, a review date is chosen and shortly before this date, the system will automatically flag the published care plan for review.</p>	
<p><b>Review and Edit</b></p> <p>At this point, both administrative and clinical users have the ability to update the care plan. However, care plans may need to be reviewed and edited before they reach their review date, for example if a patient's condition deteriorates, their symptoms change, or they change their mind about previously expressed preferences.</p> <p>Something to note: when a user chooses to update a care plan, a new draft of the care plan is created but the original care plan remains published and available to urgent care users. A patient can have, at most, one published and one draft care plan.</p>	

### Complete Life Cycle

The original published care plan continues to be available until a new draft is approved and becomes published, at which time urgent care viewers will be able to see the updated care plan, and the previous plan will be archived and no longer available to view.

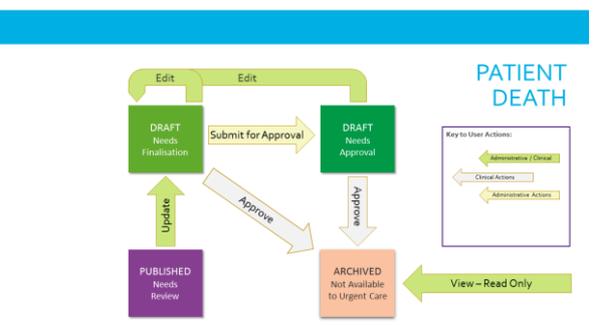
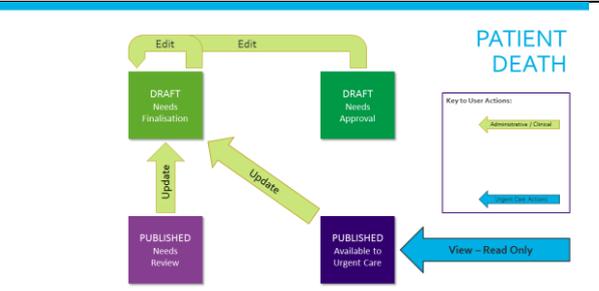
And the cycle create-edit-approve-review-update-approve continues over time, as many times as necessary, to ensure that the care plan has the most up-to-date information about the patient's care needs.



### End of Life Cycle

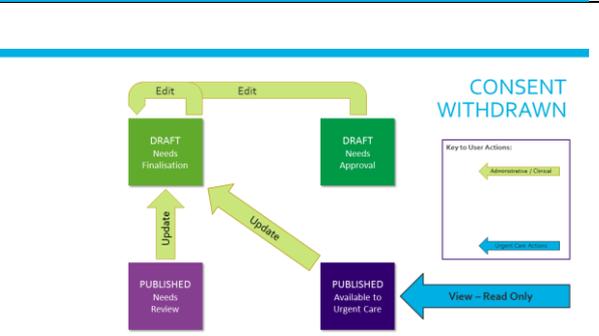
Care plans reach the end of the life cycle in one of two ways.

First is when the patient dies. The date of death is entered into the care plan and the care plan must then be approved via the standard process. In this case, however, after the care plan is approved, it is archived and no longer available to urgent care viewers, though administrative and clinical users can continue to see a read-only version of the care plan.

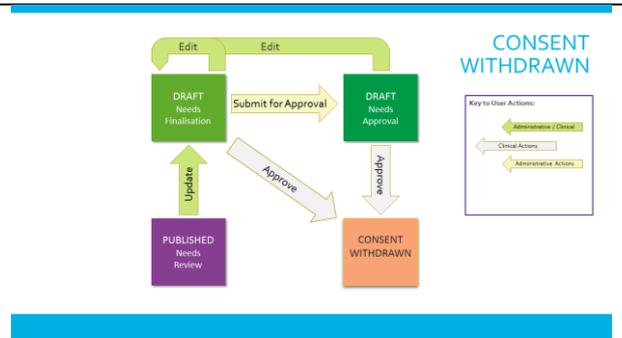


### Consent Withdrawn

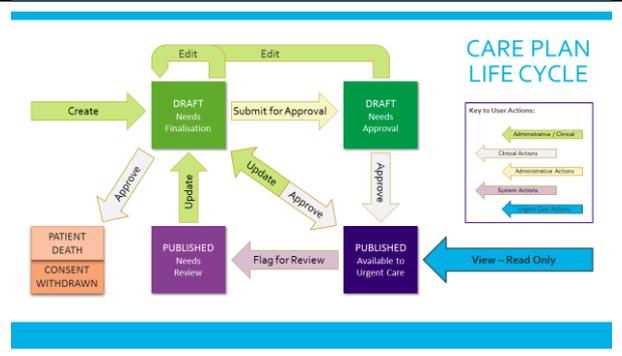
The second way in which a care plan reaches the end of the life cycle is when consent for the care plan is withdrawn, for example in the case when a patient decides that they no longer wish to have a care plan available. When consent is withdrawn, the consent setting of the care plan is edited to reflect this choice.



Once the change has had clinical approval, the care plan will no longer be available to any user.



**Summary**  
 A care plan begins when an administrative or clinical user creates the care plan. When the care plan is complete, a clinical user approves the care plan so that it is published and available for urgent care users to view. The cycle of updating and approving the care plan will continue over time until care plan consent is withdrawn or the patient's death is recorded.



### 1.1.3 Key Points for Urgent Care (text)

**Care plans which are available to urgent care users have been approved by a clinical user.**

Urgent care users will not see care plans if:

- a) Consent has been revoked.
- b) The patient is deceased.

CMC care plans exist as guides to assist your decision making, but in all cases you should rely on your professional experience and best judgement.

## 2 Viewing a Care Plan

### 2.1 Viewing a Care Plan

#### 2.1.1 Introduction (text)

This lesson describes how care plans can be used in an urgent care situation to help triage a call and make a decision about the patient's treatment.

It demonstrates:

- How to find a patient's care plan.
- How to access critical information in a timely fashion.
- How to access additional and supporting information when time allows.

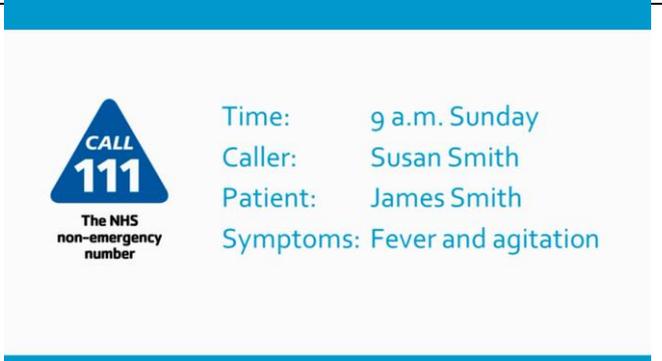
By the end of this lesson, you will be able to:

1. Find a patient's care plan.
2. Identify care plan icons.
3. Navigate among care plan screens.
4. Correctly answer questions about information in the patient's care plan.

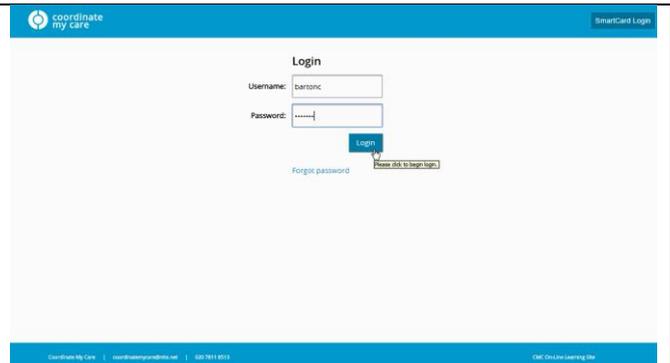
#### 2.1.2 Viewing a Care Plan Demonstration (video)

Watch the video [here](#).

