



PHYSIOTHERAPY PRACTICE MANAGEMENT SYSTEM

(PRIVATE PRACTITIONERS)

INTRODUCTORY MANUAL

Thank you for taking the time to look at the Tynedale Physiotherapy Practice Management system. This manual is designed to give you a quick overview of the system covering the following areas:

- Basic introduction to computer terminology
- Installing the software
- Locating and creating patient records
- Recording treatments
- Printing letters
- Creating recalls
- Booking appointments.

If you have any queries or experience any problems using this system please telephone our help desk on 0191 4283341.

GETTING STARTED

The Physiotherapy Practice Management system (PPMS) has been designed to suit a range of physiotherapists, starting with those who simply wish to record basic patient information such as name and address. However, for physiotherapists who wish to enter more detailed information, or organise their correspondence and accounts, the system allows them to record a large amount of additional information and to manipulate it to produce reports and statistics.

THE MANUALS

We have prepared three manuals to support the system. These are:

- **Introductory Manual.** This manual.
- **User Manual.** The User Manual describes all the basic features of the system, as well as explaining how to set the system up on your computer. It also describes how to use the basic accounting features and how to send letters and e-mails to patients.
- **Advanced Manual.** The Advanced Manual describes how to create further reports from the information already entered and how to make more use of the accounting information held against each patient. It also explores the other options that are available on the system, such as how to define new treatment options.

EXPLANATION OF SOME TERMS USED

The system is based on menus and screens, similar to most computer systems. For those new to computers, some of the terminology used in these manuals is explained below. For those more familiar with PC's and Windows you can skip to page 5.

Standard Windows terms

'Left click' (usually shortened to 'click') means position the cursor over the required menu, field or button and click the left button of the mouse. Similarly, 'right click' means click the right button of the mouse, while 'double click' means click the left button of the mouse twice in quick succession.

Capital letters are used to describe specific keys on the keyboard, for example SHIFT, TAB, ALT, CTRL, and RETURN.

The '+' symbol is used to indicate that the key to the left of the '+' should be held down while the key to the right is pressed. For example, 'SHIFT + F' means that the SHIFT key should be held down while the 'F' key is pressed once.

A 'pop-up menu' is a list of options that is superimposed on the current screen. When you make your selection, the menu disappears and you are left with the current screen.

The word 'desktop' is used to describe the display on the computer monitor when no windows (including this Physiotherapy system) are visible, and when the physiotherapy icon is visible.

Menus and options

The system uses menus to navigate to, or select, a particular function. The second line on the screen contains the words File, Edit, Physiotherapy Main Menu etc. When the cursor is placed over one of these, and the left button of the mouse is clicked, a drop down list of options (a 'menu') appears on the screen. Further sub-menus may be available; these are indicated by an arrow at the right of the option. Options listed on a menu are shown in these manuals in double quotes, e.g. "Patient Record".

Screens

Information is entered into the records using computerised forms which are known as screens. The format and layout of the screens varies according to the information to be entered and the further options available, but the basic approach is the same. Each screen contains areas for entering data (called fields), and buttons to select another screen or perform an action (e.g. save). Some screens also contain boxes to view data entered elsewhere.

Patient Record

The Patient Record screen is the screen that you will use most often being the main screen where most patient information is entered and retrieved. It is selected from the Physiotherapy Main Menu. Chapter 3 of the User Manual describes the screen and its functions in detail.

Fields

Fields are the areas on a screen where information is entered, either by using the keyboard or by selecting an option from a menu. In these manuals, field titles are shown in *Italics*. Guidelines for the type or format of the information to be entered in any field are often given on the bottom line of the screen when the mouse cursor is in the field.

To move to a new field, position the cursor over the required field and press the left mouse button (left click). Alternatively, use the TAB key to move to the next field, or hold down the SHIFT key and use the TAB key to move to the previous field.

Boxes

Boxes are areas of a screen that the system fills in from information you have provided elsewhere. They provide a means of viewing associated information on a screen. Box titles are shown in *Italics*.

Buttons

Buttons are provided on a screen to select an action. Most buttons are at the bottom of a screen, but they do appear elsewhere. In these manuals, the names of the buttons are shown in ***bold italics***. If they are greyed out on the screen, that feature is not available at that time.

Many of the screens in the system use the same standard buttons. These include:-

- ***Add***. Used to create a new record, e.g. a patient record
- ***Edit***. Used to change details within a record
- ***Find***. Used to find a particular record that has already been entered
- ***Next***. Moves to the next record
- ***Back***. Moves to the previous record
- ***Delete***. Deletes the record which is currently displayed on the screen (use with care)
- ***Ok***. Saves the record which is currently displayed on the screen, closes the screen and reverts to the next highest level
- ***Quit***. Closes the current screen and reverts to the next highest level
- ***Cancel***. Clears the current screen - any information that has been entered is lost.

To select the action, left click on the button. Alternatively, hold down the ALT key and type the letter underlined on the button (e.g. ALT + E for Edit).

Moving within the screen

Some screens, particularly the correspondence screens, are too long to fit on the monitor, in which case arrows will appear on the right hand edge of the screen, with a scroll bar between them. To see further down the screen (called 'scroll down'), use the mouse to click on the down arrow at the bottom right of the screen, or to drag the scroll bar downwards. To see further up ('scroll up'), click on the up arrow at the top right of the screen, or drag the scroll bar upwards.

Saving the information

After entering all necessary information on a screen or record, click on the ***Ok*** button or press the RETURN key to save the data to the hard drive of your system. If the information entered is not required, click on the ***Cancel*** button which will remove all the information entered on the current screen.

Closing the system

To exit the system when you have finished using it, close the screen by clicking on the ***Quit*** button. Then click on the File menu, move the cursor down until "Exit" is highlighted and click left. Alternatively, you can click on the red cross at the top right-hand corner of the screen.

INSTALLING PHYSIOTHERAPY PRACTICE MANAGEMENT

When you insert the CD into the drive, the setup programme should run automatically. If it does not, you will need to run the SETUP.EXE file from Windows Explorer. Follow the installation instructions on the screen. When the software is installed you will return back to your desktop with a new icon called 'Physiotherapy Practice Management'.

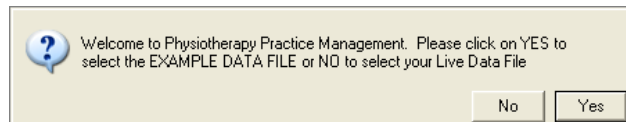
Double click on the Physiotherapy icon to load the Physiotherapy software. You maybe prompted for your user name and serial number. The serial number is C7RSI 446967 12365.

Selecting the data file

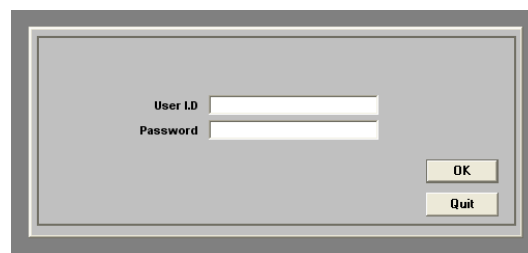
The software comes with two data files:

- An example data file that includes a few patient records, treatments and appointment diaries. Use this to try out the system before entering live data. (You can enter your own patients on the sample data file but the information will be lost if you decide to purchase the software)
- The 'live' data file which is empty but includes quick setup routines for setting up your clinics and appointment diaries. Use this data file after you have assessed the system and want to use it live with your own patient records.

