Clinical®
By Medical Director

Clinical Workbook

Manual designed and written by
Train IT Medical for AH&MRC

July 2026

AH&MRC
Aboriginal Health & Medical Research Council of NSW

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Introduction

Purpose of this guide

This guide provides clinical staff with the knowledge and procedures required to effectively use MedicalDirector Clinical within an Aboriginal Community Controlled Health Organisation (ACCHO). It is designed to support consistent clinical documentation, accurate patient record management, preventative health activities, chronic disease management, recalls and reminders, clinical coding, and other day-to-day clinical workflows.

The guide outlines standard workflows and best-practice procedures to assist clinicians in delivering high-quality, culturally safe, and patient-centred care while maintaining compliance with organisational policies, privacy legislation, RACGP Standards, accreditation and reporting requirements.

This document should be used as both a training resource for new clinical staff and a reference guide for experienced users performing clinical activities within MedicalDirector Clinical.

Intended Audience

This guide is intended for clinical staff working within an Aboriginal Community Controlled Health Organisation (ACCHO), including:

- General Practitioners (GPs)
- General Practice Registrars
- Nurses and Nurse Practitioners
- Aboriginal Health Workers and Aboriginal Health Practitioners
- Allied Health Professionals
- Visiting Specialists and other authorised clinical users

The guide assumes users have basic computer skills but limited experience using MedicalDirector Clinical. It focuses on the clinical functions of the system and does not cover practice administration, appointment management, billing, Medicare claiming, or other workflows performed primarily within Pracsoft.

Software version

The guide is current for version 4.3a of the MedicalDirector software. As software functionality is updated periodically, some screens and features may differ slightly depending on your practice's installed version and configuration.

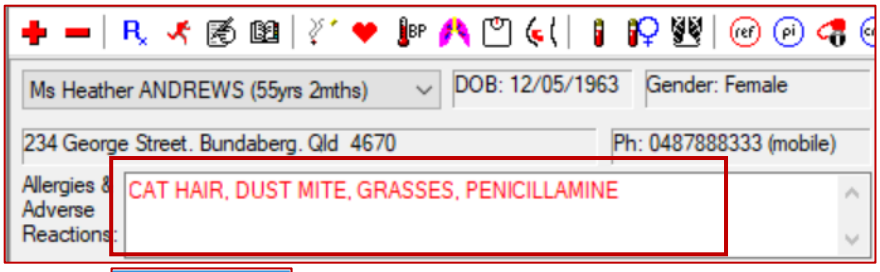
Topic 1 – Recording essential clinical data

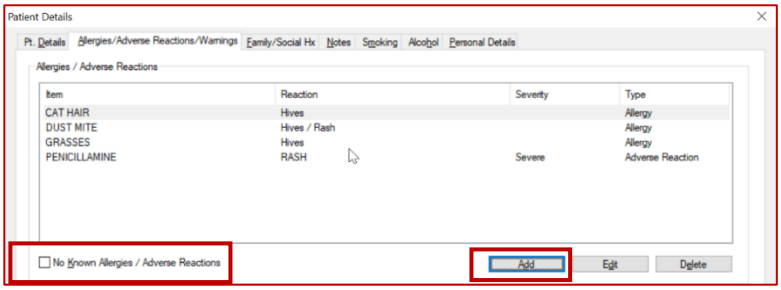
Health Summary data

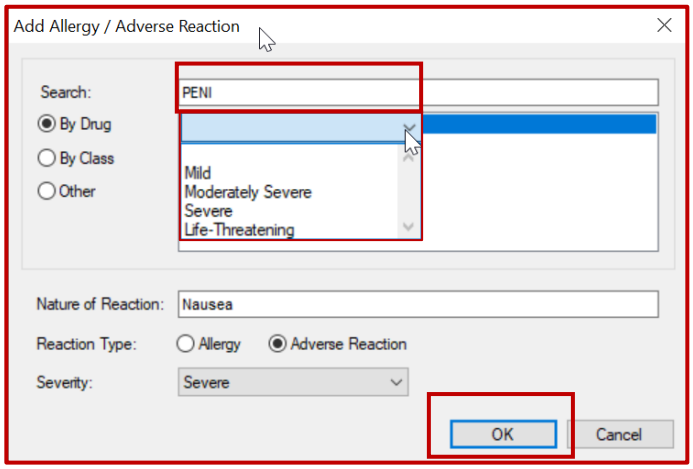
Adding allergies and adverse reactions

Allergy information can be entered on the patient record in the upper left corner of the window. This information is displayed in red. If the patient has no allergies or adverse reactions, tick 'No Known Allergies/Adverse Reactions' to indicate the patient has been asked about allergies.

1. **Open** a patient record **(F2).**
2. **Double-click on the Allergy panel** in the patient demographic area at the top of the screen to go directly to the allergies and adverse reactions section.
3. Select the **Add** button.
4. Select a **Search** option: By Drug, By Class or Other (for non- medications).
5. **Enter the first few characters of the item** into the Search field. As you type in a drug name or class, a list of names is displayed matching the search. Double click a name from the list to select it.
6. Enter the **Nature of Reaction** using free text (e.g. rash, nausea etc).
7. Select a **Reaction Type** (Allergy or Adverse Reaction).
8. Select the **Severity** of the reaction from the dropdown list.
9. **OK** to save.







Note: You must use 'By Class' method or 'By Drug' method when searching and choose a name from the dropdown list to generate automatic alerts when a medication is prescribed. If you add a medication name via the 'Other' method, then **no** automatic alerts will be triggered.

Adding Past Medical History

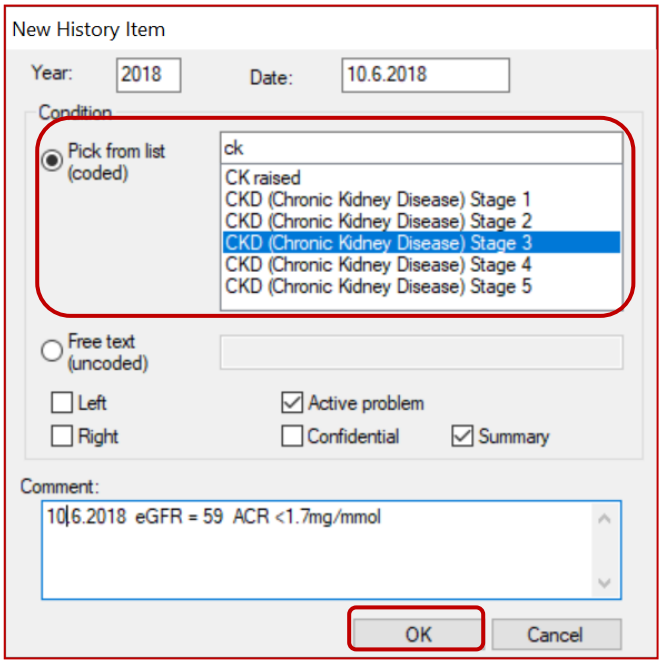
Clinical coding

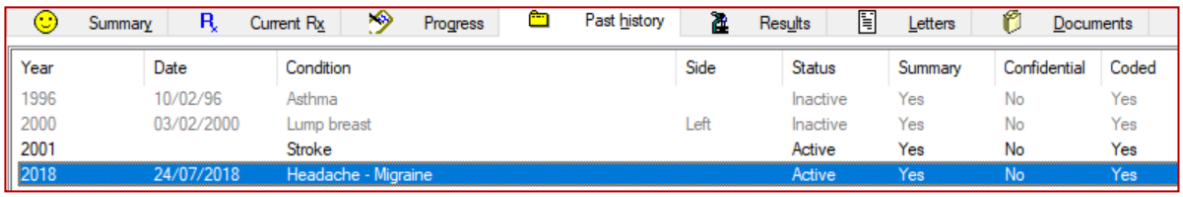
Diagnoses are added using the **Past history** screen or via the **Reason for Visit** button in the Progress Notes tab of Medical Director Clinical. The diagnosis should always be chosen from a coded list rather than using free text.

Adding a coded diagnosis in the patient record / consultation:

1. Open the patient record **'F2'.**
2. Select the '**Past history'** tab.
3. Select the **red '+' button** in the top left of the screen.
4. **Enter the current date** in the date field.
5. **Enter 'care'** the 'Pick from List' field then **double click** on the care coordination to select it.
6. Tick '**Active Problem'** to indicate the condition is current.
7. Enter **Comment**/s to describe further details of the issues being addressed in the consultation.
8. **OK** to save.







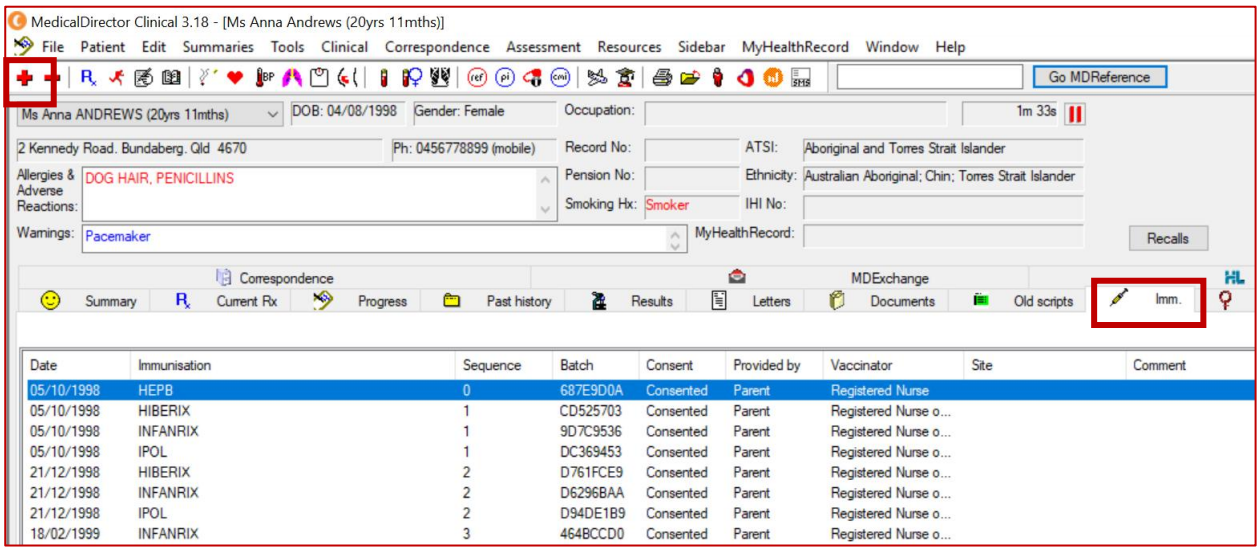
Recording Immunisations

Adding an adult immunisation

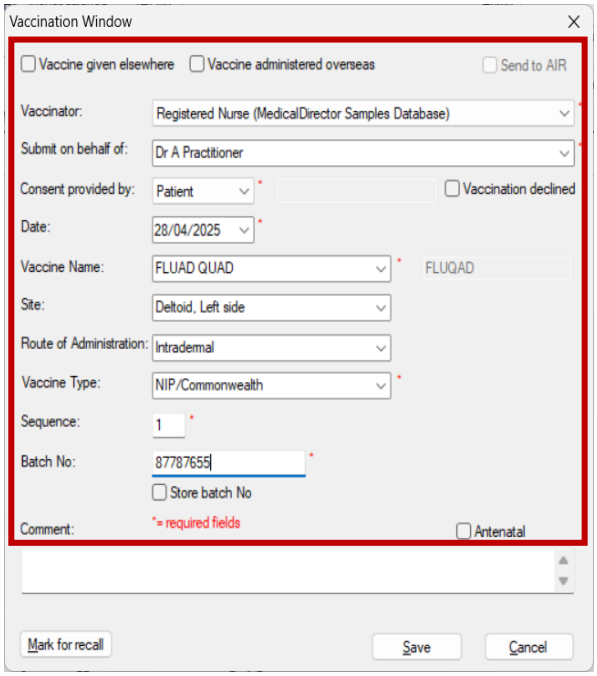
1 Open the patient record **(F2)**

2 Click on **Immunisation tab**

3 Click on the **Red Plus sign** +



The Vaccination window will display.