Duration: 6:00

Voice-over Script	Notes for Video
<p><b>Introduction</b> Let's look at an example of how a care plan can be used to help triage an urgent care call and treat a patient.</p>	
<p><b>Scenario</b> This is our scenario: It's 9 a.m. on Sunday morning and Susan Smith has called 111 to say that she is concerned about her husband James, who seems feverish and agitated.</p>	

We can see from the 111 system that James has a CMC care plan and so we log in to the CMC system to review James's plan.

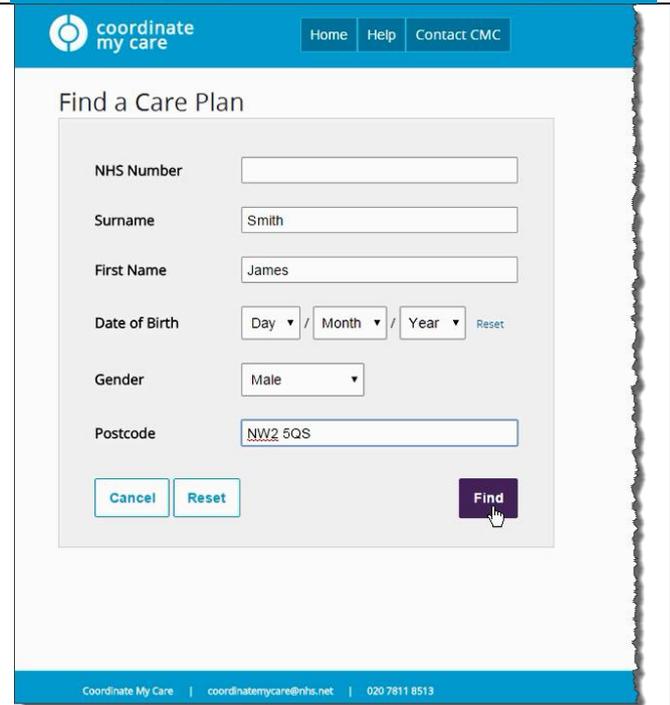


**Searching**  
When we log in to the Coordinate My Care system, the home screen will prompt us to find a patient. A search can be done using an NHS number or patient demographic details.

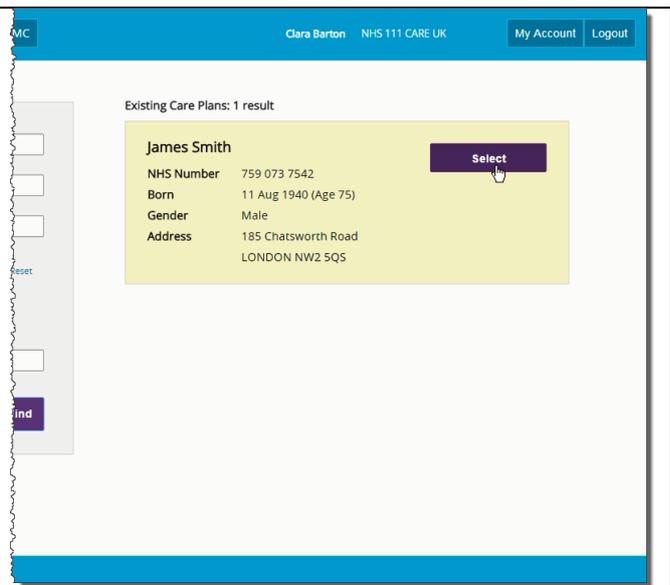
Susan was upset and could not remember her husband's year of birth, but was able to provide their home post code, so we will enter:

**Surname:** Smith  
**First Name:** James  
**Gender:** Male  
**Post Code:** NW2 5QS

And then click **Find**.



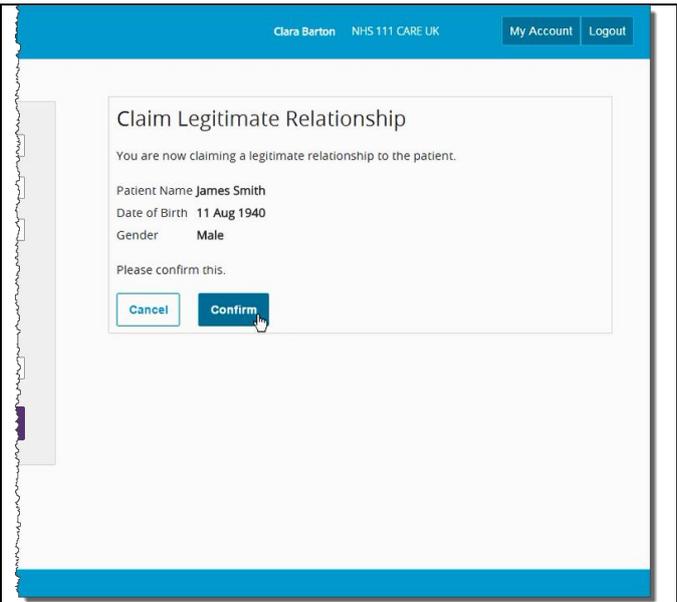
**Search Results**  
Published care plans which match the search criteria will be displayed along the right-hand side of the screen. Let's click **Select** to open James's care plan.



### Claim Legitimate Relationship

Because patient data should only be viewed by those who have a legitimate clinical reason to see it, we are asked to confirm our legitimate health care relationship with the patient.

Let's click **Confirm** now.

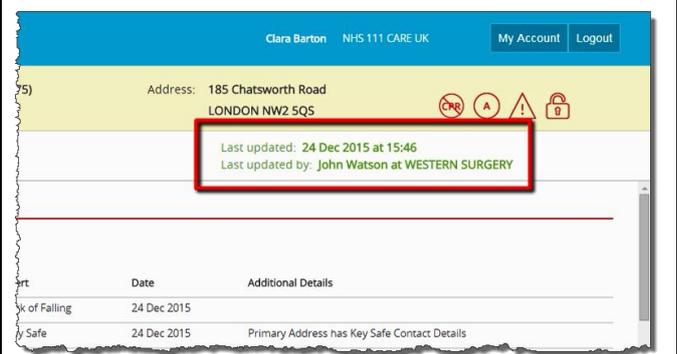
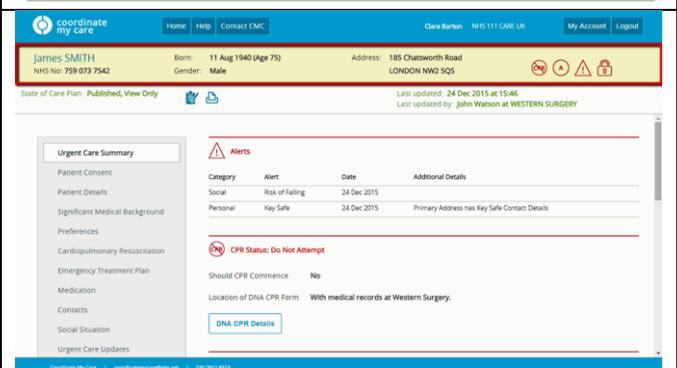


### Patient Banner

James's demographic details are displayed along the top of the screen in the patient banner. Here we can see James's age, his address and icons that let us know:

James should not receive Cardiopulmonary Resuscitation (CPR), he has an allergy recorded, he has personal alerts and his house is accessible via a key in a key safe. These icons act as links to more detailed information, some of which can be found in the urgent care summary.

Below the patient banner we see the date on which the care plan was reviewed and the clinical user who approved it. CMC recommends that care plans are reviewed quarterly, or more often if there have been changes in the patient's condition or preferences. In general, we can expect the approval date to be within the past 90 days.