So for now, you want to use the example data file. On the popup screen below which should be on your computer, left click on *Yes* to select the example data.



The screen changes to the following.



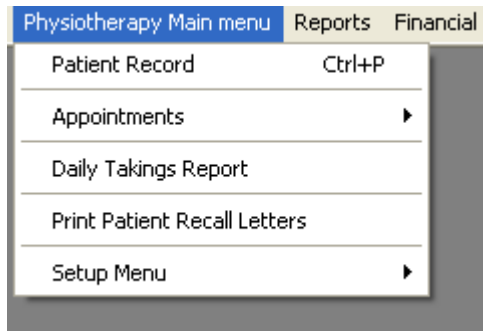
In the *User ID* type in **PHYSIO** and leave the password blank. Click left on the **Ok** button. If you decide to purchase the software you can create your own User ID's for each member of staff at your practice.

There is no time limit for this example software, but you are limited to a maximum on 25 patient records.

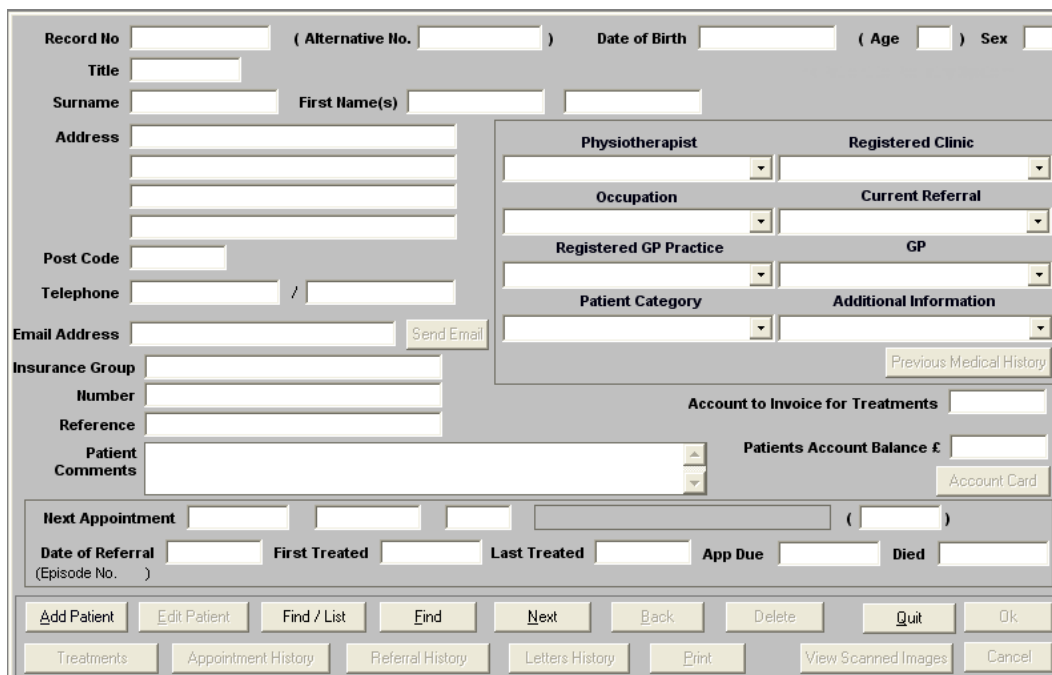
THE PATIENT RECORD CARD

The system now displays a blank screen with the menu titles at the top.

To begin with we will take a look at the Patient Record screen. Click on the Physiotherapy Main menu, move the cursor down until “Patient Record” is highlighted and click again. Alternatively press CTRL + P.



The screen now changes to bring up the blank Patient Record screen as below.

A screenshot of a patient record form. The form is organized into several sections. At the top, there are fields for 'Record No', '(Alternative No.)', 'Date of Birth', '(Age)', and 'Sex'. Below these are fields for 'Title', 'Surname', and 'First Name(s)'. The 'Address' section has four lines of text input. 'Post Code' and 'Telephone' fields are also present. The 'Email Address' field has a 'Send Email' button next to it. The 'Insurance Group' section includes 'Number' and 'Reference' fields. A large 'Patient Comments' area has up and down arrow buttons. To the right, there are several dropdown menus: 'Physiotherapist', 'Registered Clinic', 'Occupation', 'Current Referral', 'Registered GP Practice', 'GP', 'Patient Category', and 'Additional Information'. There is also a 'Previous Medical History' button. At the bottom right, there are fields for 'Account to Invoice for Treatments' and 'Patients Account Balance £', with an 'Account Card' button. The bottom of the form features a row of buttons: 'Add Patient', 'Edit Patient', 'Find / List', 'Find', 'Next', 'Back', 'Delete', 'Quit', and 'Ok'. Below this row is another row of buttons: 'Treatments', 'Appointment History', 'Referral History', 'Letters History', 'Print', 'View Scanned Images', and 'Cancel'. There are also fields for 'Next Appointment', 'Date of Referral (Episode No.)', 'First Treated', 'Last Treated', 'App Due', and 'Died'.

Creating a new record

Click left on the **Add Patient** button at the foot of the Patient Record screen to start to create a new record.

Very little information must be entered for a patient; it is up to you to decide how much you wish to enter.

The system allocates the Record No. automatically starting from 00001, so the cursor skips the first field and is positioned in the *Alternative No* field.

Use either the mouse, or the TAB and SHIFT + TAB keys, to move the cursor to the three obligatory fields – *Date of Birth*, *Sex* and *Surname* – and enter the patient's particulars. If you do not know the date of birth, it can be left as the default date and changed later.

Now move around the other fields and enter as much or as little as you wish. The main ones used are: *Title*, *First Names*, *Address*, *Post Code* and *Current Referral*.

There are eight fields (Physiotherapist to Additional Information) at the right of the screen whose entries are selected from a popup menu. Left click in the field to obtain the list of possible entries, and left click again on your choice. If the list is long, you will have to scroll down through the list to find your choice.

Entering information

Information is entered into the fields of a screen in a similar way to that in any other Windows based software. For those new to computers, here are a few pointers.

Before entering any information, check that the cursor is in the required field. If it is not, move to the field using the TAB key, or position the cursor in the field and left click. SHIFT + TAB moves to the previous field.

Typing into fields

When the cursor is in the required field, enter information simply by using the keyboard. When you have completed a field, press the TAB key to move to the next field. Do not use the RETURN key. If you accidentally press RETURN click on **Edit Patient** to continue entering data.

If you make any errors, use the backspace key to correct them. Or, highlight the error using one of the following three methods, and then type in the correct information which will replace the error.

- Use the arrow keys or the mouse to place the cursor at one end of the error, hold down the SHIFT key and move the cursor to the other end using the arrow keys.
- Use the mouse to place the cursor at one end of the error, hold down the SHIFT key, use the mouse to move the cursor to the other end of the error and left click.
- Use the mouse to place the cursor at one end of the error, hold down the left button of the mouse and drag the mouse to move the cursor to the other end of the error.

Validation of contents

If you try to move the cursor from a field and the computer beeps, it means one of two things:

- The information entered is not valid for that field. For example, in one field you enter the patient's sex. Valid characters here are M and F. If you enter Y, the computer will beep and not let you past that field until you either click on the *Cancel* button or enter M or F.
- No information has been entered, but the system requires that the field is completed. For instance, Reference Codes and often Descriptions cannot be left blank.

