

Service/Programme Dashboard: Events & Appointments

Ideally, whenever interaction has taken place, a Service **Event** OR an **Appointment** should be used to capture the details of that interaction (for statistical/reporting purposes) and at the same time, it's the perfect place to add clinical records relating to that Event or Appointment.

Events and Appointments can be added from the **Service** workspace OR the **Programme** workspace, using Events and Appointments. From a worklist, click the **Service** OR **Programme** shortcut, and scroll down to find **Events and Appointments**.

Events and Appointments

+ Create Appointment

+ Add Event

In **Events** (past occurrence) or **Appointments** (scheduled), click **Add Event** or **Create Appointment** to add details, then in the event/appointment, click the record type to add. Records created from an Event or an Appointment will be visible in that event/appointment AND in the Timeline AND in All Clinical Records. (see **Appointments and Clinics QRC**)



Types of Records and actions available after completion

Progress Notes

Select a template > Save > Submit > AFTER Submitting: Edit - Download

Assessments & Forms

Select a template > Save > Next - Submit > AFTER Submitting: Edit

Letters

• Select a template > Generate > Submit > AFTER Submitting: Edit - History - Preview - Download

Tasks

Select Due Date and add details > Submit > AFTER Submitting: Edit - Download

Files & Documents

• Upload a file > Submit > AFTER Submitting: Edit - Redact - Delete - Download

Edit	Redact	Delete	Download	History	Deactivate
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Active Worklist

Add Notes (not linked to an Event) directly from the Active Worklist (and Crisis Management Worklist) These notes will be displayed under All Clinical Records

Alerts	Person Details	Collaborative Care Team	Service	Status	Programme Details	Care Team	Notes	MDT	Appt	Referral Reason	Actions
	Kax Brych 04/05/2012 (12)	Mental Health & Addictions	Integrative Community Therapy	9	(\div)	🍇 🍪	•	\bigcirc	+		Q ⊕ ⊇ ≡₊
Add Note	25	×									
Searc Privac Progre	h y Discussion Note ess Note	↓ Sort			Click the No Save, then	o tes icon, sel add content	ect the to the	Note notes	s tem temp	plate re late.	quired,
SOTAF	P Note										

My Caseload Assessment icons: Add Notes and Assessments (not linked to an Event) from My Caseload Ā These notes and assessments will be displayed under All Clinical Records Add new Draft Submitted 0/2 MDT Appointment Referral Reason Last Notes Assessments Alerts Person Details Collaborative Care Team Service Add/Edit Care Team Actions Contact -Crownie XXI (dr Adult MH Clinical Ē⊕ A A Æ + Mental Health & Addictions General Adult ila; Adult Mental 01/01/1997 (27) . Health Nurse ⊕≡₊

Person/Care Team/Service/Programme Workspace

From the menu, click (All) Clinical Records to display a sub-menu of the record types to view/add.

යි Person View	8≝ Combined Timeline	All Clinical Records				
Shared Care Plans	2024 A	Search	Q Toggle advar	nced search + Add		
Referral & Triage	• 05/11/2024	All Assessments & Forms Le	etters Progress Note	es Files & Documents Tasks		
Whānau & Trusted Others	15:07 - Document	Mental Health & Addictions (General Adult - Whangarei) 🧪 🛞 불				
All Clinical Records	Mental Health & / General Adult - Addictions / Whangarei	Document title Docu	ument category	Document sub-category		
Legal Tab	Previous Assessment	Previous Assessment Asses	ssment	Risk		
Collaborative Care Teams +	• 01/11/2024	Specialty Servi	ice	Sub-service		

Person View: Add a Clinical Record (not linked to an Event)

From the Dashboard menu, click All Clinical Records

1. Click Add and select a record type 2. Click Save

Assessments & Forms	Cancel	This field is	s required Save	
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3. Select the sub-type and Save

×

Generate a Letter on letterhead from a Letter template

1H GP Letter	Progress Upd	late			•
Letter				G	enerate
ssigned To	*				$\overline{}$
Sue Knox (S	K Adult MH C	linical)			•
Status *					
Finalised					-
Care Team Re	ecipient				
					-
Deborah Pun	g (Mental He	alth)			×
Send to	person				
Send to	person's reg	istered GP			
**This featur	re is under de	evelopment al	nd not avail	lable at ti	his time
Custom R	ecipients				Add
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Letter template Select as appropriate Click Generate to open the template

Assigned To* is the author/person to Finalise

Status* stays in Draft until Assigned To person selects Final (No-one else can select Final)

Care Team Recipient(s) lists Care Providers as recipients in Notifications, ready for sending manually

Send to person lists the name and address of the person receiving care as a recipient in Notifications, ready for sending manually

Send to person's registered GP this feature is under development and not available at this time

Add Custom Recipients with Name and Address to add as recipients in Notifications, ready for sending manually

Add or Edit the Subject*

Content

Format text using styles H1, H2, Normal, etc.