## Urgent Care Summary

The **Urgent Care Summary** is an aggregation of the most important information in the care plan.

Further detail about the information displayed in the Urgent Care Summary is available using the navigation menu on the left.

At the top of the Urgent Care Summary are alerts about the patient's medical condition or living arrangements.

Beneath Alerts is the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) status section.

Below this is information about accessing the patient's home, including any details about the patient's key safe.

From the diagnosis section, we can see that James has been diagnosed with Parkinson's Disease.

coordinate my care | Home | Help | Contact CMC | Clara Burton | NHS 111 CARE UK | My Account | Logout

James SMITH | NHS no: 759 073 7542 | Born: 11 Aug 1940 (Age 75) | Gender: Male | Address: 185 Chatsworth Road LONDON NW2 5QS

State of Care Plan: Published, View Only | Last updated: 24 Dec 2015 at 15:46 | Last updated by: John Watson at WESTERN SURGERY

- Urgent Care Summary
- Patient Consent
- Patient Details
- Significant Medical Background
- Preferences
- Cardiopulmonary Resuscitation
- Emergency Treatment Plan
- Medication
- Contacts
- Social Situation
- Urgent Care Updates

**Alerts**

Category	Alert	Date	Additional Details
Social	Risk of Falling	24 Dec 2015	
Personal	Key Safe	24 Dec 2015	Primary Address has Key Safe Contact Details

**CPR Status: Do Not Attempt**

Should CPR Commence: No

Location of DNA CPR Form: With medical records at Western Surgery.

[DNA CPR Details](#)

coordinate my care | Home | Help | Contact CMC | Clara Burton | NHS 111 CARE UK | My Account | Logout

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**Alerts**

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**CPR Status: Do Not Attempt**

Should CPR Commence: No

Location of DNA CPR Form: With medical records at Western Surgery.

[DNA CPR Details](#)

**Home Access**

Living Condition: Lives with Spouse or Partner

Type of Accommodation: Detached House Or Bungalow

Key Code Details: Call wife (Susan) for keysafe details.

Other Access Information: (not specified)

**Significant Diagnoses**

Category	Diagnosis	Details
Neurological	Parkinsons Disease	

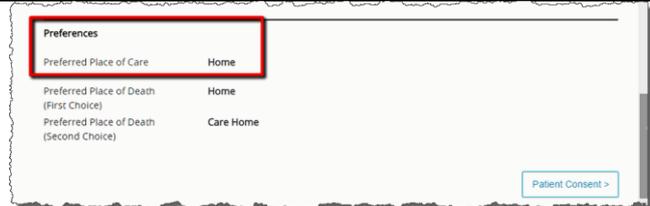
Ceiling of Treatment: Treatment of any reversible conditions (including acute hospital setting if needed) but not for any ventilation or CPR

Ceiling of Treatment Details: (not specified)

WHO Performance: 3. In Bed Or Sitting In A Chair For More Than Half The Day. Will Need Some Help In Looking After Yourself

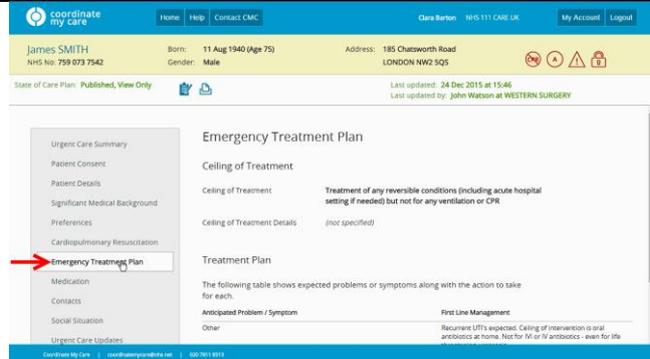
Date of WHO Performance: 24 Dec 2015

We can also see that James’s preference is to be cared for at home, if possible.



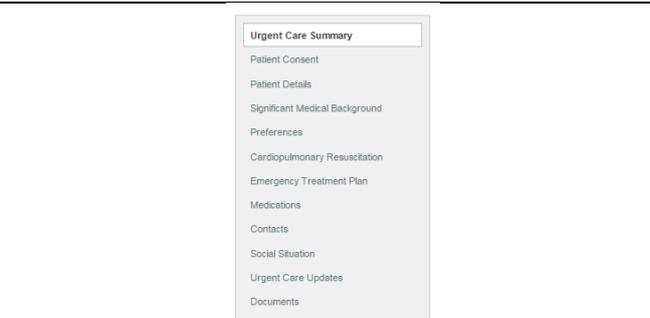
### Emergency Treatment Plan

We may be able to honour James’s preference to be cared for at home by reviewing his anticipated symptoms and management plan. We will find this information under the **Emergency Treatment Plan**. At the top of this screen is the ceiling of treatment which will help guide decisions about James’s care. In James’s case, his care team did anticipate infections and as a first line management, requested that he be administered oral antibiotics at home and stressed that he should not be given IV antibiotics.

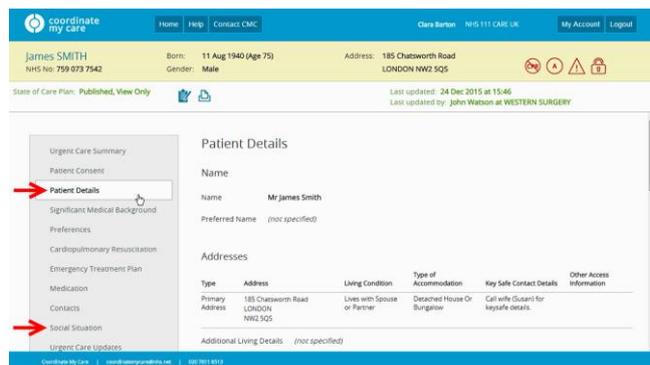


### Navigation Menu

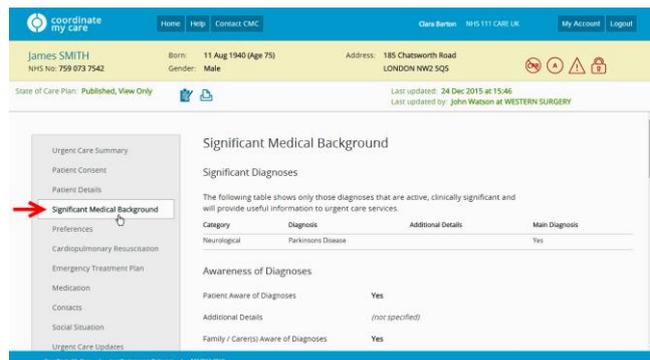
The navigation menu provides access to many additional details not presented in the urgent care summary.



Details about the patient’s living arrangements, access to the property and visiting risks can be found on the Patient Details and Social Situation screens.



More information about the patient’s diagnosis and prognosis can be found on the Significant Medical Background screen.



Details about the patient's medication, including location in the home, is on the Medication screen. Keep in mind that this list includes medication deemed relevant to urgent care situations and does not necessarily list all the medication which the patient has been prescribed.

Details about the patient's allergies can also be found on the Medication screen.

If we want to contact a member of James's care team, their details are listed in the Contacts screen.

Additional comments about James's preferred places of care and of death, if any, are given on the Preferences page.

### Cardiopulmonary Resuscitation

If the call to 111 about James had been for a more immediately life-threatening situation, then we could find more details about James's resuscitation status on the Cardiopulmonary Resuscitation screen.