In either case, you will need to change the entry in the field. Examples of acceptable entries are often shown to the right of the field. Also, when the mouse cursor is in the field, guidelines for the format of that field may be given on the bottom line of the screen.

Changing the contents of an existing field

If you use the TAB key to reach a field which has already been completed, the contents will be highlighted (selected). Typing anything now will delete the contents, unless you move the cursor with the right arrow first.

However, if you use the mouse to reach a field which has already been completed, the contents will not be highlighted, and anything typed will be added to the field, unless you highlight the field first.

Saving the Record

When you have finished registering the patient, click on the *Ok* button to save the record. The patient's record will be allocated a number and saved on your computer.

Finding a record

To find a patient record you will need to click on the **Find** button. The cursor will then move to the *Record No* field. Type in **00001** and then click on the **Ok** button. (Press the RETURN key if you prefer).

This opens the Patient Record screen for patient number 00001, Mrs Fletcher.

The screenshot shows a patient record form for Mrs Jane Fletcher, patient number 00001. The form is divided into several sections:

- Personal Details:** Record No (00001), Title (Mrs), Surname (Fletcher), First Name(s) (Jane), Date of Birth (28 FEB 1966), Age (38), Sex (F).
- Address:** 23 Alston Drive, Sunderland, SR12 5BB, Telephone (0191 323434), Email Address (JANE@EMAIL.COM).
- Clinical Information:**
 - Physiotherapist: John Patterson
 - Registered Clinic: Compass Physio - Room 1
 - Occupation: Aerobic Instructor
 - Current Referral: Self Referral
 - Registered GP Practice: BRIDGE ROAD MEDICAL CENTRE
 - GP: BROWN, P
 - Patient Category: Aerobics
- Accounting:** Account to Invoice for Treatments (PAT00001), Patients Account Balance (£ 20.00).
- Appointment History:** Date of Referral (1 DEC 2004), First Treated (1 JAN 2005), Last Treated (4 FEB 2005), App Due (25 FEB 2005).

At the bottom, there are navigation buttons: Add Patient, Edit Patient, Find / List, Find, Next, Back, Delete, Quit, Ok, Treatments, Appointment History, Referral History, Letters History, Print, View Scanned Images, and Cancel.

In this screen you can see that we have entered a clinic and physiotherapist. This would normally be done if you work from several locations and have several physiotherapists working with you. However, the Clinic names could just as easily have been setup as the Physiotherapists name if that is what you prefer. The GP practice and GP codes can be entered allowing you to produce GP letters or reports.

If you have mistyped the record number click on **Find** and try again. You can also search in the fields *Surname*, *Alternative No.*, *Address*, *Post Code* and *Telephone number*. However you can only search on one of these fields at a time.

After you have selected a record using the **Find** button, you can use the **Next** button to find the next record in sequence. Normally this is in alphabetic order of the surname, but if you use the **Find** button to search on another field, for instance the *Record No*, clicking on the **Next** button will take you to the next record in numerical order. In the same way, the **Back** button will take you back through the records in alphabetical order.

Often the preferred method for finding patients is using the **Find/List** button. This allows you to search on several fields at a time and will display a list of all the patients that match your criteria. After locating the patient in the list, double click on their name and the full record will be displayed.

Amending a record

You are likely to want to change or add to the information in a record at some point after you have saved it. To do this, first search for the record to be changed using the ***Find*** or ***Find/List*** buttons as above.

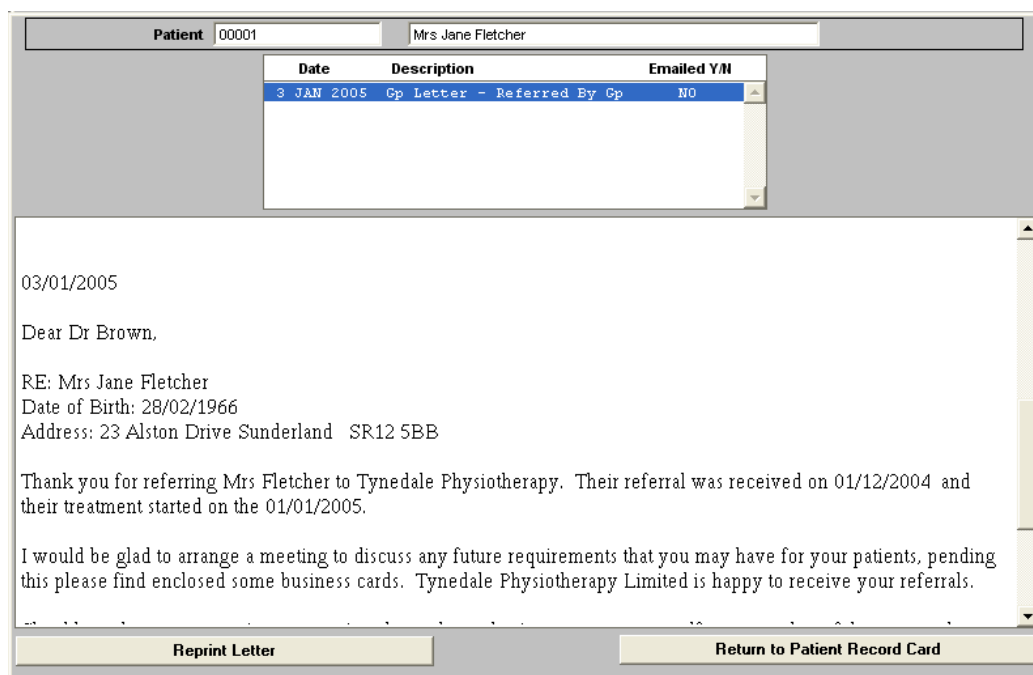
Then click on the ***Edit Patient*** button, which allows you to change or add to your entries in the fields. Make your changes in the same way as you would enter them when creating a record.

Finally, click on the ***Ok*** button to save your changes, or the ***Cancel*** button to discard them. If you click on the ***Ok*** button, the screen reverts to the Patient Record screen that you were editing. If you click on the ***Cancel*** button, the screen will revert to a blank Patient Record screen.

Letters history

This provides an audit of all letters/emails which have been sent either to the patient or to their GP.

When you click on the ***Letters History*** button on Mrs Fletcher’s Patient Record screen the following screen is displayed.



A list of all the letters that have been sent to the patient or their GP is displayed in the scroll box at the top of the screen. Clicking on any letter in the scroll box will display the contents of the letter in the box below.

In this example one letter has been created for Mrs Fletcher and sent to her GP to acknowledge her referral. Click on the ***Return to Patient Record Card*** button to return Mrs Fletcher’s Patient Record screen.

Previous Medical History

This button is used to enter details of the patient’s past medical history. This can be entered either as free text or you can use the drop down lists to select standard descriptions for conditions and medication. If you choose this latter method you can use the Report menu to analyse the patient database.

	Medical Conditions	Medication	Doseage
1	Diabetic		
2	Depression		
3			
4			
5			
6			
7			

(Use Dropdown Lists if you intend to use Report Generator to produce reports on Medical data)

Other functions

Functions available by clicking on other buttons on the Patient Record screen include:

- **Treatments** Record and view and treatment details
- **Appointment History** Print a report to the screen showing which appointments were attended, cancelled or not attended
- **View Scanned Images** Any correspondence from the patient or GP can be scanned and the images stored with the patient record
- **Print** Print patient record and treatment details
- **Send Email** Send a quick note to the patient using e-mail.
- **Referral History** A list of the dates and reasons of referral for this patient

PATIENT TREATMENTS

The Physiotherapy system provides three ways to record patient treatments. These range from recording that the patient has attended to entering complete treatment records. Two methods are via the **Treatment** button on the Patient Record screen, the third is from the appointments system.