Click each section to overtype details as appropriate

Enter your signature block Click Submit

NB: AFTER Submitting and/or Finalising a letter, it can STILL be edited - a reason for editing is required



Submit

Preview and Download letters onto letterhead

 Once Submitted, the buttons in the top right allow further actions, including Preview [Please check that a letter is Finalised by the author before Previewing]



2. From the Preview screen, Download the letter to see it presented on Health NZ letterhead



3. Once downloaded via Preview, the letter can be Printed or Saved as required



Notifications

ALL submitted letters are listed in Notifications, so take care to ONLY download, print/post **FINALISED** letters.

- 1. In Notifications > Letter, filter letters by Status, Template, Author or Person name
- 2. Any recipients indicated in the letter are displayed in the **Recipient** column, each recipient letter is displayed in a separate row, allowing the date sent for each to be recorded
- 3. From Actions, Download the required letter, then select Print or Save as required.

Letters are presented on Health NZ letterhead when you use the **Download** button, but not via **Preview**.

Notifications Letter	Is Custom Le	Full Name	Status	▼ Templ	ate 🗸 Recip	pient	Assigned to	• ×
	Person Details	Recipient	Template	Is Custom	Letter Sent	Status	Assigned to	Actions
	BL/, Test 13/01/2000 (25)	Debaral. Long Address:	MH GP Letter Progress Update	O		Draft	Sud Xnex (S.: Adult MH Clinical)	İ
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	BL* :, Test 13/01/2000 (25)	Fred Dagg Address: 10 Marcha Road, Avenues, Whangarei 0110	CH Standard Declined referral letter	v	\bigcirc	Finalised	Debarah Folig (Child Health)	ê ±
	BLAC, Test 13/01/2000 (25)	Test Blat. Address: 1 Hospital Road, Horahora, Whangarei 0110	CH Standard Declined referral letter	0	\bigcirc	Finalised	Deborated ong (Child Health)	ê ±
	BL/ad, Test 13/01/2000 (25)	Test Bl Address: 1 Hospital Road, Horahora, Whangarei 0110	CH MDT Referral Acknowledgement Letter	0	02.05.2025 09:24	Finalised	Debotal: Fong (Thild Health)	ê ±

As each letter copy is downloaded and printed (then posted) or saved (then emailed), please record the date:

Click to record and click Yes to confirm

Letter Sent	Are you sure that you want to mark this letter as sent? $ imes$
\bigcirc	Yes No

Inpatient > Whiteboard > HONOS

Bed Name	Person Details	Admission Date	Estimated Leave Date	Length Of Stay	Delayed Discharge	Honos	L/S L/Review	Responsible Clinician	OBS	Leave	Acuity	Notes	Actions
PONO 4	്ച്നുക 01/01/1997	03.12.2024	17.12.2024	7 days ago		\oplus							1

From **Inpatient**, select the **Whiteboard**, then under **Honos**, click **+** to create a **HONOS**. This form is completed on Admission and Discharge OR every 3 months, to be collated for MoH reporting.

Add a Core Document

Core Documents are living documents continually updated as required for the life of the Person's MyWai record. From the Service workspace, if the **Core Documents** option is displayed, click to see the **Add** button. A list of Core Documents for your Service will be displayed, if your Service is using Core Documents.

Once added, a Core Document displays in **Core Documents** as well as in **Clinical Records** under the **All** heading

The green bar indicates that Core Documents have been added to this record

Core Documents

Add a Problem

A list of issues that a person identifies they are dealing with at that point in time are Problems, which may be active or inactive.

A problem is something that is being experienced at that point in time and though may lead to a diagnosis is not necessarily a diagnosis i.e. anxiety due to a stressful situation does not necessarily lead to a clinical diagnosis of some form of anxiety. Alternatively, one diagnosis may be indicated by many problems i.e shortness of breath, & wheezing may be the problems that indicate asthma.

- 1. From the **Person Dashboard**, from the horizontal menu, scroll across to click on **Problems**
- 2. Select Add Problem
- 3. Select a Code Set (which could be Other) and enter details
- 4. Add a Date & Time for when this problem began
- 5. Add an End Date if appropriate (not mandatory)
- 6. Select a Service if appropriate and click Submit

Add Diagnosis

A medical condition with a status (provisional/principal/etc) that has been defined by a medical professional with the ability to make the diagnosis.

A diagnosis may not be a problem for a person at that point in time i.e. asthma that is well managed is a diagnosis but is not a problem.

- 1. From the **Person Dashboard**, from the horizontal menu, scroll across to click on **Diagnoses**
- 2. Select Add Diagnosis
- 3. Select a **Code Set** (**SNOMED**, **DSM-IV**, **ICD-10**) and begin entering a diagnosis, then select a match
- 4. Select a **Type of Diagnosis** (**Principal**, **Provisional**, **Other**), and date for the diagnosis
- 5. Select a Service for the source of this Diagnosis and click Submit



Brancis Elikat	NHI:
DOB: 61,03,1017 (27 Years)	
Gender: Female / Wahine	
Diagnosis	
Code Set *	
🔵 SNOMED-CT 💿 DSM-IV 🔵 IC	D-10
Diagnosis (DSM-IV) * DSM-IV	
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Attention-Deficit/Hyperactivity Disorder Co	ombir 🗙
Type of Diagnosis *	
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12 Dec 2024, 08:48 pm	
End Date	
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This date must be after start time	
Services	
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