Medication

Category	Allergy or Reason for No Known Allergies	Date	Severity	Additional Details
Environment	Dust	24 Dec 2015	Mild	

Drug	In Patient's Home	Date	Additional Details
CO-CARBEDOPA (SINEMET) — 10mg/100mg — Oral — Three Times a Day	Yes	24 Dec 2015	

Contacts

Role	Name	Contact Information	Organisation Contact Information	Additional Details
Patient's Registered GP	Organisation	WESTERN SURGERY	Office Phone 01753855450 Email WESTERN.SURGERY@western.nhs.uk	
Provider	Dr John Watson	01837-840223	Office Phone 01753855450 Email WESTERN.SURGERY@western.nhs.uk	

Preferences

Preferred Place of Care: Home (not specified)

Preferred Place of Death (First Choice): Home

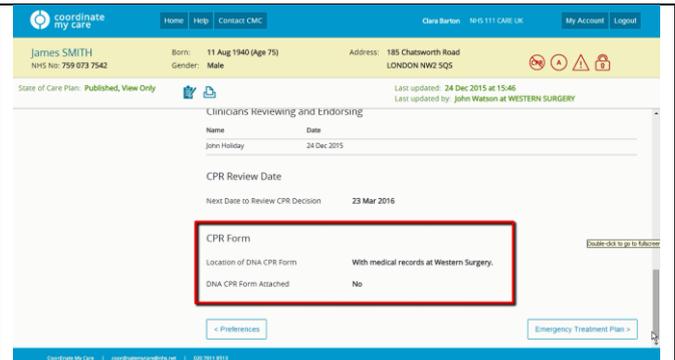
Preferred Place of Death (Second Choice): Care Home (not specified)

Cardiopulmonary Resuscitation (CPR) Discussion

Discussion	Yes
Patient Discussion	Yes
Date of Discussion	24 Dec 2015
Summary of Discussion	Patient is too frail to receive CPR
Family Discussion	Yes
Date of Discussion	24 Dec 2015
Summary of Discussion	Family supports patient's wishes.

CPR Decision

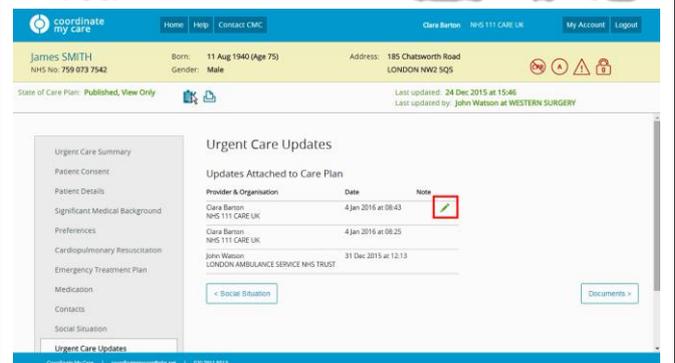
Keep in mind that an electronic DNACPR form has the same validity as a paper form, though in some cases a scanned paper form may be attached to the care plan or the physical location of a paper form may be provided.



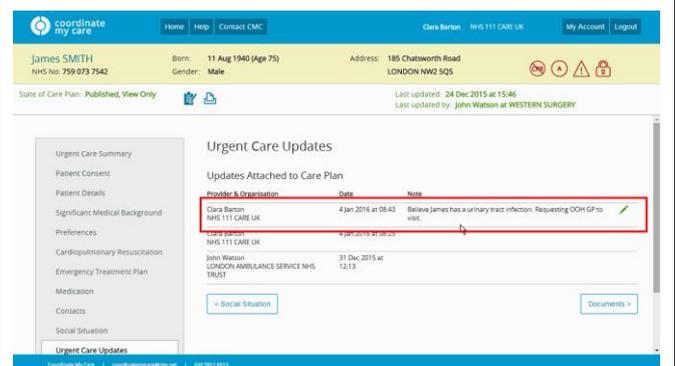
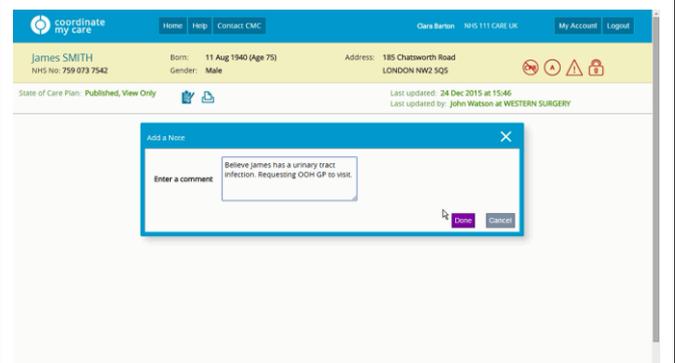
**Urgent Care Updates**  
Based on the information in the care plan and on further discussion with Susan, we determine a working diagnosis of urinary tract infection and decide to request a visit from an out-of-hours GP to assess James at home and prescribe oral antibiotics.



When we opened James's care plan, an urgent care update was automatically created. We can add a note to this urgent care update to record our decision and rationale.



The update will be available to the rest of James's care team when they access his record to help them make decisions about his ongoing care.



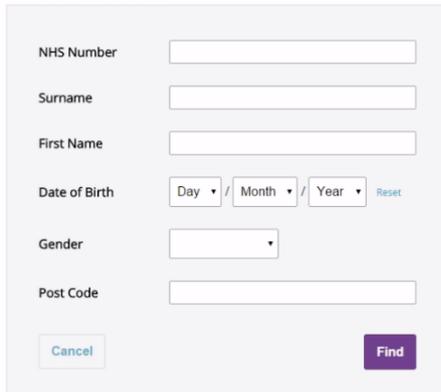
### Summary

To summarize, urgent care users have the ability to search for a patient's care plan, view the urgent care summary of the most important medical information and then browse to various pages of the care plan for more details. Automatically added urgent care updates can be further supplemented to keep a record of the decisions made about the patient's immediate symptom management.

### 2.1.3 Patient Search (text/image)

The minimum required search criteria to find a patient's care plan are:

#### Find a Care Plan



NHS Number

-OR-

Surname plus Post Code or Date of Birth

-OR-

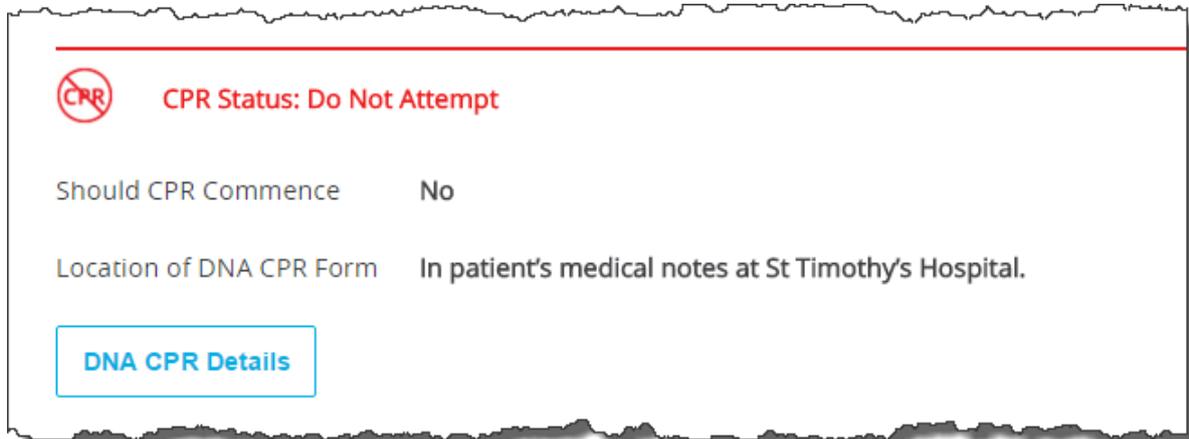
Gender or First Name plus two other criteria.