To access the treatment history screen, select the **Treatment** button on the Patient Record screen. The view below shows the treatment history screen for Mrs Fletcher.

The screenshot displays the 'Patient Treatment History' screen for Mrs Jane Fletcher (Patient ID: 00001). The interface includes a 'Patient Recalls' section with 'Add Recall' and 'Remove Recall' buttons. The main 'Patient Treatment History' table shows the following data:

Position	Standing
Flexion	90
Differentiation	Eased by
Position	Crook lying
Extension	60

The 'Treatment Notes' section contains the following text:

Activity: mobilisation of Right SI joint. Pa Grade IV for 10 seconds. Improvement made.

Activity: home exercise programme
Patient to do exercises everyday

Activity: DTF of lateral epicondyl. Medial

At the bottom, there are buttons for 'Add Detailed Treatment', 'Add Basic Treatment', 'Amend Treatment for 4 FEB 2005', 'Quit to Patient Record', 'Print', 'Delete Treatment', and 'Print Letter'. A status bar indicates 'Record will be locked 365 day(s) after treatment was inserted' and 'Rec No. 2'.

This screen displays a full treatment history including treatment notes and patient comments. If you scroll through the list for Jane Fletcher you will see that she has had only one treatment on the 4th February. This included a Cervical Mobility Test, mobilisation therapy and was given a home exercise programme.

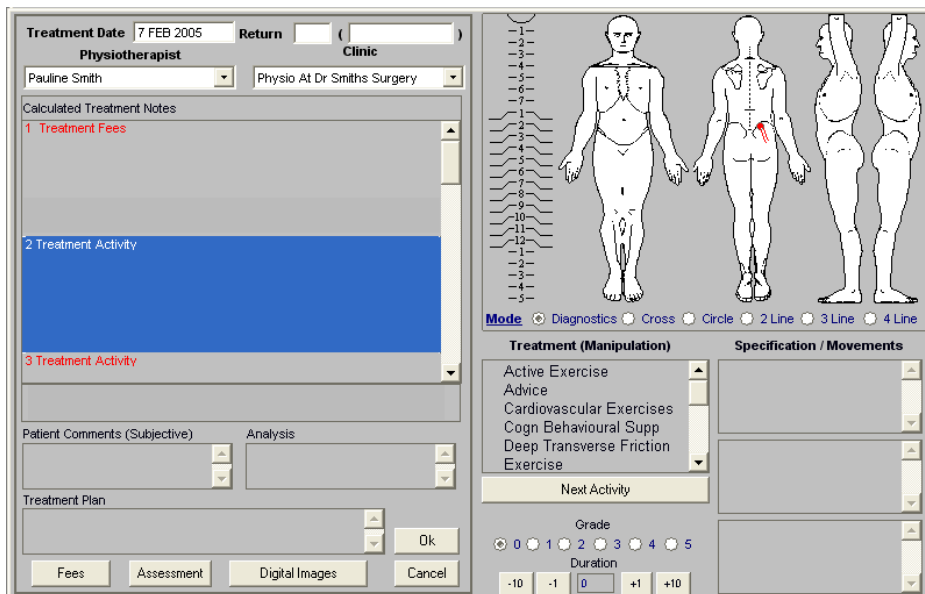
Detailed and Basic Treatments

There are two methods of recording treatments on the treatment history screen. There is a detailed treatment screen that includes Anatomy charts, the facility to draw images and automatic treatment notes. However, for customers who like to keep things simple, the Physiotherapy system we have added a simplified treatment screen for just entering treatment notes. These notes can be entered either via the keyboard or using 'ViaVoice Pro' voice recognition software.

All treatments are locked after a set number of days. Once a treatment is locked it cannot be amended. If you record all your treatment notes on the computer it is important that you can prove that your records were not altered at a later date. Some other systems don't lock the treatment but only register the date it was last amended. Since the system date can easily be changed on the computer this, in our opinion, does not prove that the record has not been tampered with. Because this system locks the record you can prove it hasn't been changed.

Detailed Treatments

We will start by looking at the detailed treatment screen. To begin, click on the **Add Detailed Treatment** button.



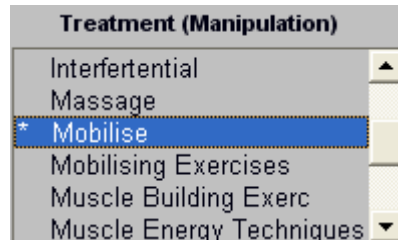
This version of the treatment screen displays the spinal column and four body chart diagrams. In addition to this there are Treatment and Specification/Movement lists as well grade and duration. The system includes examples but you can set up your own descriptions if you prefer

On the left of the screen there are boxes displaying your calculated treatment notes as well as patient comments, Analysis and Treatment plan.

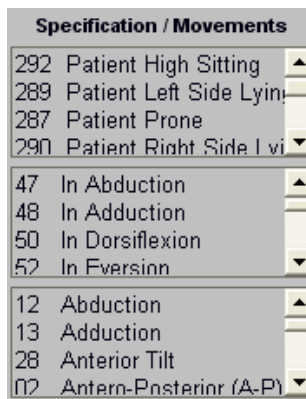
For each consultation you can perform up to 9 different activities. For each activity you can select up to 7 anatomical locations and one treatment. As you select these the software automatically creates the treatment notes based on standard key phrases. However, a lot of treatments can be performed in different ways. For instance a treatment maybe administered using a left or right rotation. For this reason, after selecting your treatment, the three Specifications/Movement lists will display related descriptions to add more detail to your notes. You can then select a Grade and a duration. Additional notes can also be typed in to add any specific details about this consultation.

To demonstrate this we will recreate our original example.

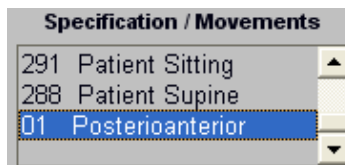
To begin, move your mouse over the *Treatment (Manipulation)* list and scroll down until you find **Mobilise**.



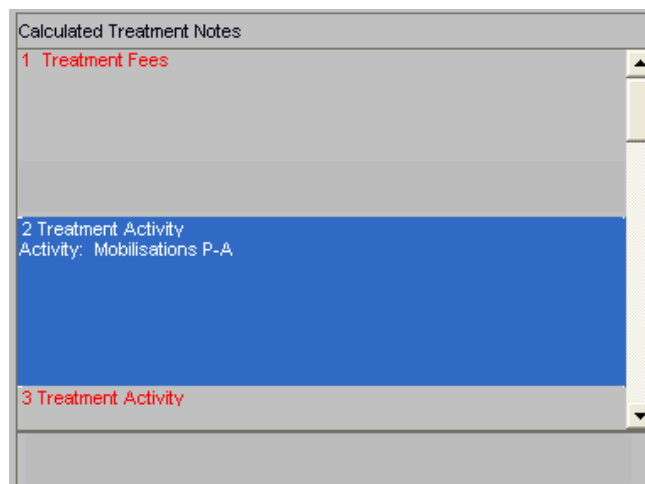
When you have found it, click on the line and an asterix will appear to its left and a list of *Specifications/Movements* which could be used with this treatment appear in the 3 boxes to the right.