4 The **Send to AIR** tickbox will be Ticked if approved for transmission to AIR.

5 Select **Vaccinator**

6 Select **Submit on behalf of**: (to send electronically to AIR this must be a doctor).

7 Record **Consent provided by**:

8 Check vaccination **Date** is correct

9 Select Vaccine name

10 Select site and route of vaccination

11 **Type of vaccine** from list

12 Record **Sequence No.**

13 Record **Batch number**

14 Click **Mark for recall** and enter details as required.

15 Click **Save**

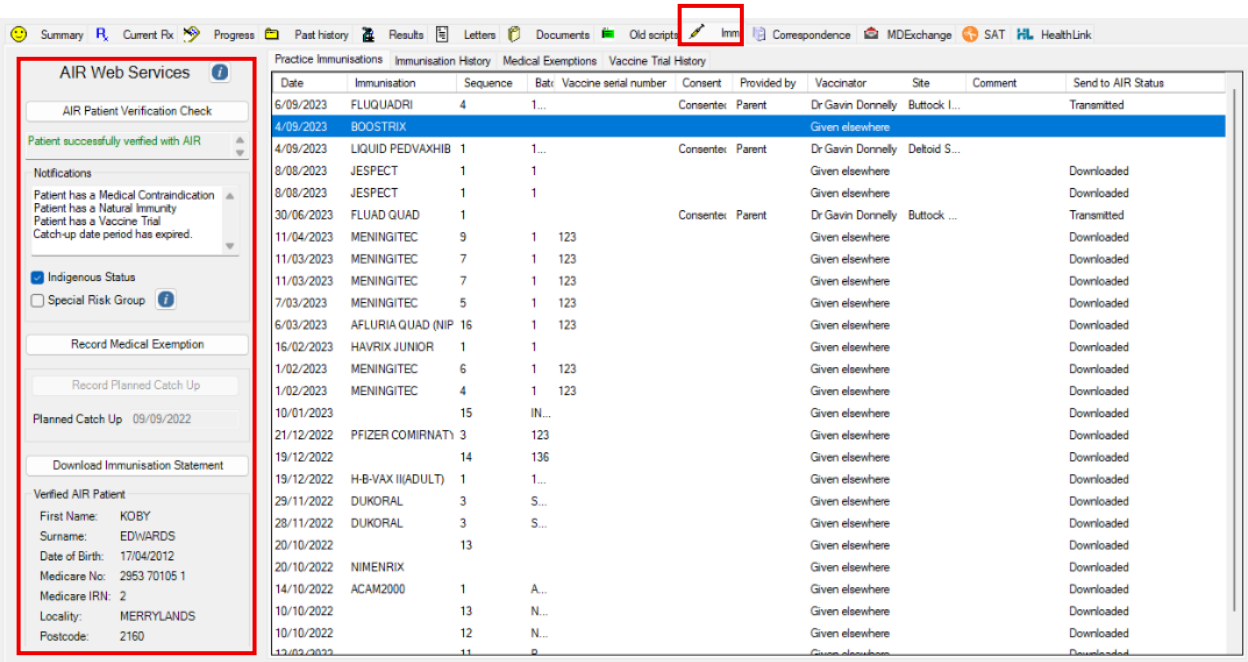
The details of eligible vaccines marked as ‘Send to AIR’ will automatically be sent to the register from MD clinical, if configured.

Note: If updating a patient’s immunisation record it is possible to tick the box “Vaccine given elsewhere” or ‘Vaccine administered overseas’ as applicable.

The Australian Immunisation Register (AIR)

The AIR Web Services pane displays information recorded on the AIR and is accessible when you click on the Immunisations tab in the patient record. Use the following options to interact with AIR:

- **AIR Patient Verification Check** - conduct a live patient verification check with AIR including patient Indigenous status and special risk group status
- **Record Medical Exemption** - click to record a medical exemption for the given patient.
- **Record Planned Catch Up** - click to record a planned catch up for the given patient.
- **Download Immunisation Statement** - click to download the patient's immunisation history statement from AIR.

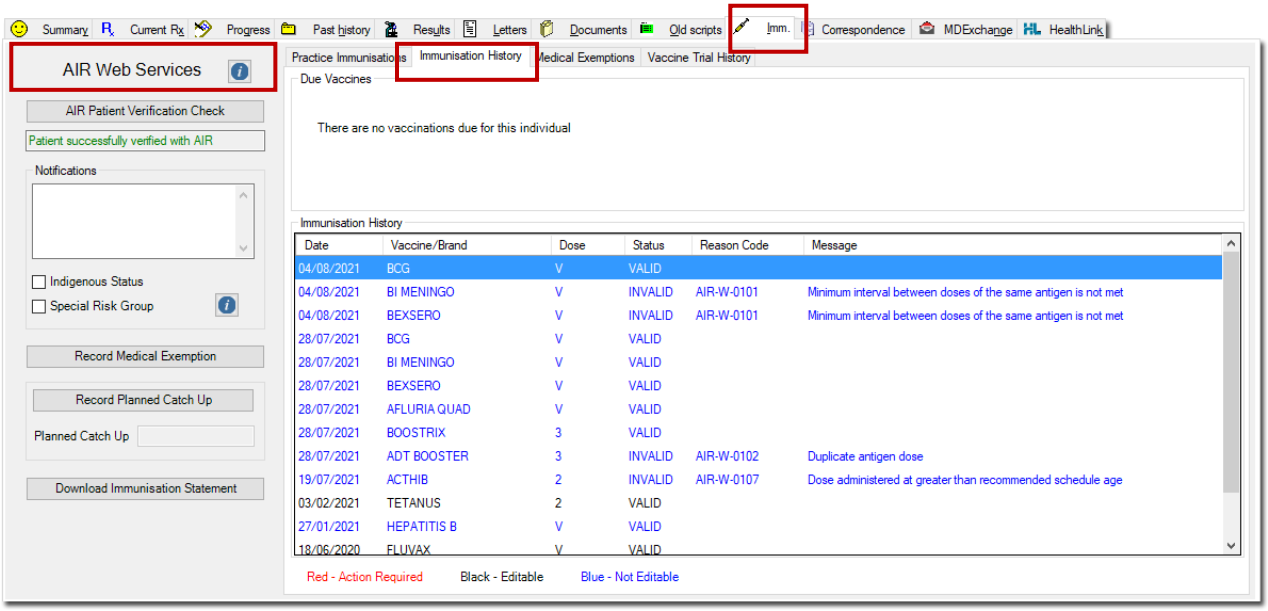


Access the Australian Immunisation Register (AIR)

1 Access the Immunisations (Imm) tab from within the patient record.

2 Select the **Immunisation History** tab to display the patients immunisation history as recorded with AIR.

- **Red** records indicate that some action is required.
- **Black** records are editable. Only immunisations administered at your practice are editable.
- **Blue** entries are those recorded with AIR and are not editable.

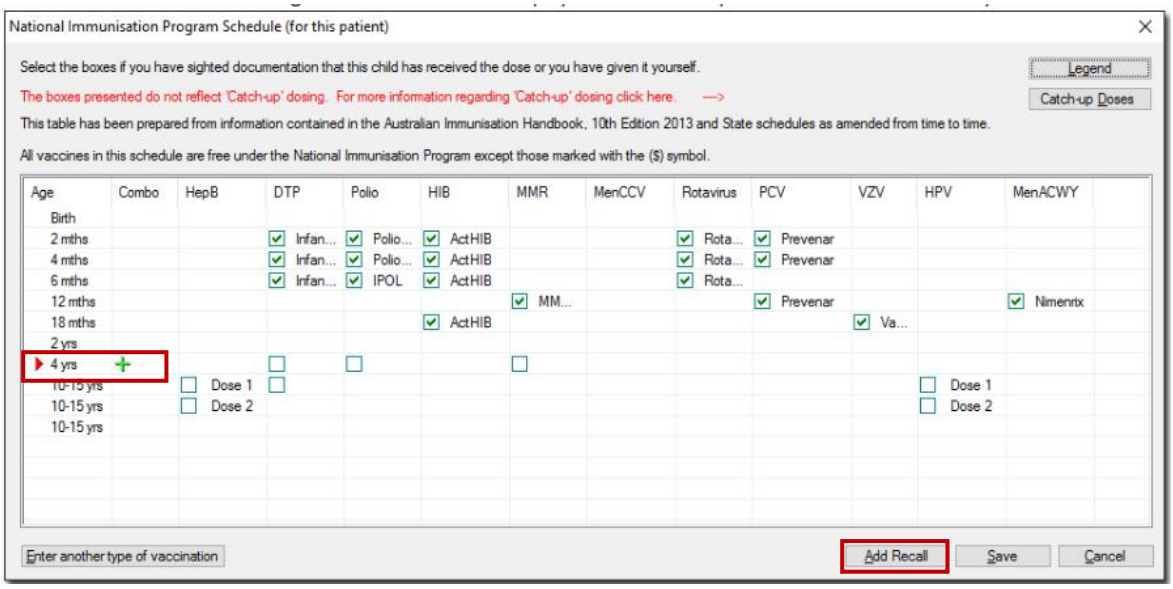


Adding a childhood immunisation

To add childhood (patient <20 years of age) immunisations:

1. Open patient record **(F2)**
2. Click on **Immunisation** tab, to open on the National Immunisation Program Schedule (for this patient)
3. Click on the **red plus + sign** (or press **F3)**

The National immunisation Program Schedule (for this patient) will appear. **Always choose the combination vaccines first by clicking on Green 'Plus' sign as this will automatically tick all components.**



- A green arrow indicates that the patient's schedule is up-to-date for the specified age range. A red arrow ▶ indicates their schedule it not up-to-date.
- For vaccines not yet administered, indicated by an empty check box or a green cross .

4 **To record a vaccination, click** ✚**Add** for a particular age-vaccine combination

5 **To record combination vaccines, in the Combo column, click** ✚**Add.**

6 Click **Enter another type of vaccination to record other vaccines not listed**.

7 Select **Vaccinator –** who administered the vaccine.

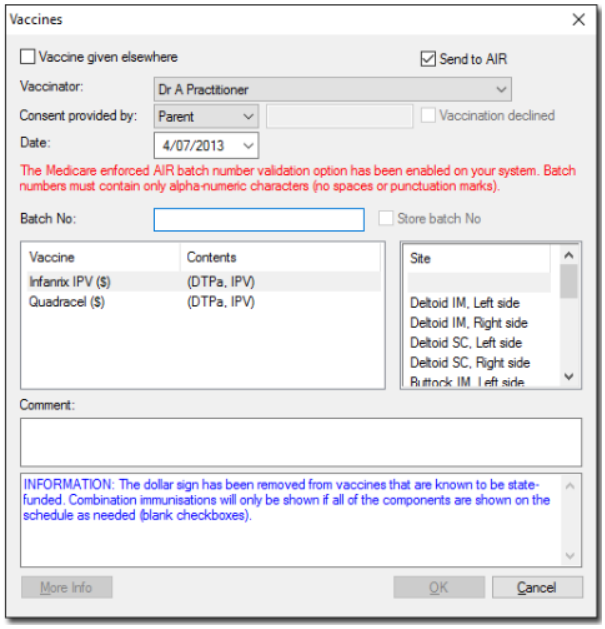
8 Record **Consent provided by**:

9 Check vaccination **Date** is correct

10 **Select a vaccine name, site and route of administration** from the drop-down lists.