As an urgent care user, your search results will only include published care plans, i.e. those that have been approved by a clinical user. Draft care plans, care plans for deceased patients and care plans where consent has been withdrawn will not be returned via a patient search.

#### 2.1.4 DNACPR (text/image)

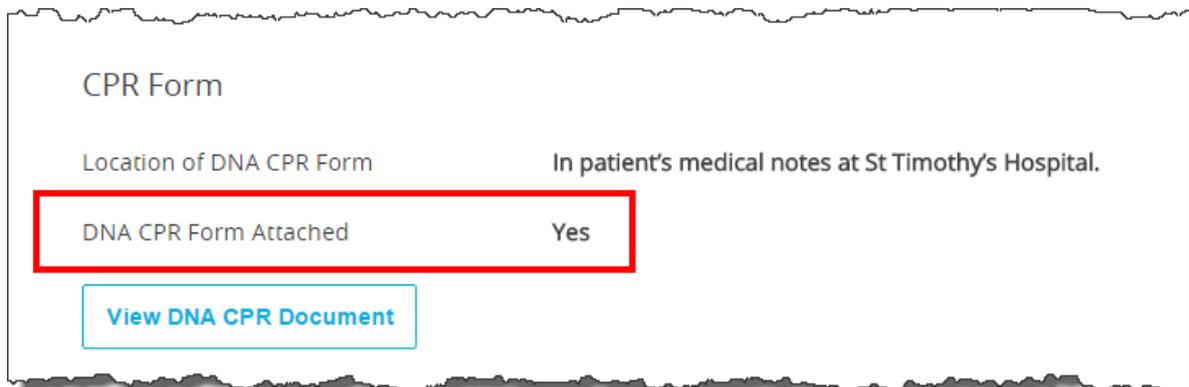
When a patient is not for CPR, the details about that decision – including the discussion held among the patient, the patient’s family and the endorsing clinician about the clinical implications of CPR – can be recorded as part of the patient’s care plan. **An electronic record of the DNACPR decision is as authoritative as a paper copy.**

If a signed paper DNACPR form exists, the physical location of the form should be given.



The screenshot shows a digital interface for CPR status. At the top left, there is a red circle with 'CPR' inside, followed by the text 'CPR Status: Do Not Attempt' in red. Below this, there are two rows of text: 'Should CPR Commence' with the value 'No', and 'Location of DNA CPR Form' with the value 'In patient's medical notes at St Timothy's Hospital.' At the bottom left, there is a blue button labeled 'DNA CPR Details'.

The paper form may also have been scanned and attached to the care plan. You can see if a DNACPR form has been attached to a care plan from the Cardiopulmonary Resuscitation screen.

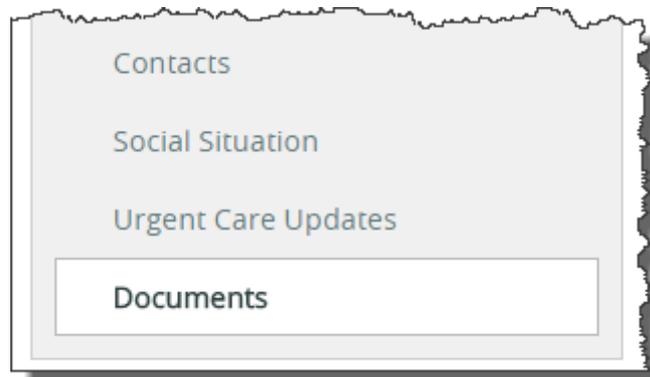


The screenshot shows a digital interface for a CPR form. At the top, it says 'CPR Form'. Below that, there are two rows of text: 'Location of DNA CPR Form' with the value 'In patient's medical notes at St Timothy's Hospital.', and 'DNA CPR Form Attached' with the value 'Yes'. The 'DNA CPR Form Attached' row is highlighted with a red border. At the bottom left, there is a blue button labeled 'View DNA CPR Document'.

The scanned form can be viewed using the Documents screen.

### 2.1.5 Viewing Documents Attached to a Care Plan (text/images)

Occasionally, some data may only be available in a care plan in an attached document. To view documents within a care plan, navigate to the **Documents** tab on the left side of the screen.



This will pull up a list of any documents attached to the current care plan. Select the **View** button on the right to view the contents of the attachment. In the care plan below, you will see that there is one document attached to the care plan: a DNACPR form. Select the **View** button on the right to display the contents of the attachment.

Documents

Documents Attached to Care Plan

Type	Title	Date/Time	Uploaded By	Additional Details
Do Not Attempt CPR Document	DNACPRscan	8 Dec 2015 at 19:11:10	John Watson at WESTERN SURGERY	<a href="#">View</a>

### 2.1.6 Medication (text/image)

The list of medication provided in a care plan is advisory and the following things should be taken into consideration when making care decisions:

1. The medication listed is that deemed relevant to urgent care; the list cannot be assumed to detail all of the medication the patient has been prescribed.

Medication

Medication List Location *(not specified)*

Drug	In Patient's Home	Date	Additional Details
DIAZEPAM — 10 mg — Oral — Once a Day	Yes	11 Dec 2015	
DEXAMETHASONE — 16 mg — Oral — Once a Day	Yes	11 Oct 2015	

The Medication List above is intended to guide urgent care services; it is not a prescription and should not be used to dispense or administer medication.

- Medication entered before the CMC system was upgraded in November 2015 will be identifiable by the designation “Migrated Medication” in the **Drug** field. Over time, as clinicians review a patient’s care plan, they will be updating or removing these entries as appropriate.

Drug	In Patient's Home	Date	Additional Details
Migrated Medication			Route: Intravenous Type of drug: IV/IM Anxiolytic/Sedative Drug (generic name): Midazolam Dose and units, e.g. mg, mcg etc.: 1mg Max Frequency/24hrs: frequency 1 extra line

### 2.1.7 Icon Reference List (text/image)



The patient is not for CPR.



The patient has allergies.



The patient has medical, personal or social alerts.



The patient’s home has a key safe.



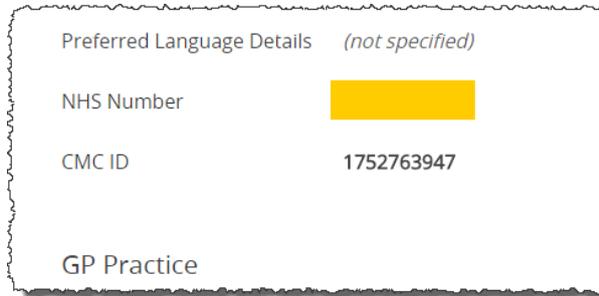
Shortcut to print the patient’s care plan.



Shortcut to edit urgent care updates.

### 2.1.8 Duplicate Care Plans (text)

The Coordinate My Care system is designed to minimise the possibility of duplicate care plans being created for a patient, however duplicate care plans may sometimes happen. If you encounter a patient for whom there appears to be duplicate care plans, please contact CMC and provide the CMC IDs for the care plans. CMC IDs can be found on the Patient Details screen and are not considered to be patient-identifiable information.



Phone: 020 7811 8513

Hours: Monday to Friday from 9am to 5pm

Email: [coordinatemycare@nhs.net](mailto:coordinatemycare@nhs.net)

### 2.1.9 Viewing a Care Plan Simulation

In this simulation you will find and view the care plan for a patient named Laura Jones.