Using the top list scroll down until you find **Posteroanterior**, and then click on it.



If you now look at the Calculated Treatment notes on the left hand side of the screen you will see that the notes are already being created.



Activity: Mobilisations P-A.

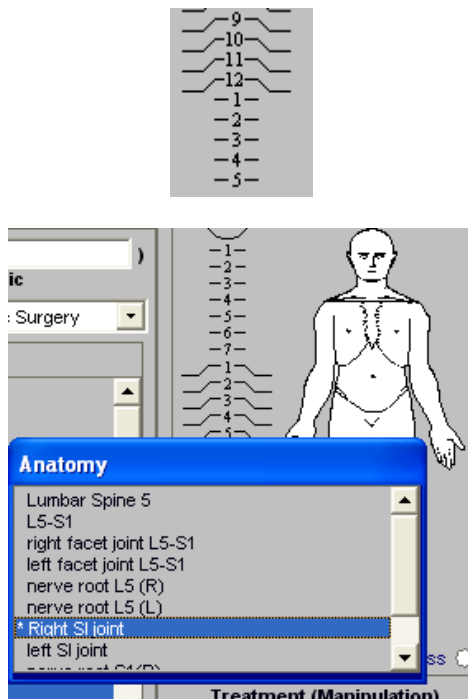
PPMS INTRODUCTORY MANUAL

Behind each description in the list is a standard phrase for that item. In our treatment notes we abbreviate Posteroanterior with P-A. You may describe things differently which is why the software allows you to amend these, add new ones and delete the ones you don't want to use. See the Chapter 9 in the Advanced manual for more details.

We now need to select which part of the body is being Mobilised. To do this make sure the mode is set to Diagnostics.



Then move the mouse over number 5 in the lumbar spine and click.



The anatomy list for that part of the spine will be displayed, which again can be amended if you prefer. Continue by clicking on Right SI Joint and then move the mouse away from the list.

This has now been added to the treatment notes.



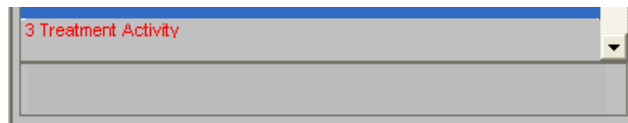
To continue select a grade..



and a duration..



You can add your own additional treatment notes in the box below the calculated notes if required.



If there are more details to record for this treatment click on the *Next Activity* button and then select the next anatomy location and treatment.

Calculated Treatment notes

The Calculated treatments are created by adding together the standard treatment notes in the following order:-

1. Treatment (Manipulation)
2. Anatomical Location(s)
3. Specification/Movement List One,
4. Specification/Movement List Two
5. Specification/Movement List Three
6. Pressure
7. Duration

If you prefer to structure your notes in a different order, this again can be amended. For more details on how to do this see the User Parameters section in the Advance manual.

Tips

To deselect a Treatment either double click on the selected treatment line to remove completely or select another treatment in the list.

To deselect a Specification/Movement - scroll down to the bottom of the list and click on the blank line.

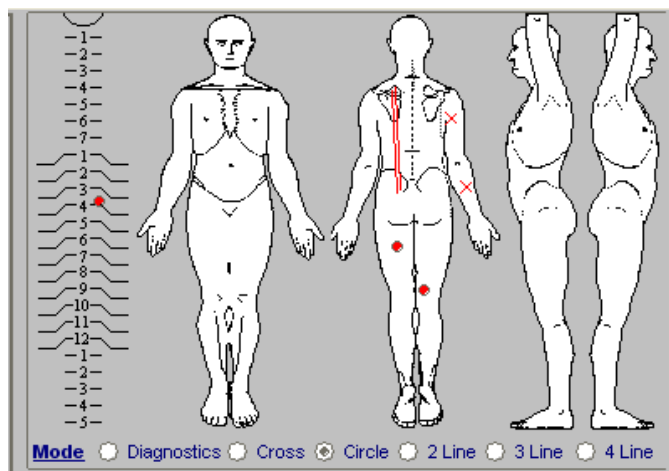
To deselect an Anatomical location, begin by clicking onto the location in question to redisplay the anatomical list. The selected location will have an asterisk to the left of the description. Click on the line to remove the asterisk and then move the mouse away from the list.

Drawing Circles, Lines and Crosses



Often you will want to use diagrams to represent pain or discomfort. The PPMS software allows you to record these electronically as part of the patient treatment record.

Begin by selecting the type of image to draw. Then, for circles and crosses click once on the area on the body chart with the **Left** mouse button. For lines, you need to click and drag before leaving go of the button. This will draw a line between the two points. To remove an object, click on it with the **Right** mouse button without dragging.



These images are remembered as each new treatment is added. This saves you having to redraw the images each time the patients comes back for a consultation. It also means that your treatment records have an audit of your diagrams. The diagram six months ago may be different from today. Editing or viewing previous treatments show the diagrams as they were on that date.

Fees button

Clicking on the **Fees** button replaces the left half of the screen with fees and invoicing options. In the above example, Self funding has been selected with a standard price of £20.

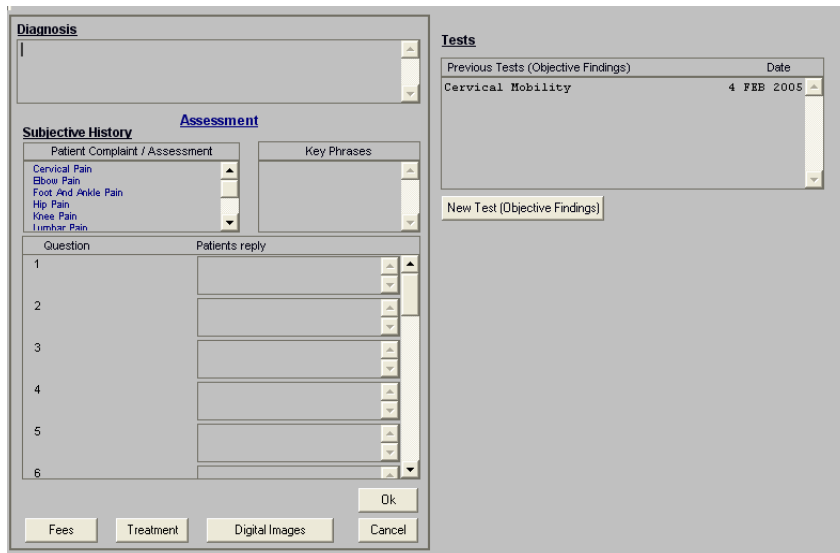
The Physiotherapy system allows you to define treatment prices from which you can select up to 7 per treatment. The system calculates the total treatment charge but allows you to amend it if discounts are to be given to the patient. You can also enter how much the patient has paid.

Fees are broken down into Treatment charges and Stock items. Stock items are selected in the same way as Treatments, by clicking on the description in the list. If you are selling 2 or more of an item hold down the SHIFT key whilst clicking in the list and then enter the quantity sold.

There are two buttons for printing out Invoices or Receipts. The **Invoice This Treatment** button will print out an invoice for the patient and it will also update the customer's sales ledger with the invoice and payment details. If the patient or an insurance company is to be invoiced for the full course of treatments you can use the **Invoice Outstanding Treatments** instead, to produce one invoice for the full course of treatment.