11 **OK to Save.**

Note: When entering past immunisations please check date as Medical Director automatically inserts a date calculated from the child's date of birth and this may not be correct.

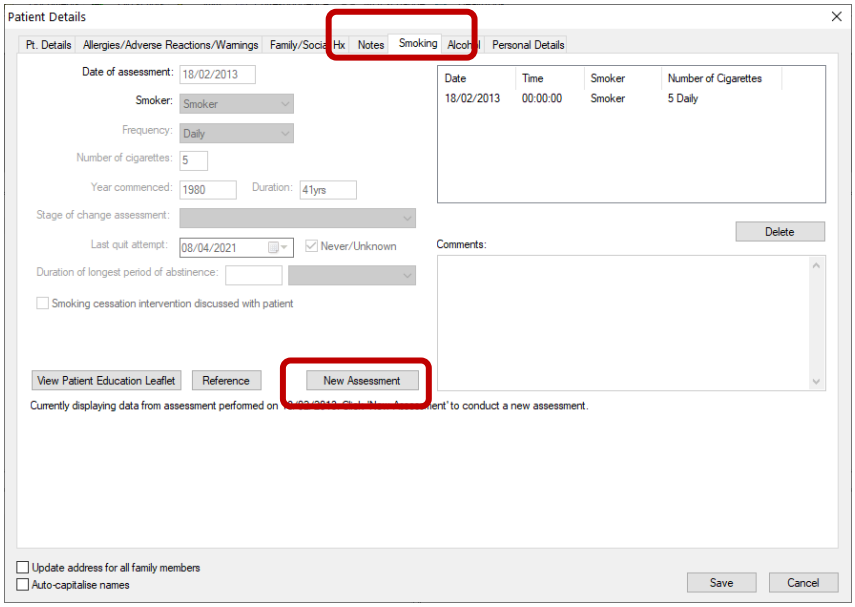


If updating a patient's immunisation record it is possible to tick the box "Vaccine given elsewhere"

Note: you can select the 'Immunisation History' tab to see details of vaccines given elsewhere and sent to AIR.

Recording risk factors

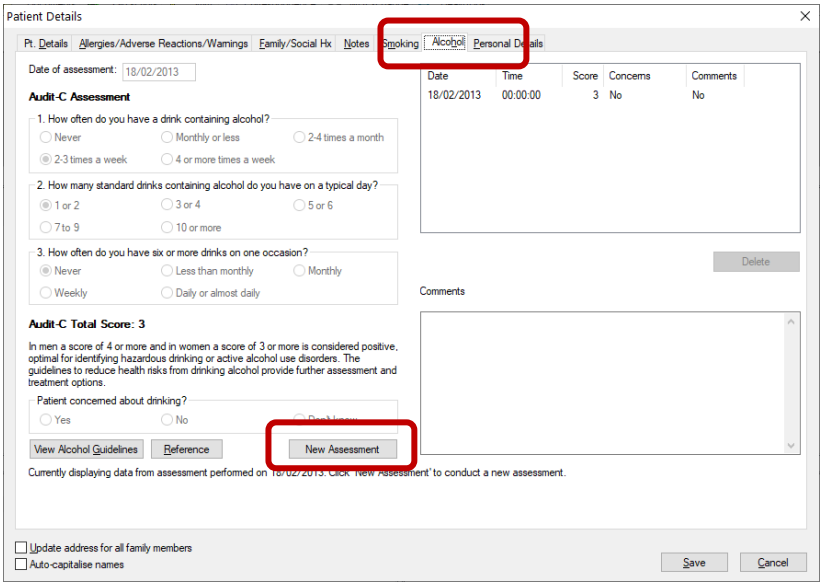
Information entered in these areas provides data to enable searching for preventative health items. The drop-down pick lists offer a wide range of options such as Never Smoked and Quit Attempts.



Record a smoking assessment

1. **Open the patient record**
2. Select **Patient > Details**
3. Select **Smoking tab**
4. Select **New Assessment**
5. **Complete all details**
6. **Save**

Record an alcohol assessment

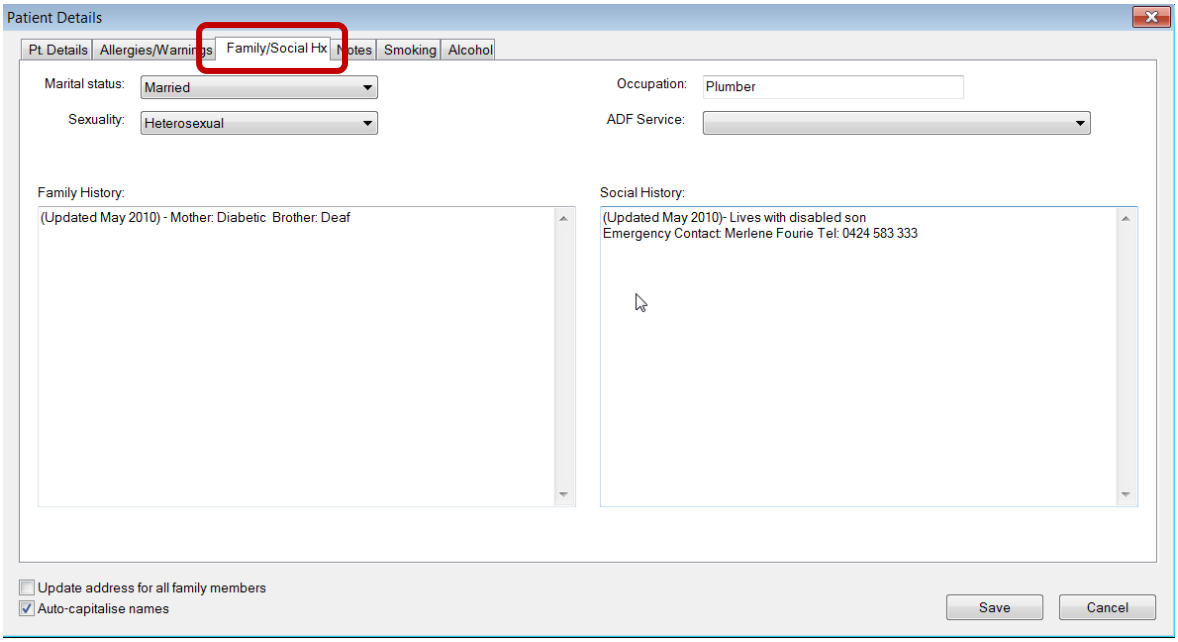


1. **Open the patient record**
2. Select **Patient > Details**
3. Select **Alcohol tab**
4. Select **New Assessment**
5. **Complete all details using the Audit C** Assessment.
6. **Save**

Adding Family/Social History

1. **Open the patient record**
2. Select **Patient > Details**
3. Select **Family / Social History tab**
4. Select **Marital Status**
5. Select **Sexuality**
6. Select if an **ADF Service** member
7. Update the **Family and Social history text fields** with any relevant details.

Information entered under the Family/Social Hx tab will be imported into templates/care plans etc. as relevant.



Tip: Show 'active' medical records (accreditation requirement) by dating your Family/Social history. This will then clearly demonstrate collection of changing information over time and inform all users when the information was collected.

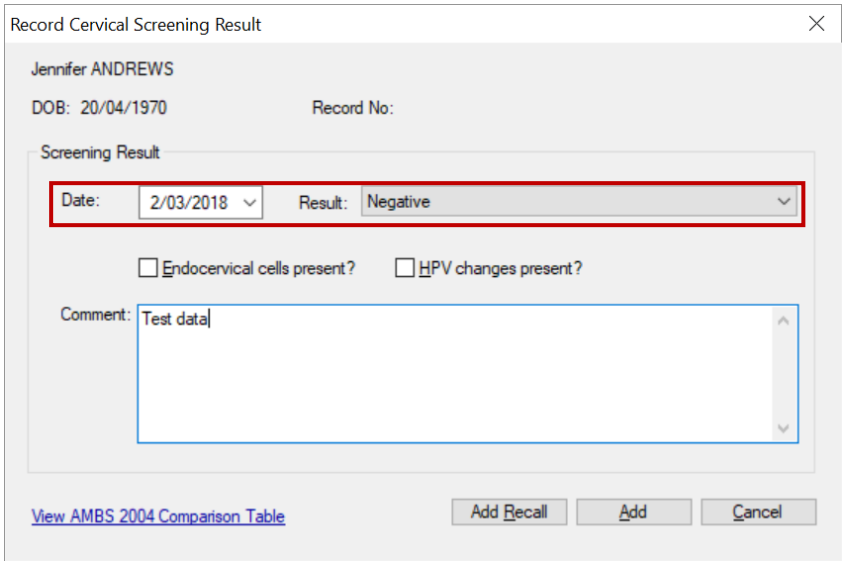
Recording cancer screening test results

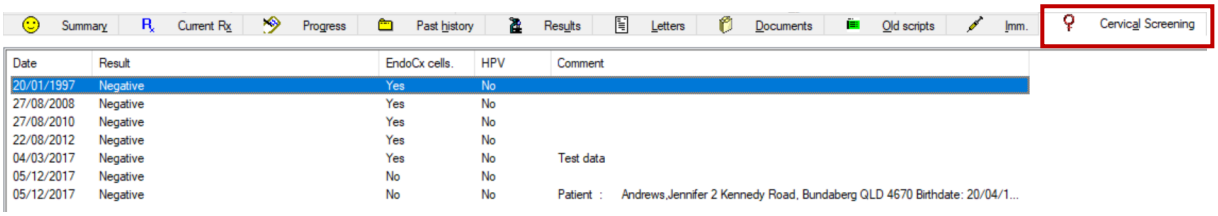
Record Cervical Screening test results (CST)

Cervical screening data must be entered manually into MedicalDirector in order for it to be recognised in search queries. Since there is no national standard coding system for Cervical Screening in Australia, the results don't automatically populate this area of the patient record. The test result must appear in the Cervical Screening tab (ie after being manually added from either the Holding File or the Results section in the patient record.

Enter CST results from from the Patient Record:

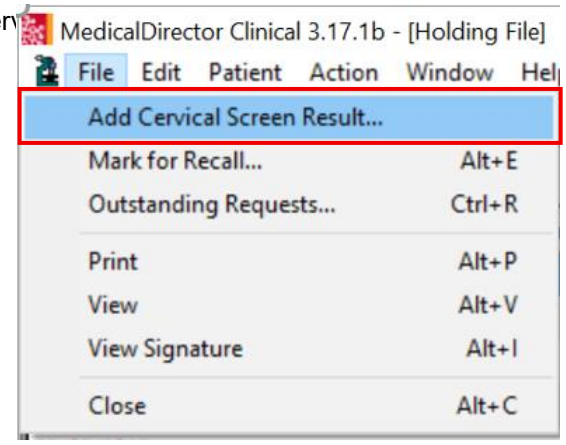
1. Select the Cervical Screening tab
2. Select the red '+' symbol at the top left of screen.
3. Enter the results of the smear:
4. Date Performed:
5. Result:
6. Endocervical Cells Present?
7. HPV Changes Present?
8. Comment
9. Select the Add button.