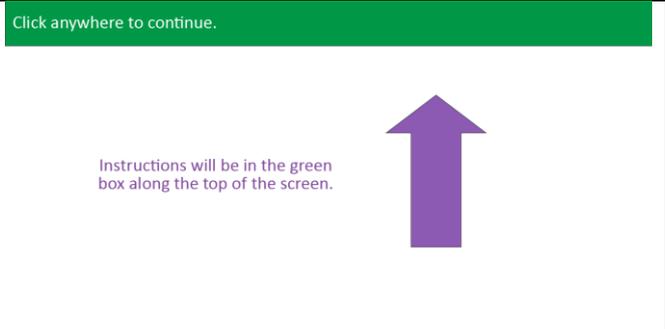
Link to simulation [here](#).

Duration: 5:00

Instructions to User	Notes for Simulation
<p><b>PRACTICE:</b> Viewing a Care Plan</p>	
<p><b>Overview:</b> In this simulation you will find and view a care plan for a patient named Laura Jones. To complete the simulation, we will need to answer several questions about the patient's care plan.</p> <p>Laura's daughter, Amanda, has called because Laura is having a seizure. Mr. Jones is at work and Amanda has not yet tried to reach him.</p>	

Instructions will be in the green box along the top of the screen.

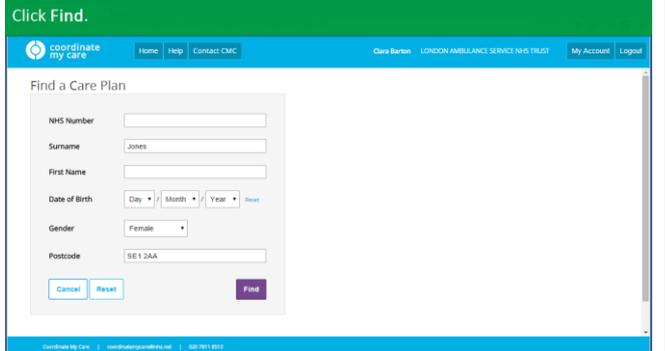
Click anywhere to continue.



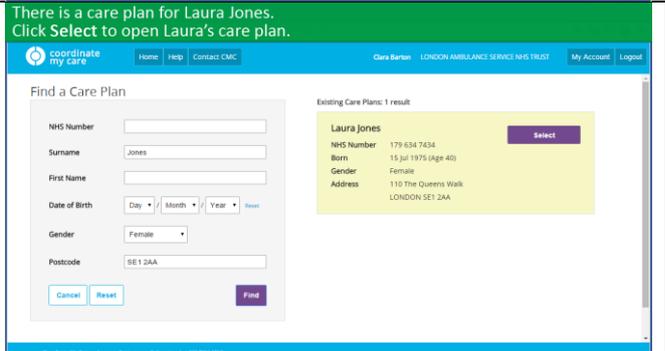
Find the care plan that you will view.  
Type **Surname:** Jones and press Tab.

Select **Gender:** Female.

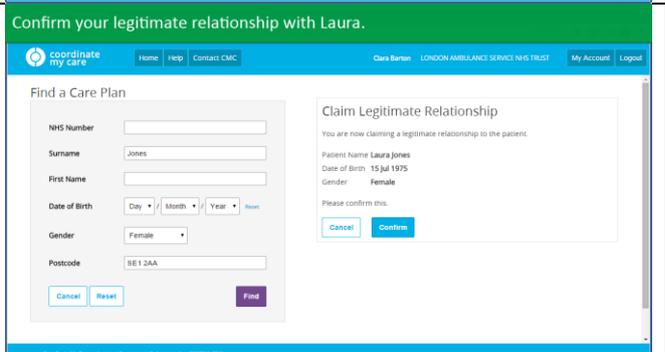
Type **Post Code:** SE1 2AA.  
Click **Find**.



There is a care plan for Laura Jones.  
Click **Select** to open Laura's care plan.

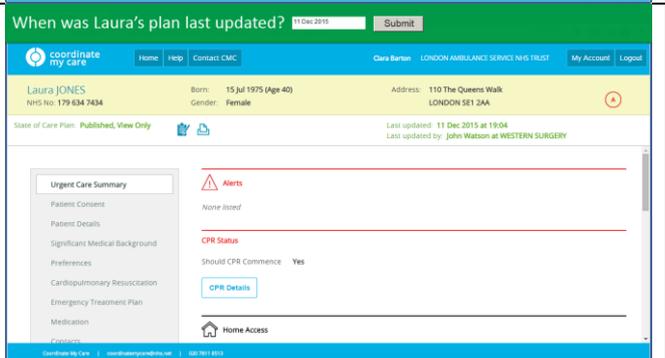


Confirm your legitimate relationship with Laura.



When was Laura's plan last updated? (03 Nov 2015)

What is Laura's house number? (110)



Does the home have a key safe access code? (No.)

Does the home have a key safe access code?

Using the urgent care summary, what type of cancer does Laura have? (breast)

Find and select Laura's ceiling of treatment.

Navigate to the emergency treatment plan. Find and click on Laura's ceiling of treatment. (Full Active Treatment Including CPR)

Did Laura's care team anticipate her seizures? If needed, use the arrows in the bottom right to scroll. (yes)

Did Laura's care team anticipate her seizures?

Browse to the Medication screen. Once a day, Laura takes 10mg of what medication for seizures? (diazepam)

Once a day, Laura takes 10mg of what medication for seizures?

Drug	In Patient's Home	Date	Additional Details
DIAZEPAM - 10 mg - Oral - Once a Day	Yes	11 Dec 2015	
DEXAMETHASONE - 16 mg - Oral - Once a Day	Yes	11 Dec 2015	

Use the Contacts screen to find the phone number for Mr. Jones. (07777 666666)

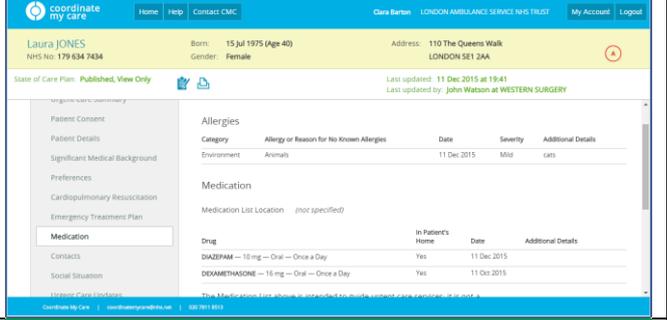
Use the Contacts screen to find the phone number for Mr. Jones.

Type	Name	Contact Details	Date Added	Address	Main Carer	Additional Details
Husband	Brian Jones	Mobile Phone 07777666666	11 Dec 2015		Yes	

Use the patient banner icons to navigate to Laura's allergy information.

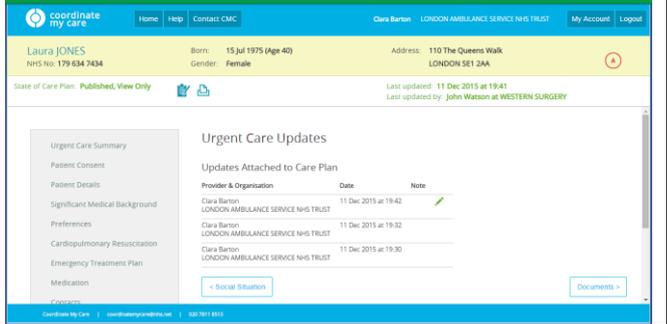
Notice the icon navigated directly to the Allergies section of the Medication screen. Next, view Urgent Care Updates.

Notice the icon navigated directly to the Allergies section in the Medication screen. Next, view Urgent Care Updates.



Edit the urgent care update created when you opened the care plan.