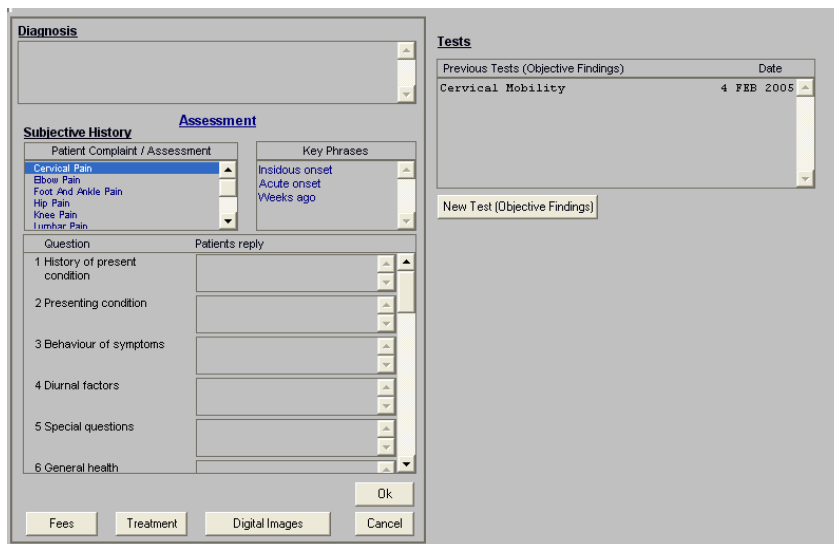
Assessment Button

This facility can be used to record an Assessment on the left side of the screen and Clinical Tests on the right. You can add one Assessment per consultation and as many Clinical Tests as are required.



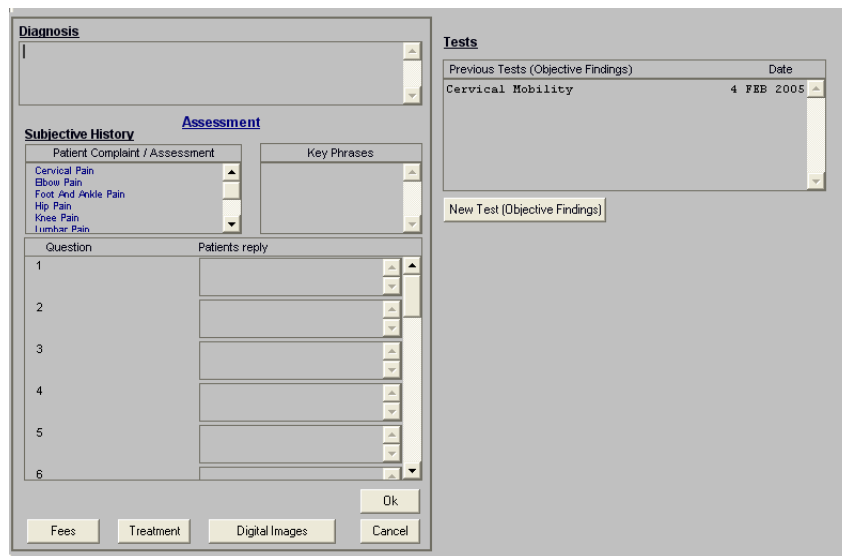
The software has some example assessments included which can be amended or you can add your own. An assessment includes a predefined list of questions and should be setup to match your existing documentation. For each question you can setup key phrases for common answers to the question being asked.

To begin, click on the Cervical Pain Assessment in the list.



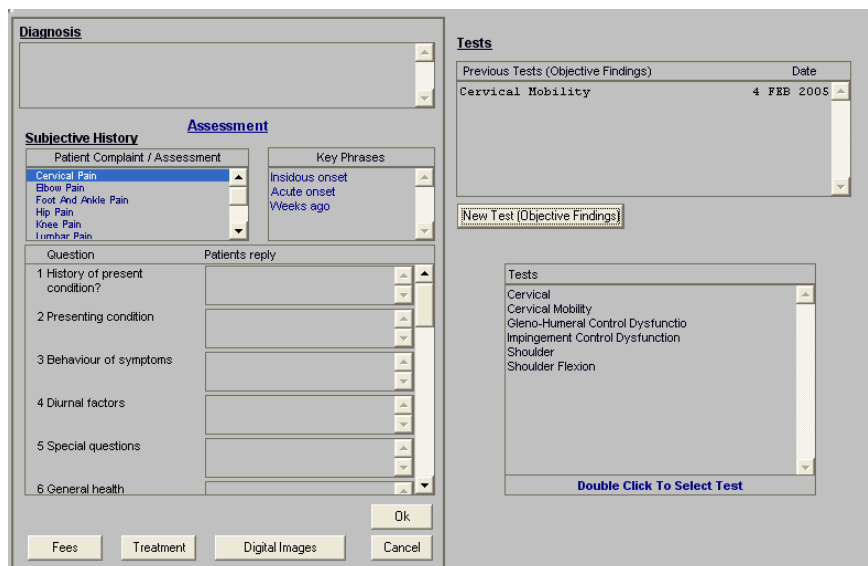
The questions for this assessment appear on the bottom half of the screen. These are the default questions but can be amended if necessary for this consultation. Click the cursor inside the *Patient Reply* box and type in the patient’s response to each question. Clicking on a *Key phrase* will automatically add the phrase to your sentence.

Clinical Tests (Objective Findings)

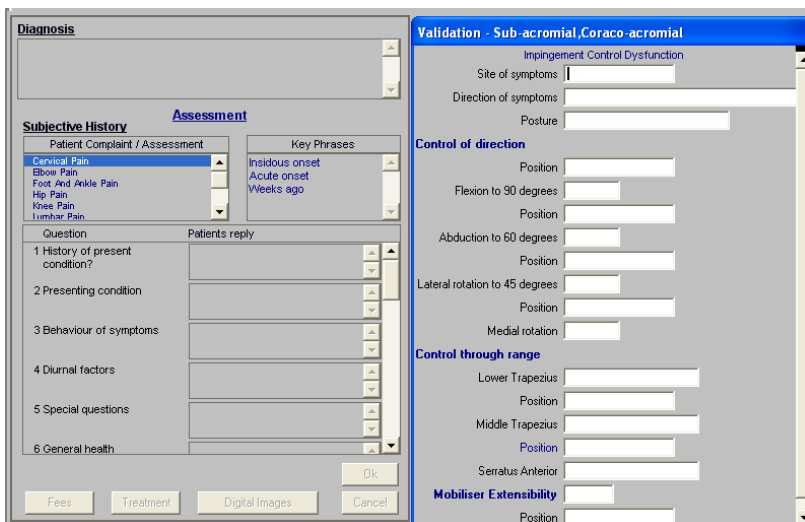


The software allows you to create templates for the Clinical tests you perform during your consultations. Each template can be setup with validation and default answers to each question. This ensures the answers given are valid and can also speed up the process when filling in the assessment.

The top right hand corner of the screen shows a list of all the Clinical tests which have been performed on this patient. In this example the patient had a ‘Cervical mobility’ test on the 4th February. You can view/amend the test by double clicking on the line in the list. To do a new test, click on the *New Test (Objective Findings)* button.



Then double click on the Test you want to perform. In this example we will select *Impingement Control Dysfunction*.