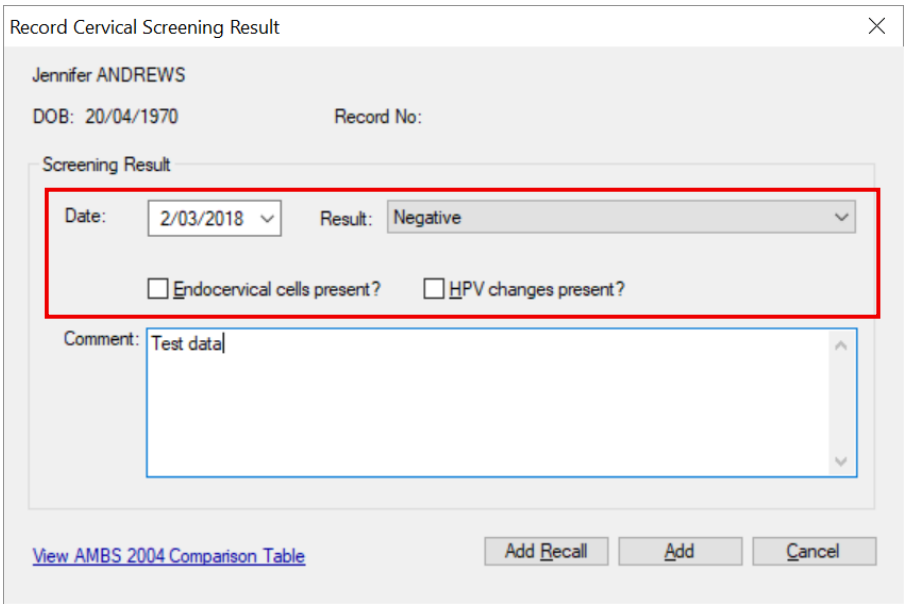




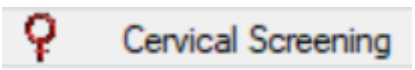
Enter CST results from the Holding File (F5)

1. **Highlight the CST result / patient record** in the Holding File.
2. Select **File>Add Cervical Screen Result**. The Record Cer
3. **Enter the results of the test:**
   - Date Performed:
   - Result:
   - Endocervical Cells Present?
   - HPV Changes Present?
4. Enter any **comments**
5. Select **Add**





This data is added to the **Cervical Screening** tab on the patient record.

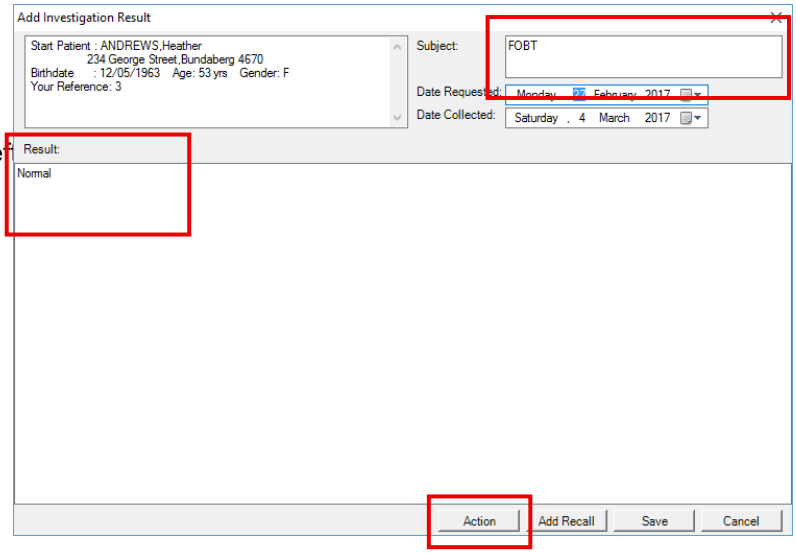


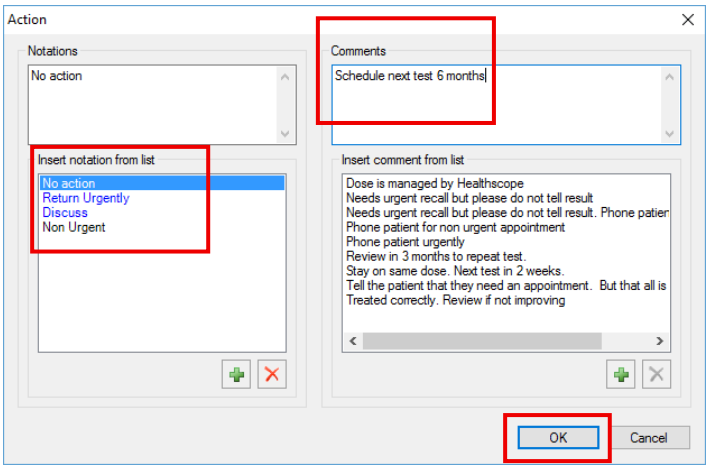
Enter bowel screening test results (FOBT)

Bowel Screening data can be entered manually into MedicalDirector in order for it to be recognised in search queries. The test name must contain 'FOBT' for it to be recognised as a Bowel screening test. The test result can be entered from the Patient record.

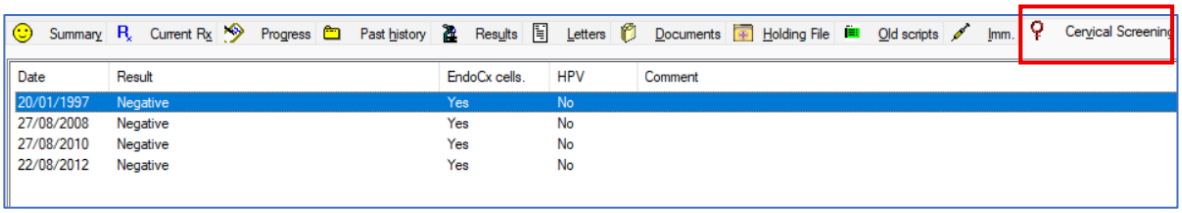
From the Patient Record:

1. Select the **Results** tab
2. Select the red '+' symbol at the top left
3. **Enter the details of the result:**
   - Subject : **FOBT**
   - Date Performed:
   - Date Collected:
   - Result: e.g. normal
4. Select the **Action** button
5. Choose a **Notation**
6. Enter a **comment as required.**
7. Select **OK.**
8. Select **Save**





This test result will be added to the list of investigation results for the patient in the Results tab.



Entering Breast Screening (Mammogram) Results

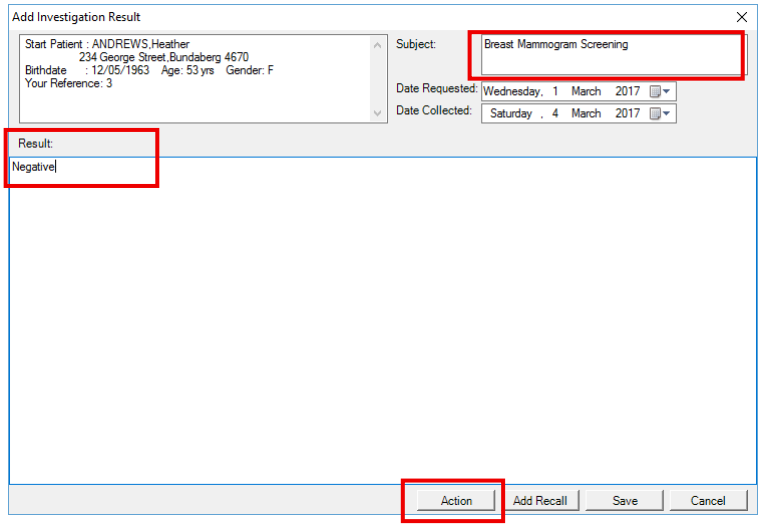
Breast Screening data must be entered into the Results tab in MedicalDirector in order for it to be recognised in search queries. The test name should be entered as 'Breast Mammogram Screening'. The test result can be entered from the Patient record.

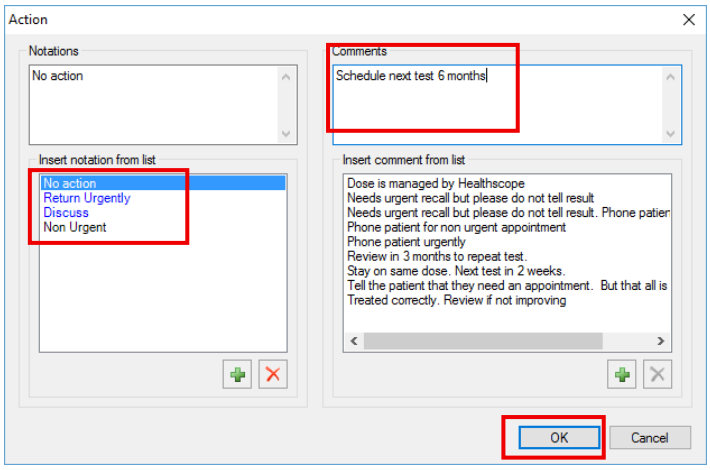
From the Patient Record:

1. Select the **Results** tab
2. Select the red '+' symbol at the top left of screen.
3. **Enter the details of the result:**

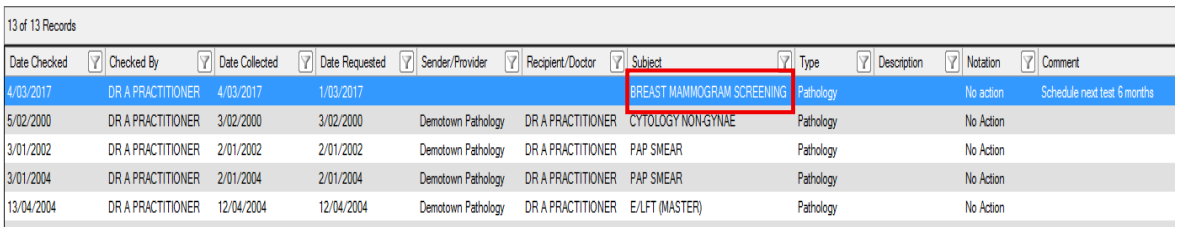
- Subject : "**Breast Mammogram Screening"**
- Date Performed:
- Date Collected:
- Result:

4. Select the **Action** button
5. Choose a **Notation**
6. Enter a **comment as required.**
7. Select **OK.**
8. Select **Save**





This test result will be added to the list of investigation results for the patient in the **results tab.**



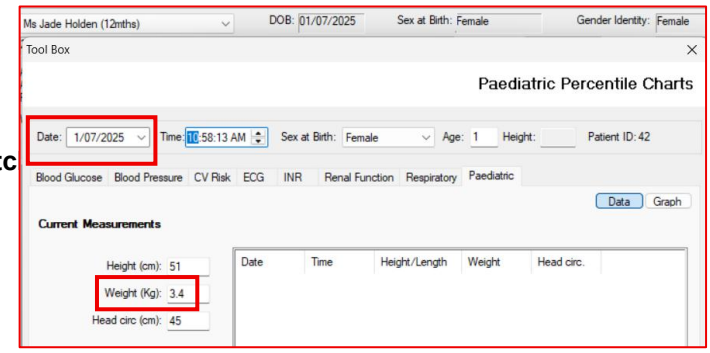
Date Checked	Checked By	Date Collected	Date Requested	Sender/Provider	Recipient/Doctor	Subject	Type	Description	Notation	Comment
4/03/2017	DR A PRACTITIONER	4/03/2017	1/03/2017			BREAST MAMMOGRAM SCREENING	Pathology		No action	Schedule next test 6 months
5/02/2000	DR A PRACTITIONER	3/02/2000	3/02/2000	Demotown Pathology	DR A PRACTITIONER	CYTOLOGY NON-GYNAE	Pathology		No Action	
3/01/2002	DR A PRACTITIONER	2/01/2002	2/01/2002	Demotown Pathology	DR A PRACTITIONER	PAP SMEAR	Pathology		No Action	
3/01/2004	DR A PRACTITIONER	2/01/2004	2/01/2004	Demotown Pathology	DR A PRACTITIONER	PAP SMEAR	Pathology		No Action	
13/04/2004	DR A PRACTITIONER	12/04/2004	12/04/2004	Demotown Pathology	DR A PRACTITIONER	E/LFT (MASTER)	Pathology		No Action	

Recording Baby Birth Weights

Observations are recorded in the using the Tool box in MedicalDirector..