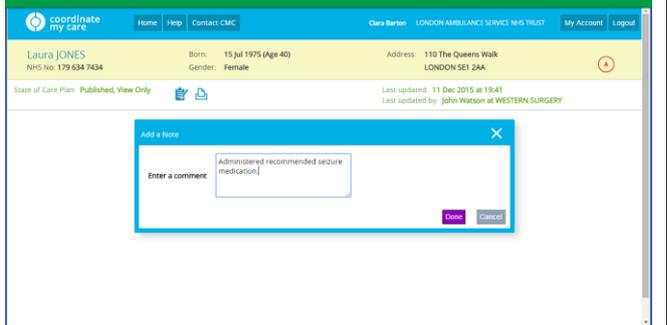
Edit the urgent care update created when you opened the care plan.



Add the text *Administered recommended seizure medication.*

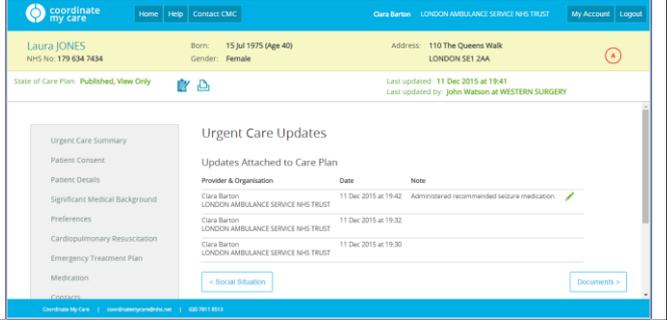
Select Done.

Select Done.

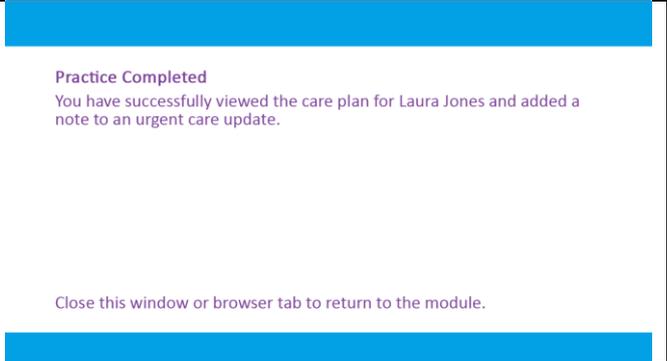


The note has been added to the update. Click anywhere to continue.

The note has been added to the update. Click anywhere to continue.



Practice completed. You have found and viewed a care plan.



### 2.1.10 Summary (text)

The urgent care summary displays the most critical information from a patient’s care plan, including any alerts, whether the patient is for CPR, the patient’s home access information and the patient’s diagnosis. Details about the patient’s care team and medication, as well as any anticipated symptoms can be viewed using the care plan navigation menu.

## 2.2 Restricted Records

### 2.2.1 Introduction (text)

In rare cases, patients with specific privacy concerns may choose to restrict access to their care plans. In the case of these restricted records, the full care plan will not be available to urgent care users. This lesson will demonstrate how to search for and “break the glass” on a restricted record.

By the end of this lesson, you will be able to:

1. Find a restricted record.
2. Break the glass on a restricted record.

### 2.2.2 Restricted Records Demonstration (video)

Watch the video [here](#).

Duration: 4:50

Video Script	Notes for Recording Video
<p><b>Introduction</b> Care plans can be restricted at the request of the patient or the patient’s clinician.</p> <p>A patient may wish to restrict access to their care plan for a variety of reasons. For example, they may be a public figure, or they may be a medical professional who does not wish to disclose a medical condition to their colleagues, or there may be other personal reasons for this decision.</p>	 <p><b>DEMOS: RESTRICTED RECORDS</b></p> <p> Personalised Urgent Care Plan</p> <p><b>WHY ARE CARE PLANS RESTRICTED?</b></p> <ul style="list-style-type: none"><li>▪ The patient is a public figure.</li><li>▪ The patient is a medical professional.</li><li>▪ The patient has other privacy concerns.</li></ul>

Requesting access to a restricted care plan is called *breaking the glass*. Each restricted care plan will include a list of users who have full access to the plan; other users will have access only to this list of authorised users.

In this demonstration we will look at:

- How care plans are restricted.
- How we determine who has full access to the care plan.
- How we can break the glass.
- What information is available to users without full access.

### How to Restrict a Care Plan

Let's begin by logging in as a clinical user.

We will open the care plan of the patient who wishes to restrict access, navigate to the Patient Consent screen, and scroll down to the **Make Record Restricted** setting.

## BREAKING THE GLASS

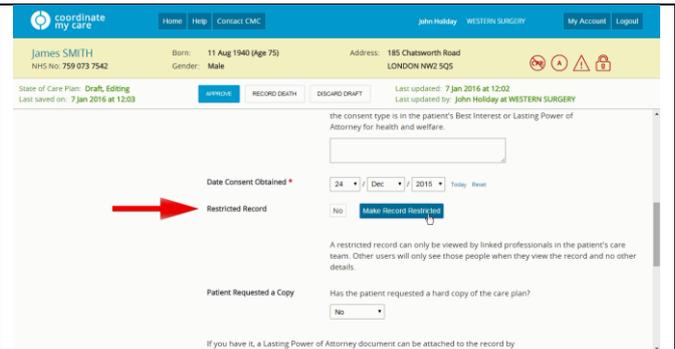
- The act of requesting access to a restricted record.
- Authorised users have full access.
- Other users have access to the list of authorised users.

## DEMONSTRATION

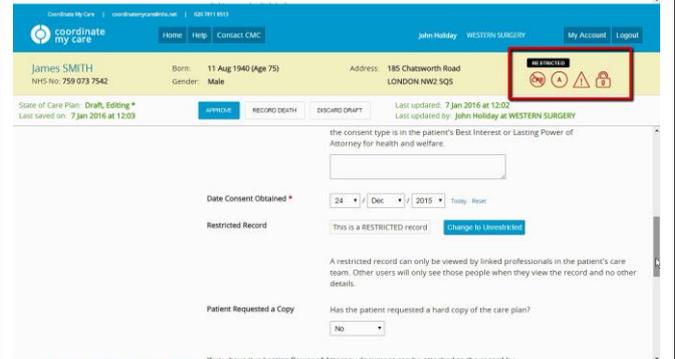
- How care plans are restricted.
- How to determine who has full access to the care plan.
- How to break the glass.
- What information is available to users without full access.

The image displays three screenshots from the 'coordinate my care' web application. The top screenshot shows the login page with fields for Username (holidayj), Password (\*\*\*\*\*), and a dropdown menu for Select Organisation (WESTERN SURGERY). The middle screenshot shows the Patient List for Mr James Smith, with a red arrow pointing to the 'Edit Draft Care Plan' button. The bottom screenshot shows the Patient Consent screen for James SMITH, with a red arrow pointing to the 'Patient Consent' tab in the left-hand navigation menu.

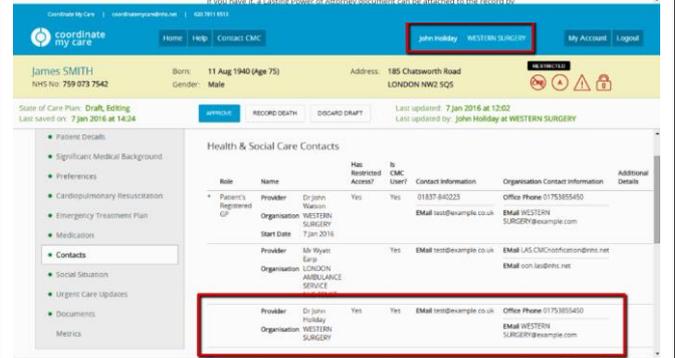
When we select **Make Record Restricted**, the care plan is restricted immediately and we can see the label *Restricted* has been added to the care plan banner. From this point forward, all CMC system users will need to break the glass to see any information about the patient's care plan.