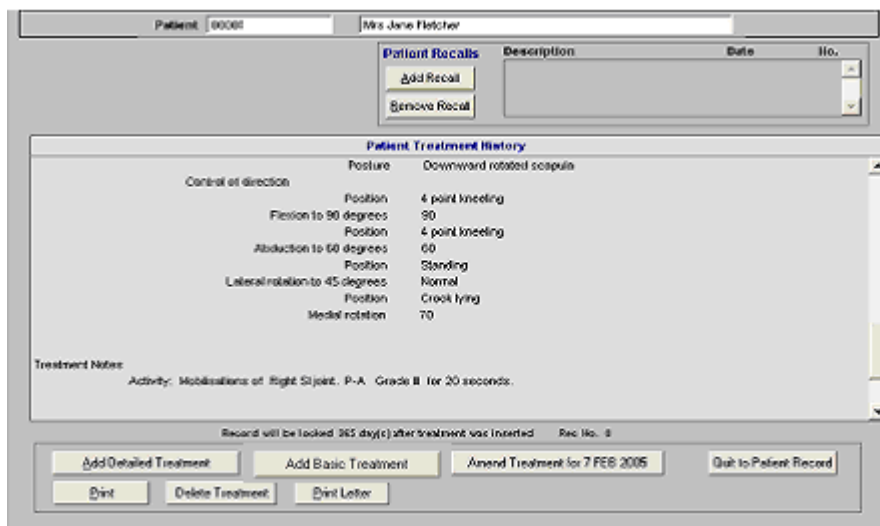


The test is displayed on the right hand side of the screen. The validation to each question (if there is any) is displayed at the top of the screen but often you only need to type in the first few characters. TAB through the screen answering questions and then click OK (or press Return) to finish. That Test will then be added to the patient’s history. Remember, these are just examples and you can create your own tests to match your existing documentation.

Digital Images

The *Digital Images* button allows you to record up to 6 JPEG images from a digital camera against each treatment.

From the digital images screen, click on the **OK** button to return to the detailed treatment screen. When you are finished here, click on the **Ok** button to save the record and return to the treatment history screen.



Mrs Fletcher’s treatment history screen now includes the treatment details you have just entered.

Add Basic Treatment

If you prefer not to use the menus of the detailed treatment screen, this second option has been added for recording basic treatment notes.

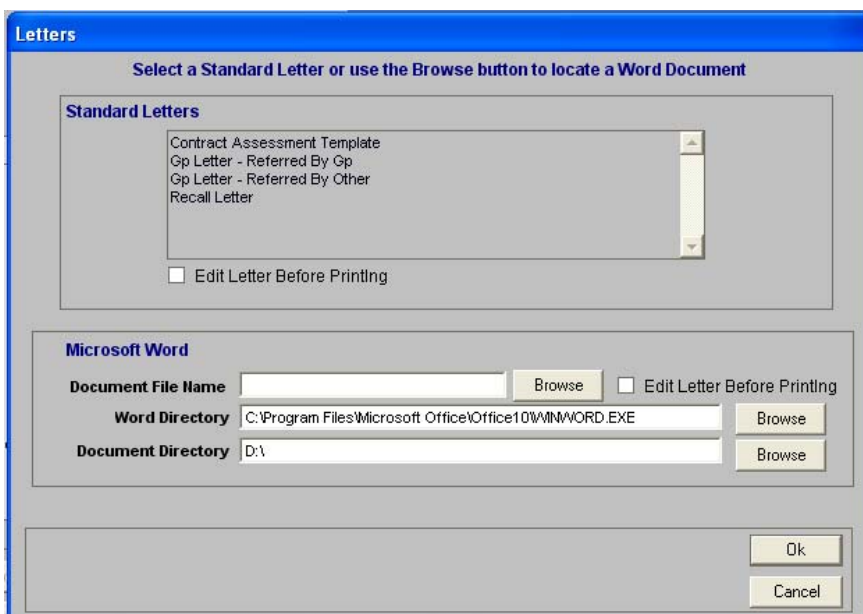
On the treatment history screen, click on the *Add Basic Treatment* button to open the screen below.

The screenshot shows a software interface for adding basic treatment. It is split into two main vertical sections. The left section contains several input fields: 'Treatment Date' with the value '19 JAN 2005', 'Return' with empty parentheses, 'Physiotherapist' with a dropdown menu showing 'John Patterson', and 'Clinic' with a dropdown menu showing 'Tynedale Surgery'. At the bottom of this section are five buttons: 'Fees', 'Assessment', 'Digital Images', 'Ok', and 'Cancel'. The right section is divided into two text areas. The top one is labeled 'Patient Comments' and is currently empty. The bottom one is labeled 'Treatment Notes' and contains the text 'Patient has been discharged'.

The right half of the screen is for typing in your treatment notes (or you can dictate notes using Via Voice). The left half contains the same buttons for *Fees*, *Assessments* and *Digital Images* as the detailed treatment screen, and they operate in the same way as on that screen.

Print Letter

The **Print Letter** button on the treatment history screen can be used to send a letter to the patient's GP informing them about their course of treatment.



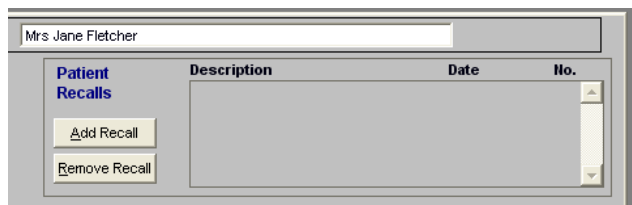
Click on the list to select one of the standard letters provided. Click the **Edit Letter before printing** check box to amend the letter before it is printed. When the letter has been printed it will be added to the patient Letter History audit trail.

You can amend the letters in the list or add your own. These letters can include patient field names so that the system will automatically fill in the patient's name and address and any clinical information.

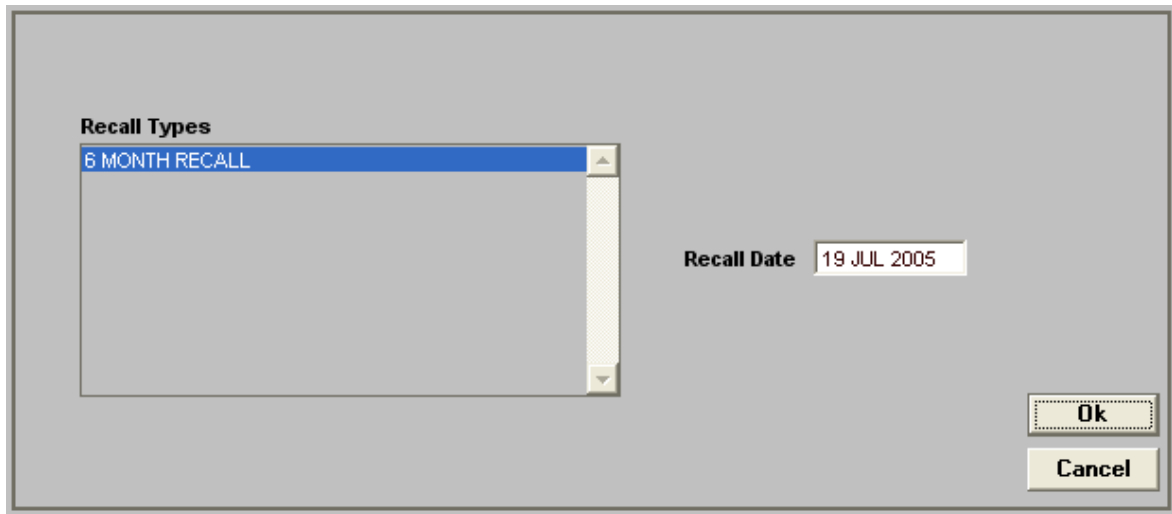
In addition to this you can also set up your letters using Microsoft Word. The presentation of Word documents are usually a lot better as it allows you to set up different fonts and styles which are not available using Standard Letters. The PPMS software will automatically load Word, merge the patient details, print out the document and then close Word when the printing is complete.