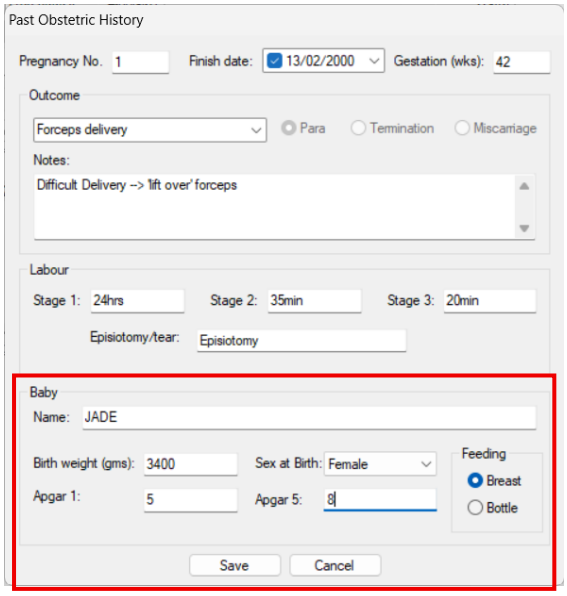
It is important to record ALL baby birth weights accurately in MedicalDirector for the data to flow through to the various reports that use this information.

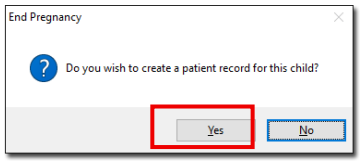
1. Open the **baby's patient record (F2)**
2. Select **Tools > Toolbox > Weight**
3. **Change the date displayed on this screen to matc essential**.
4. Enter the **baby's weight (in kg)**
5. Select '**Save'.**



To link a mother's and baby's record in MedicalDirector from the mother's obstetric record

1. Open the **mothers patient record (F2)**
2. Select the '**Obstetric**' tab
3. **Select 'End pregnancy' button**
4. **Double click to open and update**
5. Yes to confirm
6. Record the **Finish Date** (this will be the birth date) the **Outcome** and any complications
7. Enter the **delivery details**
8. Enter **Baby's name** (if known) and birthweight, sex, Apgar scores
9. Select **'Save'**.
10. If you name the child, you must also indicate its sex at birth. Upon clicking **Save** you will be prompted as to whether you wish to create a patient record for the child in Clinical.
11. **Yes**





Topic 2 – Data Cleansing

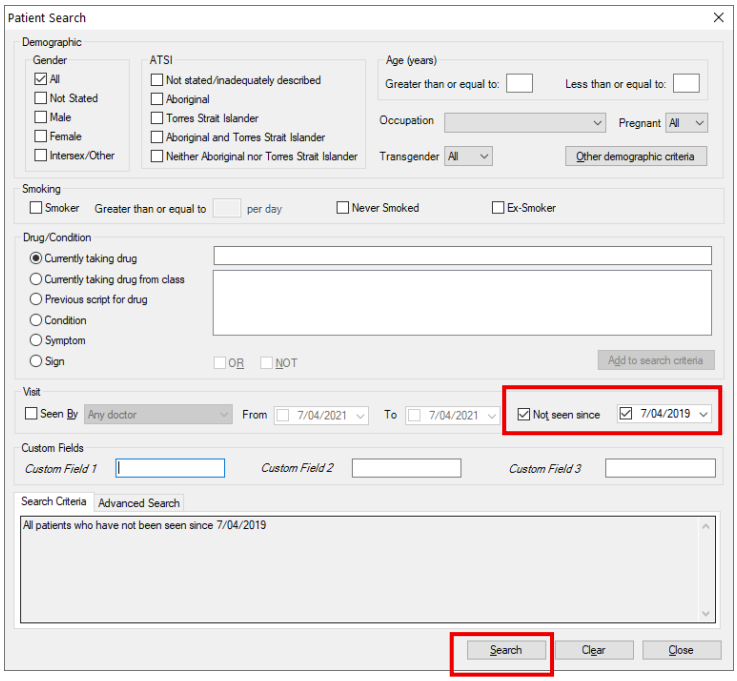
Archiving patient records

Marking patients as inactive in bulk

You may wish to **search** your patient database and mark those patients who you have not seen for many years as inactive. Marking patients as inactive is a relatively simple process as is reactivating them again.

By marking patients as inactive you are removing them from view when you **search** the database, their information is not included in standard patient **search**es and you won't send them recall letters. It is recommended to tick '**Include everyone'** when searching so you don't create duplicate records if the patient presents again.

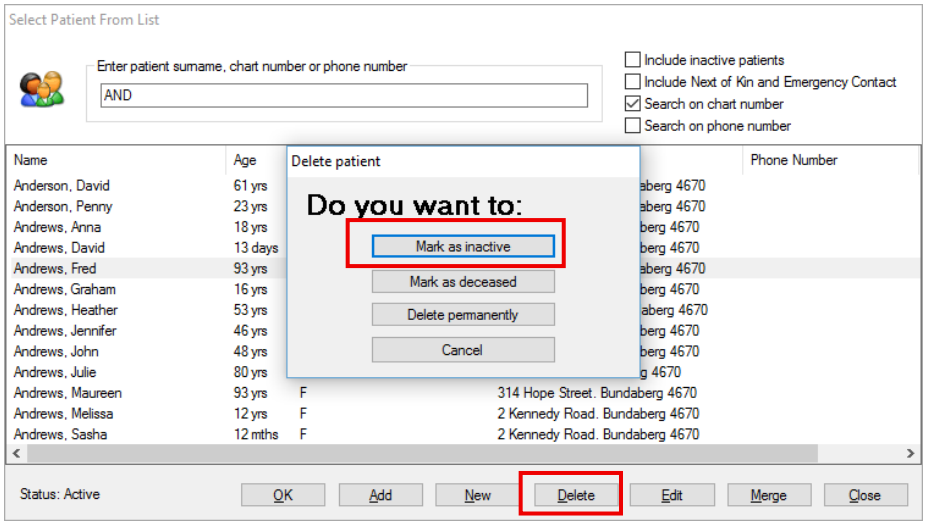
1. From the Main Screen, select **Search**.
2. Select **Patient**
3. Tick **Not seen since**
4. **Enter the date you want to use to archive records** (you can type directly on top of the year date to change).
5. **Search**
6. **Review the list** to confirm the data is correct.
7. **Click on the 'Inactivate Patients' button** from the bottom left of the screen.
8. **Yes** to confirm the inactivation.



Marking individual patients as inactive

If one patient or family inform you they are moving away you may wish to individually inactivate the patient record/s. To mark patients as inactive from the Main Screen:

1. Select **Open (F2)**
2. **Search for the patient** whom you wish to mark as inactive.
3. From the patient list click once to highlight the inactive patient then click on the **Delete** key.
4. Choose '**Mark as Inactive**'.
5. **Close**

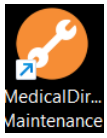


Updating health summary data

Cleaning up past medical history

The **diagnosis coder** is a useful tool if for cleaning up the Past Medical History list if you have been in the habit of entering Reason for Contact in free text (i.e. not choosing from the coded Docle pick list). This enables you to link those uncoded diagnoses with the coded choices. To use this tool:

1 Open the **MedicalDirector Maintenance app**.

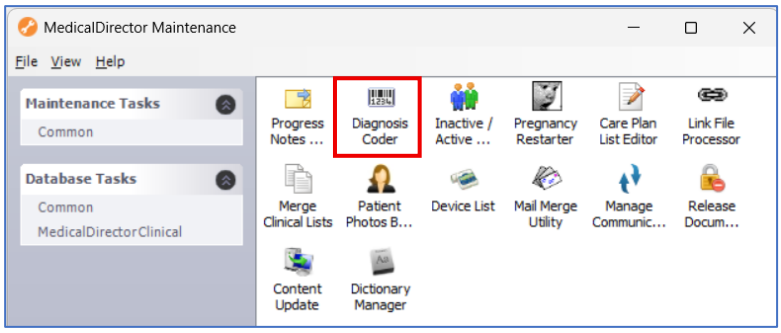


2 Enter your **Login details > OK**

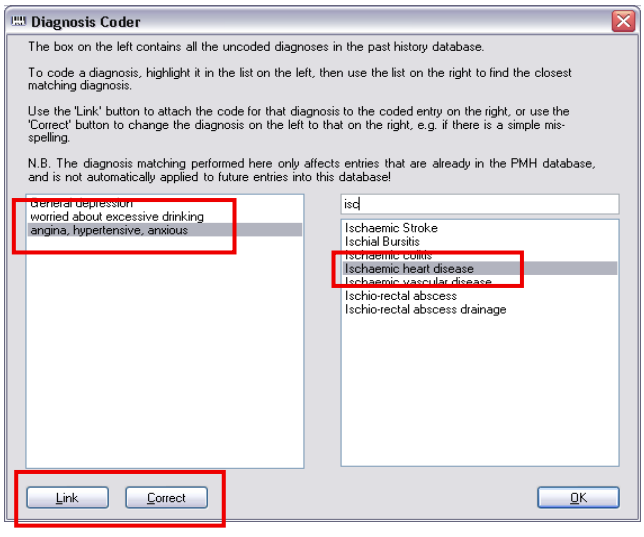
3 Select **Database Tasks > Medical Director Clinical**

4 Doubleclick on **Diagnosis Coder.**

5 **Highlight the uncoded diagnosis in the left column** that you with to link or correct.



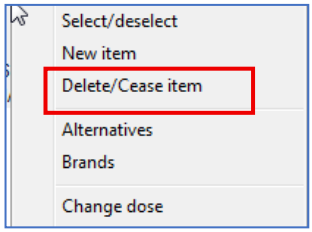
6 In the column on the right **enter the first a few characters of the correct diagnosis**. Once found, click on either **Link** (to attach the code to the coded diagnosis) or **Correct** (to change the entry to the coded diagnosis) buttons.