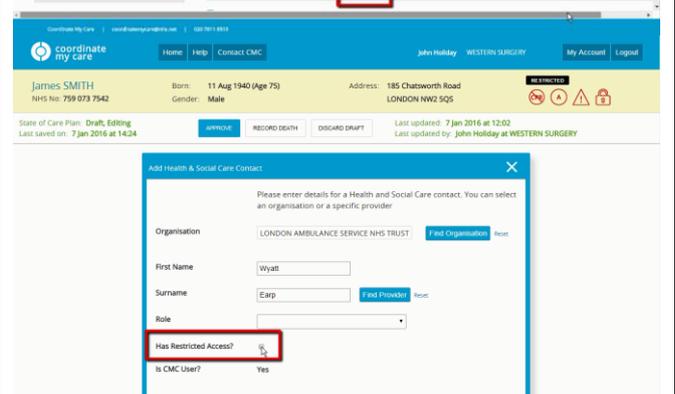
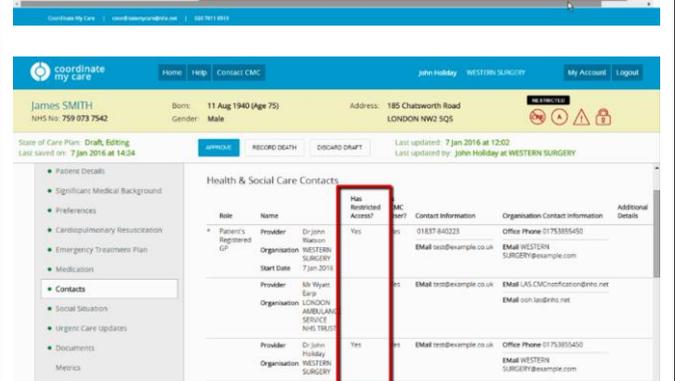
When we selected **Make Record Restricted**, we were added to the patient's list of health and social care contacts.



Notice the **Has Restricted Access** flag; this indicates that we have full access to the care plan, while other users who do not have this flag set will not have full access.



Other health and social care contacts can be given full access to the care plan by editing their information and ticking **Has Restricted Access**.



## Search – Break the Glass

Now let's look at how a user can break the glass to obtain information about the patient's care plan.

We will perform our search as an urgent care user, but the behavior is the same for clinical and administrative users.

As usual, we will put in our search criteria and click **Find**. If the search results include a restricted record, a dialogue box giving us the option of accessing the restricted record is displayed above any normal records. If we do not wish to break the glass, we can click **Cancel**, but if we choose to break the glass, then we **must** provide a comment explaining why we have chosen to do so.

Notice that we are not presented with the care plan directly, but the search results are updated to include the restricted result. This allows us to compare the demographic information of all the results and be sure we are selecting the correct record.

## Viewing the Care Plan

At this point, if we click **Select** to access the restricted care plan and confirm our legitimate relationship with the patient, we do not have access to the full care plan, but rather the contact details for the patient's health and social care contacts who have been flagged as having access to the restricted record. We can get in touch with one of these contacts who can then access the full care plan and advise us of any relevant information it contains.

## Auditing

All actions related to restricted records are audited, including any break-the-glass searches.

## Summary

Access to some care plans may be restricted in order to protect patient privacy.

The screenshots illustrate the user journey for accessing a restricted care plan:

- Login:** The user enters their username (EARTONC) and password, selects the organization (NHS 111 CARE UK), and clicks 'Continue'.
- Search:** The user enters search criteria (Surname: smith, First Name: james, Date of Birth: 11 Aug 1940, Gender: Male, Postcode: ) and clicks 'Find'.
- Dialog Box:** An 'Access Restricted Patient Records' dialog box appears, asking for a comment to justify breaking the glass. The user enters 'Caller believes that patient has a restricted care plan' and clicks 'Done'.
- Results:** The search results are updated to show one restricted record for James Smith (NHS Number: 759 073 7542). A 'Select' button is visible next to the record.
- Viewing the Care Plan:** After clicking 'Select', the user is shown the patient's details (James SMITH, NHS No: 759 073 7542, Born: 11 Aug 1940, Address: 185 Chatsworth Road, LONDON NW2 5QS) and a 'Contacts' section. The contacts table is highlighted with a red box:

Role	Name	Has Restricted Access?	Is CMC User?	Contact Information	Organisation Contact Information	Additional Details
• Patient's Registered GP	Dr John Wilson WESTERN SURGERY	Yes	Yes	01837 840223 Email: test@example.co.uk	Office Phone: 01753855450 SURGERY@example.com	
Provider	Mr Wjact Carp LONDON AMBULANCE SERVICE NHS TRUST	Yes	Yes	Email: test@example.co.uk	EMAIL: LAS.CMC@nhs.uk Email: on.us@nhs.net	
Provider	Dr John Holiday WESTERN SURGERY	Yes	Yes	Email: test@example.co.uk	Office Phone: 01753855450 EMAIL: WESTERN SURGERY@example.com	

<p>Requesting access to a restricted record is called "breaking the glass". At least one of the patient's health and social care contacts will have full access to the patient's care plan; other users who choose to break the glass will have access to contact details for the users with full access.</p>	
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### 2.2.3 Summary (text)

Access to some care plans may be restricted in order to protect patient privacy. In these cases, urgent care users may "break the glass" in order to access contact details for the patient's health and social care contacts who are flagged as already having access to the restricted record.

## 2.3 Self-Assessment

### 2.3.1 Question 1 (dropdowns)

Choose the appropriate description of each icon:

- A.  B.  C.  D.  E.  F. 

1. The patient has medical, personal or social alerts.
2. The patient is not for CPR.
3. Shortcut to print the patient's care plan.
4. The patient's home has a key safe.
5. The patient has allergies.
6. Shortcut to edit an urgent care update.

[explanation] A – 2; B – 5; C – 1; D – 4; E – 6; F – 3

### 2.3.2 Question 2

Which of the following information is displayed on the urgent care summary? Select all that apply.

- Medical, personal, social alerts
- Allergy and medication details
- DNACPR decision
- NOK contact information
- Key safe and property access information
- Emergency treatment plan
- Diagnosis
- Place of care and place of death preferences
- Consent type

### 2.3.3 Question 3

Urgent care users who break the glass on restricted records will have access to: \_\_\_\_\_.

- All of the patient's health and social care contacts.
- The patient's Emergency Treatment Plan screen, address, and access details.
- The patient's health and social care contacts who have access to the restricted record.
- The patient's Urgent Care Summary screen and social care contacts.

## Module Conclusion

### Conclusion

#### C.1.1 Module Conclusion

Coordinate My Care is a pan-London service seeking to improve patient end-of-life and urgent care through the sharing of electronic care plans among healthcare professionals. A care plan is created only with consent, and system users and partner organisations must strictly adhere to information governance policies.

Administrative and clinical users work together to review and update care plans on a regular basis to ensure that urgent care users have accurate and relevant information for assessing and treating patients in urgent care situations.

The most critical information from the care plan, including alerts, the patient's diagnosis, home access information and CPR status, is aggregated on the urgent care summary. Additional information is available using the care plan navigation menu.

Urgent care updates inform the patient's regular care team about important circumstances or outcomes that have occurred during an urgent care situation.

In the case of restricted records, urgent care users who have broken the glass have access only to contact information for the patient's designated health and social contacts.

Any duplicate records should be reported to CMC.

Feedback on this module can be provided to Coordinate My Care via email at [cmc\\_training@nhs.net](mailto:cmc_training@nhs.net).

Click the button below to notify Coordinate My Care that you have completed *CMC104 Viewing a Care Plan*. Once all of your training has been marked *Complete*, CMC will use this information to confirm that you can be provided with access to the system.