Recalls

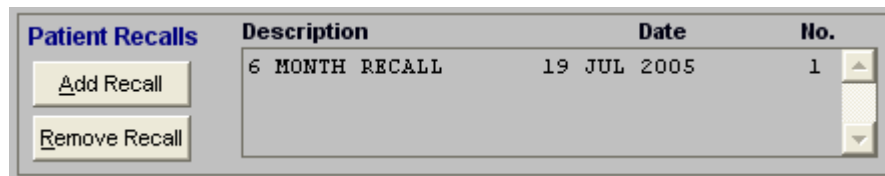
There is a Patient Recalls section at the top right of the treatment history screen.



When discharging a patient you may decide to set up a recall to check up on the patient's progress after a few months. The patient can have several recalls at one time. To create a recall, click on the **Add Recall** button. A list of standard recall types is displayed.



Select the appropriate recall and amend the recall date if necessary. Click on **Ok** and the recall will be added for this patient.



There is a facility on the Physiotherapy Main menu to print out recalls due between selected dates. The system automatically selects the correct recall letter and fills in the patient address details.

To finish with the patient treatment facility and return to the Patient Record screen, click on the **Quit to Patient Record** button.

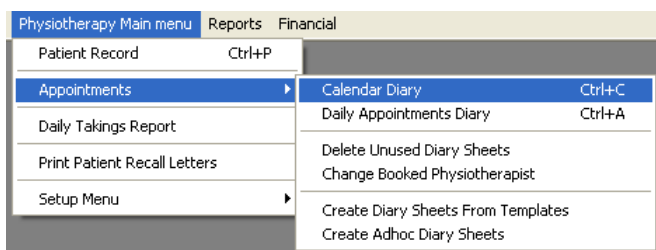
APPOINTMENTS

The Physiotherapy system provides two ways to book appointments:

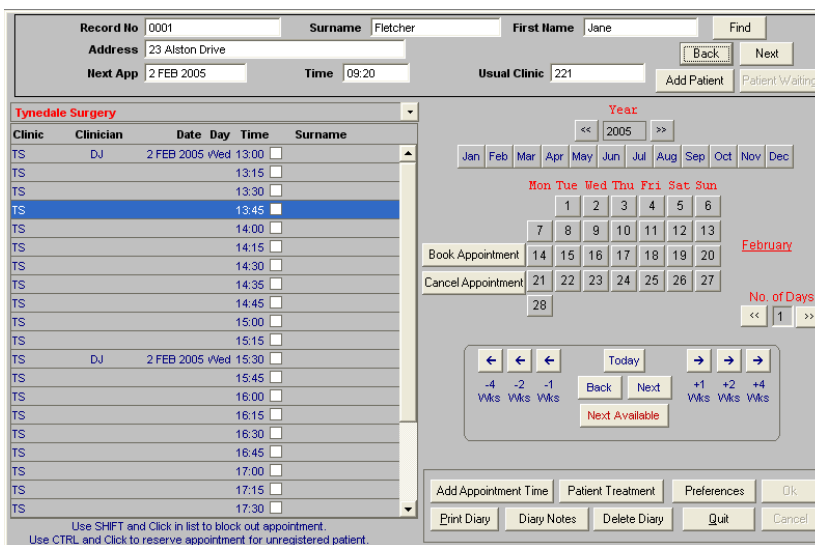
- Calendar Diary
- Daily Appointments Diary. (This shows one day at time)

Calendar Diary

The preferred option for most of our customers is the Calendar Diary which is available from the “Appointments” option on the Physiotherapy Main menu. Alternatively, press CTRL + C.



This opens the calendar diary as shown below.



The sample data file has diary sheets created until September 2007. If you are using the Sample data file, Click on *Today* and then click on *Next* (below it) to display tomorrows diary page.

The list on the left hand side of the screen displays the appointments for your selected day. If this list is empty it may be because you need to select a clinic first from the drop down list.

To change the day use the calendar on the right hand side of the screen, selecting the month and day.

The buttons below the calendar allow you to move forward and back days or weeks at a time. The *Next* button is used to display the next appointment diary. *Next Available* is used to locate the next appointment diary which is not fully booked.

Finding Patients

The top part of the screen is used to select the patient. If you have come from the patient record there may already be a patient displayed. If not, use the *Find* button (or *Find/List*) and enter the record number, surname or address and then click on the **OK** button.

Booking an Appointment

To book an appointment, click on the *Book Appointment* button and then click on the required time.

If the patient needs two or more appointment slots, click on the time and then drag down to the next line in the list. This will book the appointment and allocate subsequent times to the same patient.

Cancelling an Appointment

Click on the *Cancel Appointment* button and then click on the appointment time to remove the booking.

Adding Appointment Times

If you want to double book an appointment or work late on a particular day you can use this button to add appointments. Enter the time of the appointment and it will then be added to the list.

Blocking out Appointment Times

To block out an appointment, click on the appointment time whilst holding down the SHIFT key. This will prevent the appointment from being booked and enter the description 'Do not book'. If you hold down the CTRL key instead of SHIFT you can enter your own description.

To make the appointment available again use SHIFT and click again.

Preferences

This button allows you to alter some of the parameters (e.g. colours) which affect how the screen looks. Also, you can alter the frequency in which the date appears in the lists. The default is for the date to appear after every 10 appointments. If this were changed to 1 the date would appear in every line. There is also an option which allows you to enter a short description when the appointment is booked. To activate this, change 'Allow Appointment Notes' to YES.

Print Diary

Use the *Print Diary* button to print out the appointment diary for that day or week.

Patient Waiting

The *Patient Waiting* button can be used to highlight patients that have arrived at the clinic and are waiting to see the physiotherapist. Clicking on the patient's surname in the list will find the patient and display their details at the top of the screen. If you then click on the *Patient Waiting* button their surname will change colour. If the physiotherapist has the diary sheet displayed on their computer in the surgery, this will be updated to show that the patient has arrived when they click on the *Today* button.

Patient Treatment

This button can be used as a short cut to the patient's treatment screen. From here you can enter the treatment for the patient and then quit back to the Calendar Diary. If you do not want to enter treatment notes on the PPMS system, you can change the 'Treatment button' option on the preference screen. This can be altered so that the software will ask you if the patient has attended instead of displaying the treatment screen. If YES, the software will automatically create a treatment record and update the appointment history to say that they attended. This option would be used for physiotherapists who want use PPMS to keep a record of treatment dates but want to continue to use paper records for recording treatments details.

We hope that this will have given you an overview of how the system works. There are many more facilities built into the system which have not been covered in this booklet. Copies of the User and Advanced manuals are included on this CD and should appear under 'Tynedale Computers' on your Windows Programs menu. If you would like us to send you printed copies please contact our help desk on 0191 5294783.

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