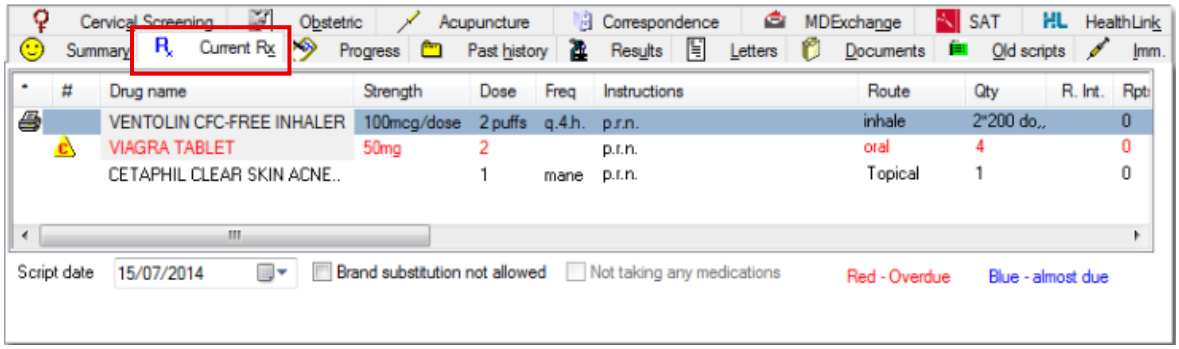
Tip: If you have always entered a particular diagnosis by free text typing in a specific way and you like that way you can Link the free-text entry to the coded diagnosis and continue to type in the way you prefer.

Cleaning up medications

Prescriptions that have elapsed will display in red
Prescriptions that are almost due will display in blue

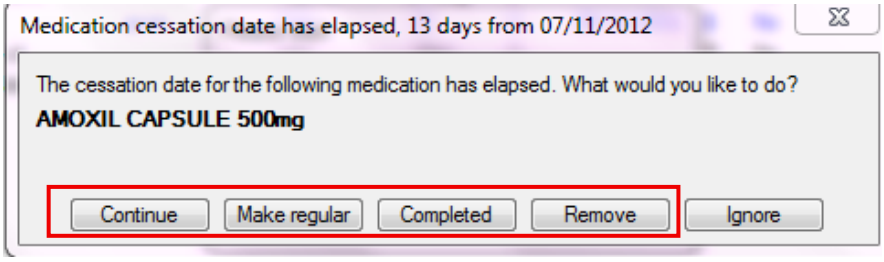


1. **Open the patient record**
2. Select **Current Rx** tab
3. **Right click on the medication** in the Current Rx list
4. Select **Delete/cease item**
5. If you are deleting the script you may be prompted to **enter** a reason for deletion and a record of deletions and their reasons is recorded.

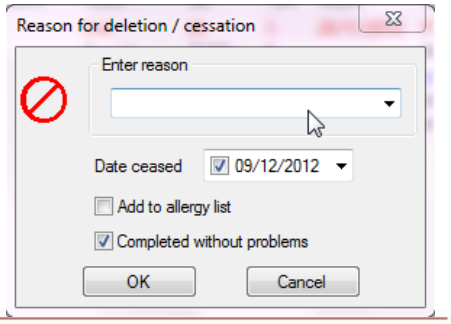


Ensuring accuracy of the Current Medication list

If limited was chosen when a medication was prescribed in MedicalDirector, when the date the medication should have finished is reached, you will see the following prompt when next opening that patient's record. If you choose to ignore it, the prompt will continue to appear every time the patient's record is opened.



Select **Continue, Make Regular, Completed or Remove** as appropriate. Any removed medications will then go to the Old Scripts section. It is vital the Current Rx section of the patient record is accurate.



Tip: If you don't know the 'reason' or if the medication was 'completed without problems' untick to leave blank.

Topic 3 – Practice Systems

Actions, recalls and reminders

MedicalDirector includes a range of built-in practice management tools that help healthcare teams deliver safe, organised and proactive patient care. These tools support practices to manage clinical follow-up, monitor preventive health activities, communicate with patients and ensure that important tasks are completed in a timely manner. When used consistently, they improve continuity of care, reduce the risk of missed follow-up and help practices meet clinical, accreditation and quality improvement requirements.

This topic explains how MedicalDirector uses Actions, Recalls and Reminders to manage patient follow-up and practice workflows. Although these features have different purposes, they work together to ensure that clinical tasks, preventive health activities and patient reviews are identified, tracked and completed. Understanding when and how to use each tool is essential for maintaining accurate patient records, supporting effective team communication and delivering high-quality patient care.

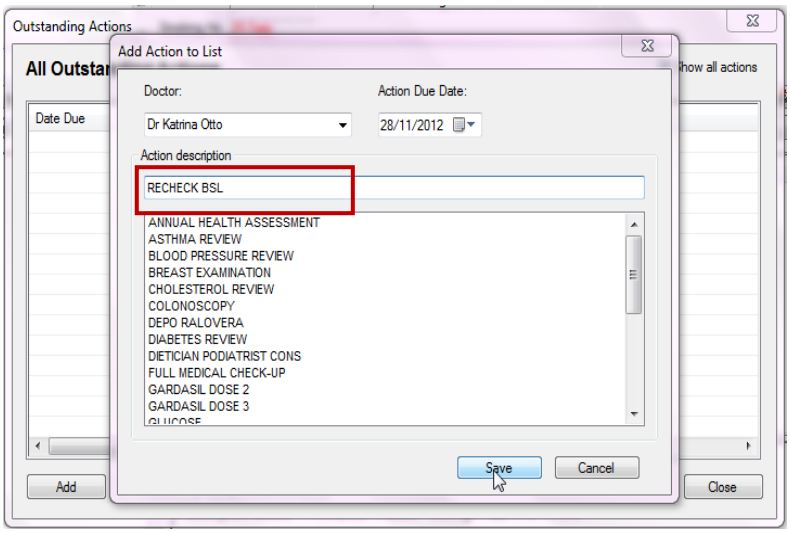
Actions

Similar to a post-it note on a hard copy file, these will alert you to items you wanted to remember (clinical or social) when you next open the patient record. Examples might include:

- Discuss smoking
- Recheck BSL
- Follow-up referral to dietician

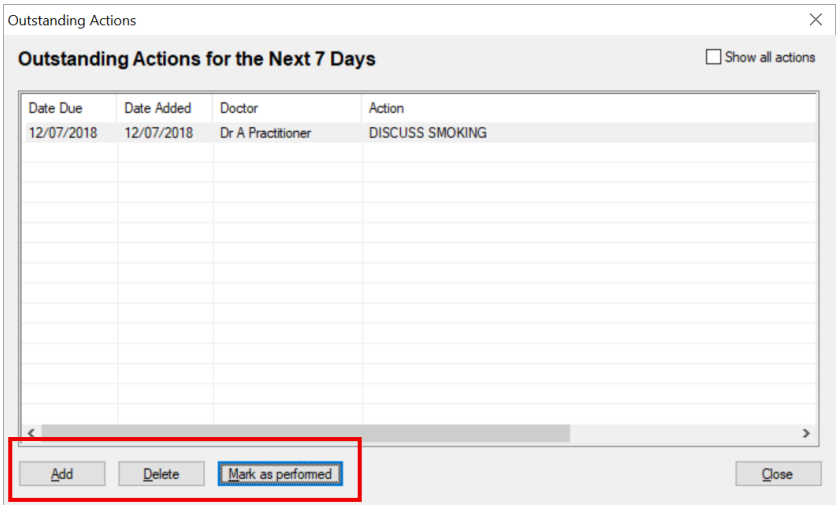
To add an Action

1. **Open** a patient record and **click** on the Clinical drop-down menu.
2. **Select** Action List.
3. Click on **Add**
4. The list that appears is your list of 'recall reasons'. You can choose from this list if appropriate or type your own Action description.
5. **Save**.



When you **add** an Action an automatic notation will be made in the progress notes.

When you **open** a patient record the Actions database is automatically checked to see if the patient has any outstanding actions due within 7 days and if so the Outstanding Actions window will appear.



Removing Actions

Actions need to be **removed** when the action is no longer relevant. Choose 'Mark as performed' if you would ever want to trace the action (e.g. clinical – Follow up Specialist Referral) or Delete if less important (e.g. social – ask about overseas trip).

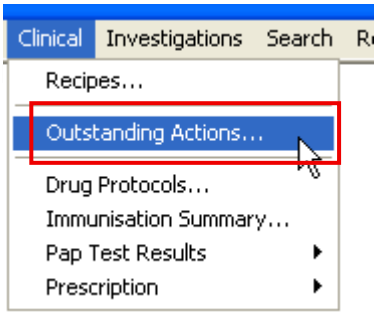
To access all actions within a patient record

1 Click on the **Clinical** drop down menu from within the patient record

2 Selection **Action List**.

Following up Actions

We can also track all patients' actions that have not yet been marked as



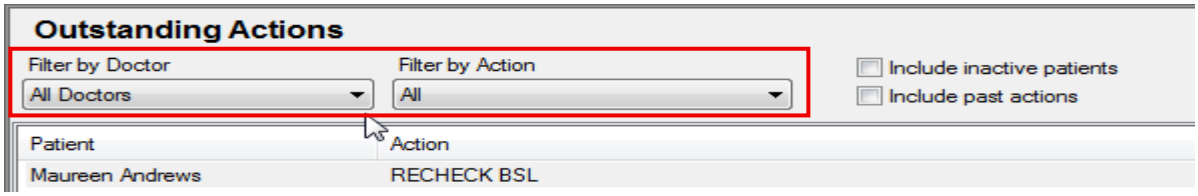
To do this, from the **Main screen:**

1 Click on the **Clinical** dropdown list

2 Select **Outstanding Actions**

In this screen, **'Filter by Action'** and filter by doctor to perform functions such as printing a list or reviewing the status of each action.

Tip: Check the outstanding actions list regularly. 'Mark as performed' clinical functions as you can then track those 'performed' actions. Delete social reminders (e.g. ask about overseas trip).

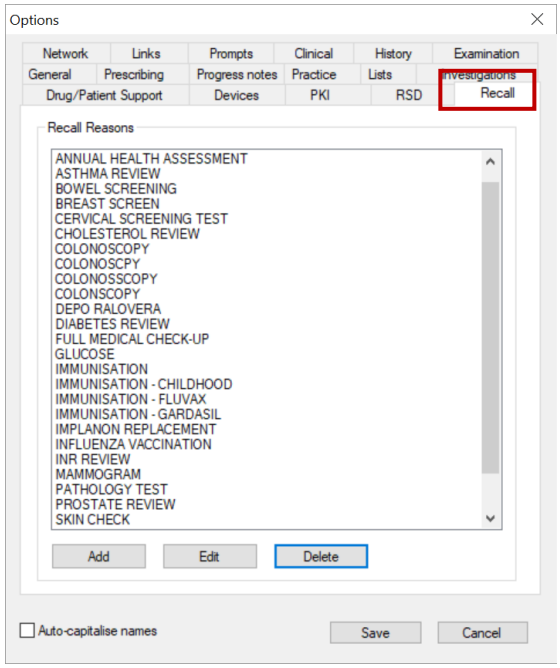


Creating an Effective Recall & Reminder List

A major difference between ‘Actions’ and ‘Recalls’ is that Recalls are regularly generated into a list and pro-actively followed up with the patient.

Therefore the first step to creating an effective recall and reminder system is often to create a clear list of recall and reminder reasons.

1. From the Main Screen, **select Tools**
2. Select **Options.**
3. Select **Recall** Tab
4. **Use the Add**, **Edit**, **Delete** buttons to create an effective list.

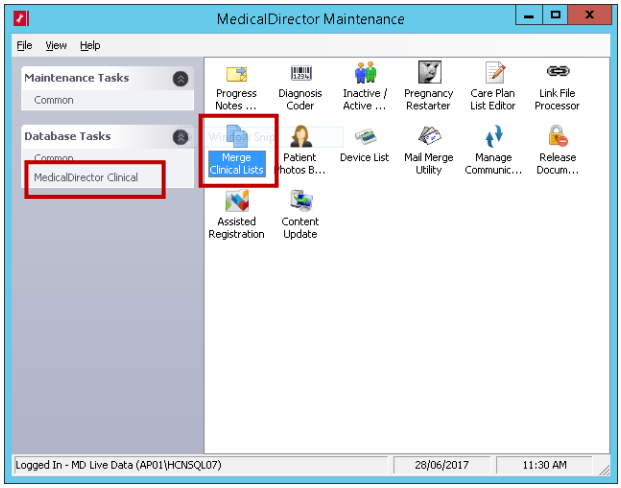


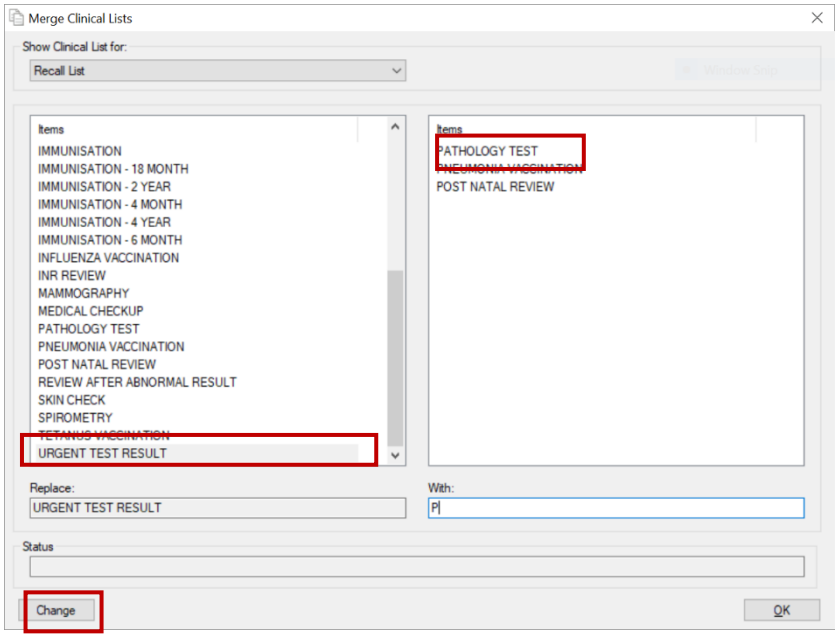
Tip: A key factor in helping ensure an effective recall and reminder system is to keep this list manageable. Have a team meeting and clearly define your recalls and reminders and ensure all staff understand the practice ‘system’.

Recall List Bulk Clean Up

To access the Recall List clean up utility that allows you to merge recall reasons and clean up your outstanding recalls in bulk. This program should be used after creating an effective recall and reminder list as described above.

1. Open the **MedicalDirector Maintenance** icon from your Desktop
2. Select **Database Tasks>MedicalDirector Clinical**
3. Double click on **Merge Clinical Lists**
4. Select Show Clinical Lists for ‘**Recall List**’
5. **Highlight an entry in the left hand column** that you want to merge with an entry in the right hand column.
6. Select the ‘**Change**’ button to effect the merge.
7. **OK** when complete.





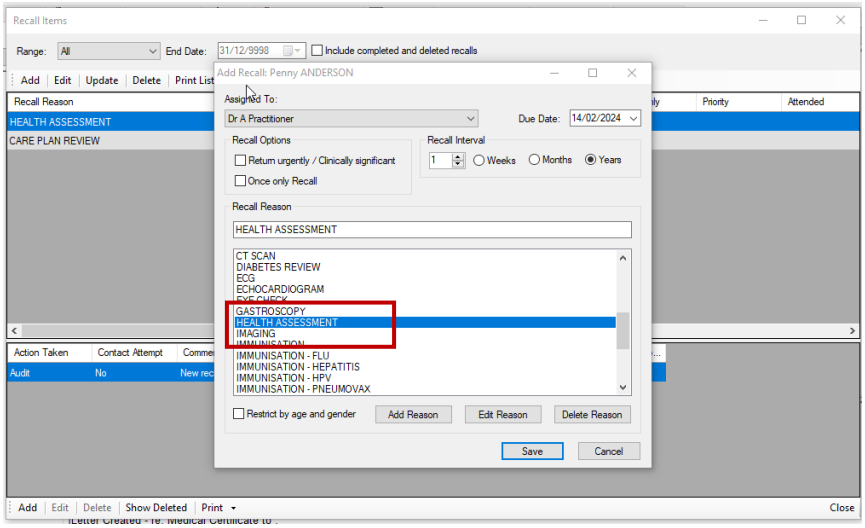
The cleanup process will help with streamlining the recall management process and provide clarity for users of the system.

Add View & Modify Patient Recalls

Adding patient recalls in the patient record/consultation



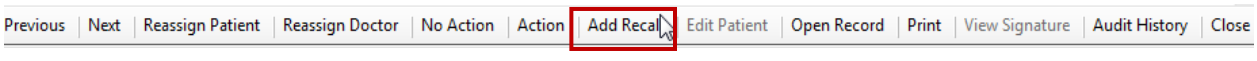
1. **Open** the patient record.
2. **Click** on the Recalls button from the area at the top of the screen. If the patient has a recall due in the next 30 days there will be a ringing phone next to the button.
3. Select the '**Add**' button at the top of the Recall Items window.
4. Choose your **reason** from the list
5. Select the **due date** for recall and interval required.
6. If this is a 'clinically significant' recall then **tick the Return Urgently/Clinically significant** box. All recalls marked Return Urgently/Clinically significant will be **highlighted** in red on lists.
7. If this is **not** a recurring recall **tick** the 'Once Only Recall' box.
8. **Save.**



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Other methods of adding a recall include:

- when **enter**ing an immunisation
- when **enter**ing a 'Review'
- when checking incoming results and correspondence in the holding file.

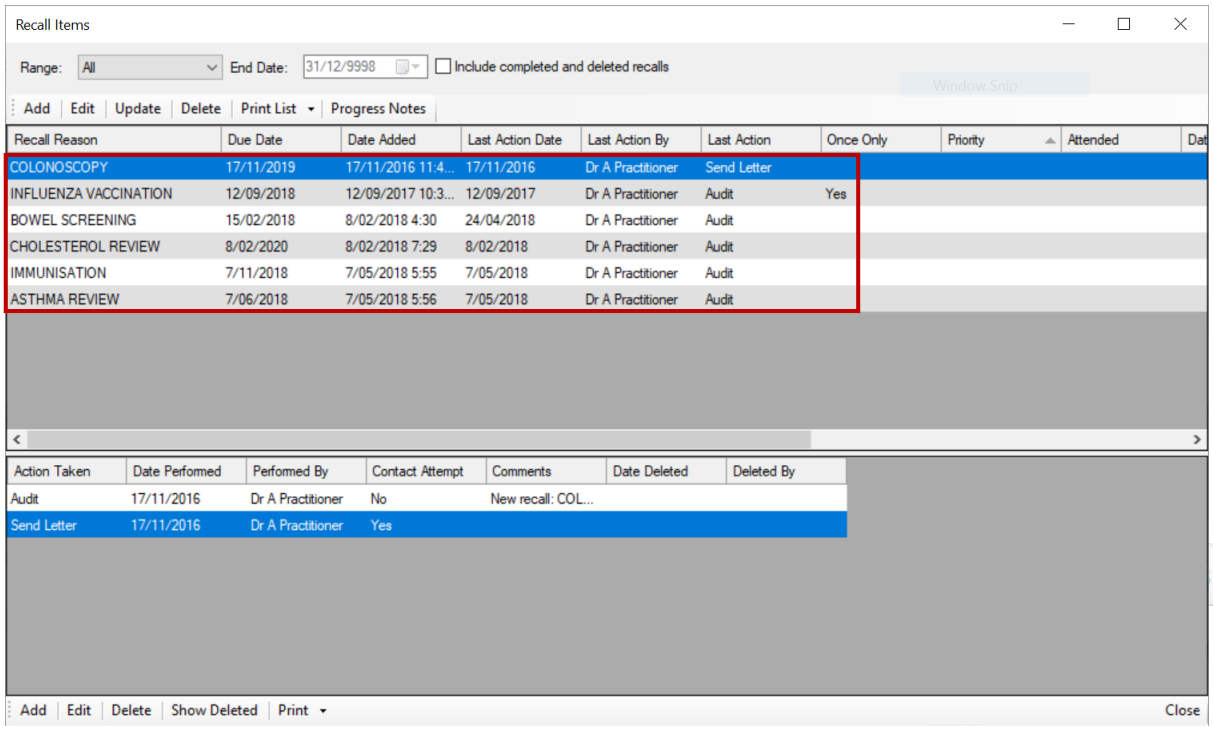


Viewing the patient recall list

From the patient screen:

1 Select the **Recalls** button - All open recalls for the patient will be displayed.

2 **Select a recall** and use the **edit, delete buttons** to update as required.



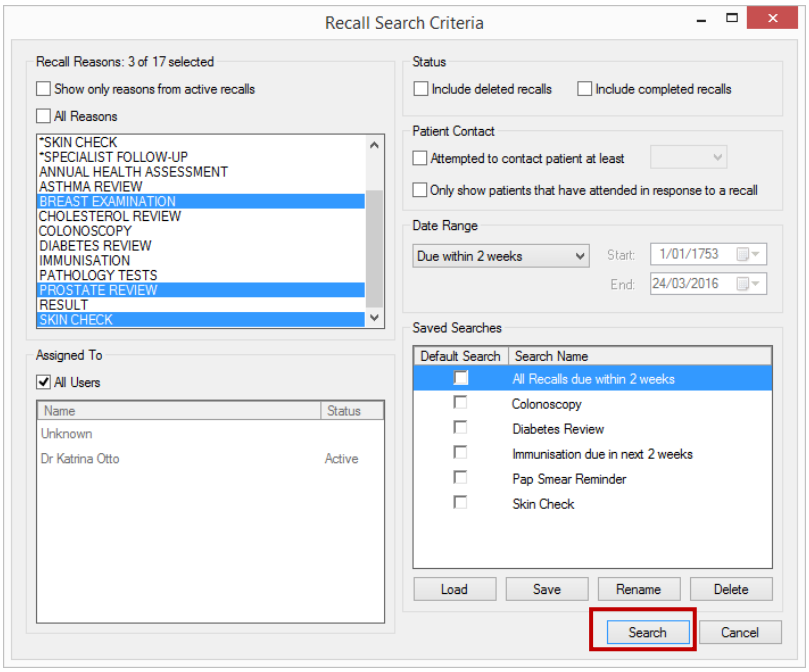
Generating patient recall & reminder lists & letters

Nursing and/or administrative staff often manage the recall and reminder system and either print lists or mail-merge directly to recall letters. We also have the option of contacting patients via sms. An audit history of contacts and a count of the number of patient contact attempts is available.

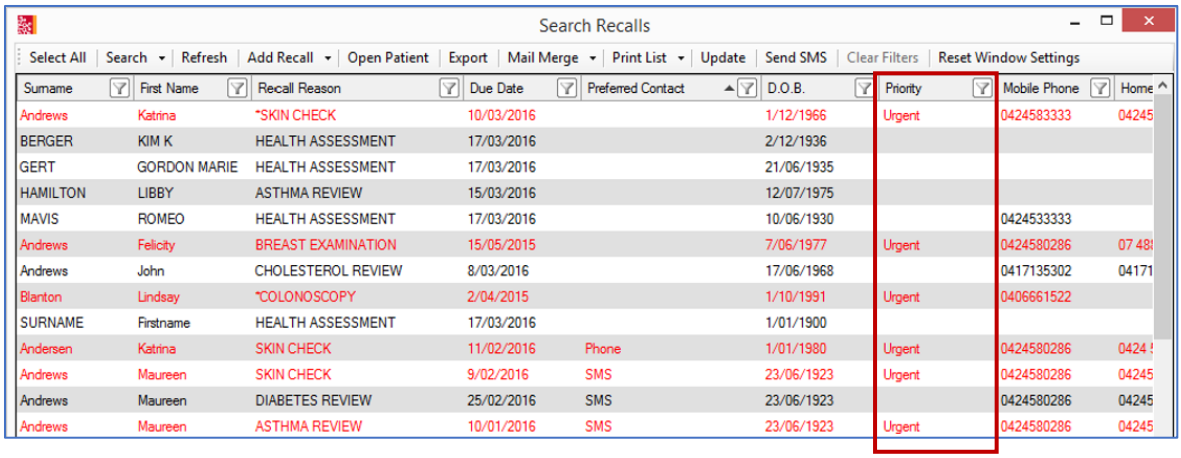
How often the list is generated and by whom will vary from practice to practice.

From the Main Screen select:

1. Select **Search** then **Recall**
2. Click to select the **reason/s** from the list that are being followed up.
3. (Use the Shift and Ctrl keys to select multiple entries from the list).
4. Select the **due date** range.
5. Select the doctor/s (or All Users).
6. Select **Search.**



A list of recalls matching the search criteria will display on the screen and Urgent Recalls will be displayed in red.

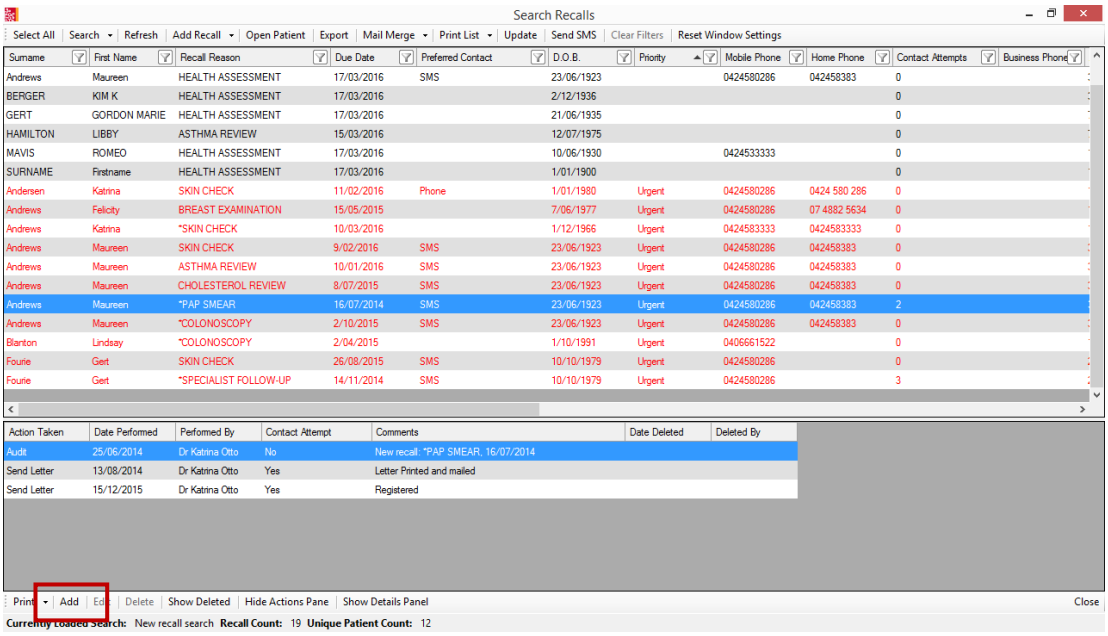


Surname	First Name	Recall Reason	Due Date	Preferred Contact	D.O.B.	Priority	Mobile Phone	Home
Andrews	Katrina	*SKIN CHECK	10/03/2016		1/12/1966	Urgent	0424583333	04245
BERGER	KIM K	HEALTH ASSESSMENT	17/03/2016		2/12/1936			
GERT	GORDON MARIE	HEALTH ASSESSMENT	17/03/2016		21/06/1935			
HAMILTON	LIBBY	ASTHMA REVIEW	15/03/2016		12/07/1975			
MAVIS	ROMEO	HEALTH ASSESSMENT	17/03/2016		10/06/1930		0424533333	
Andrews	Felicity	BREAST EXAMINATION	15/05/2015		7/06/1977	Urgent	0424580286	07 48
Andrews	John	CHOLESTEROL REVIEW	8/03/2016		17/06/1968		0417135302	04171
Blanton	Lindsay	*COLONOSCOPY	2/04/2015		1/10/1991	Urgent	0406661522	
SURNAME	Firstname	HEALTH ASSESSMENT	17/03/2016		1/01/1900			
Andersen	Katrina	SKIN CHECK	11/02/2016	Phone	1/01/1980	Urgent	0424580286	0424
Andrews	Maureen	SKIN CHECK	9/02/2016	SMS	23/06/1923	Urgent	0424580286	04245
Andrews	Maureen	DIABETES REVIEW	25/02/2016	SMS	23/06/1923		0424580286	04245
Andrews	Maureen	ASTHMA REVIEW	10/01/2016	SMS	23/06/1923	Urgent	0424580286	04245

TIP: Filter by the Priority = 'Urgent' (ie Clinically Significant recalls' by clicking in the column heading in the column called Priority. This will sort your list into Recalls versus Reminders and help to ensure those marked 'urgent' are followed up until the patient returns.

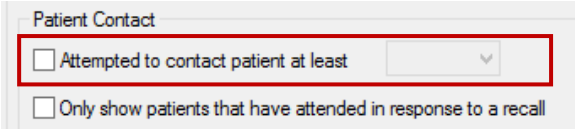
Following up Recalls and Reminders

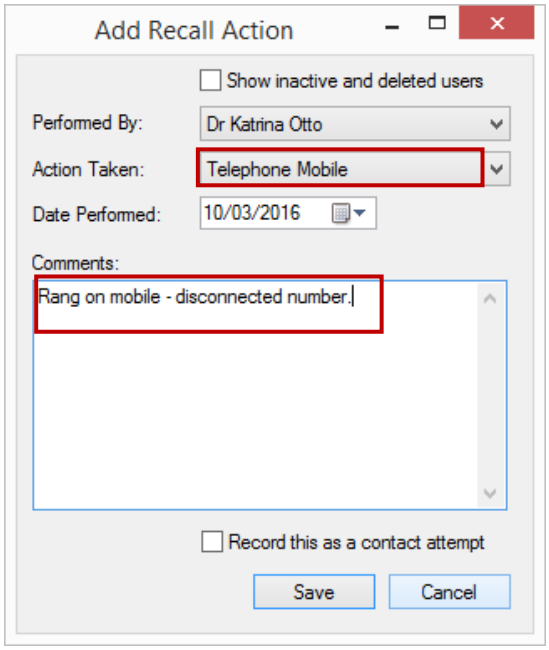
You may want to follow up recalls by sending a letter, by SMS or phone call and recording the contact attempt against the outstanding recall.



To notate individual patient follow up (from the Search>Recalls screen):

1. Click on the **Add** button from the bottom left of the recall list you have generated.
2. Select **Action Taken** eg:Telephone Mobile.
3. Notate the detail of the contact in **Comments**.
4. Tick to select '**record this as a contact attempt**' if appropriate. This will enable searching for all patients who have been marked as contacted a specified number of times.





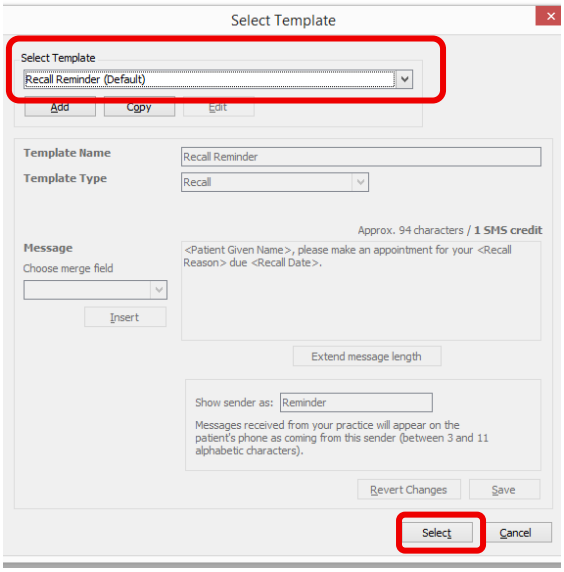
Send SMS follow-up for reminders

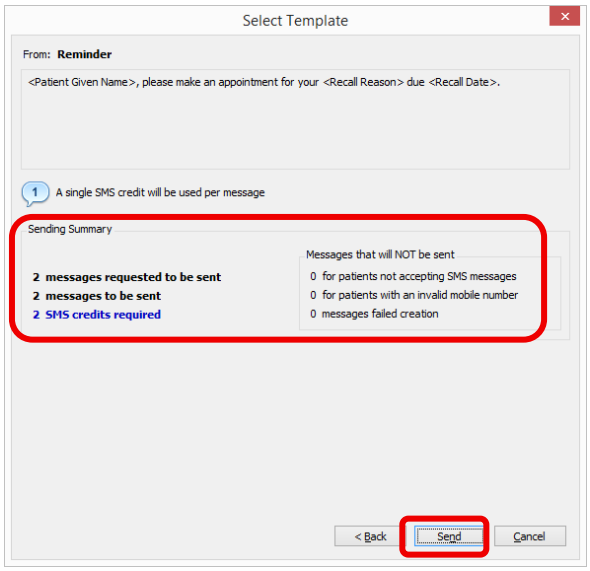
From the **Search > Recalls** screen:

1. Enter search parameters and select **Search** to generate a list of open recalls.
2. **Select one or many recall reasons from the list** (you can hold the Control key down while clicking to select multiple reasons from the list).

Andrews	Felicity	BREAST EXAMINATION	15/05/2015		7/06/1977	Urgent	0424580286	07 4882 5634	0
Andrews	Katrina	*SKIN CHECK	10/03/2016		1/12/1966	Urgent	0424583333	0424583333	0
Andrews	Maureen	SKIN CHECK	9/02/2016	SMS	23/06/1923	Urgent	0424580286	042458383	0
Andrews	Maureen	ASTHMA REVIEW	10/01/2016	SMS	23/06/1923	Urgent	0424580286	042458383	0

3. Select the **SMS Template** you wish to use from the dropdown list or Add to create a new one.
4. Click on **Select** and a confirmation will appear advising how many messages and credits will be used.
5. Select **Send.**





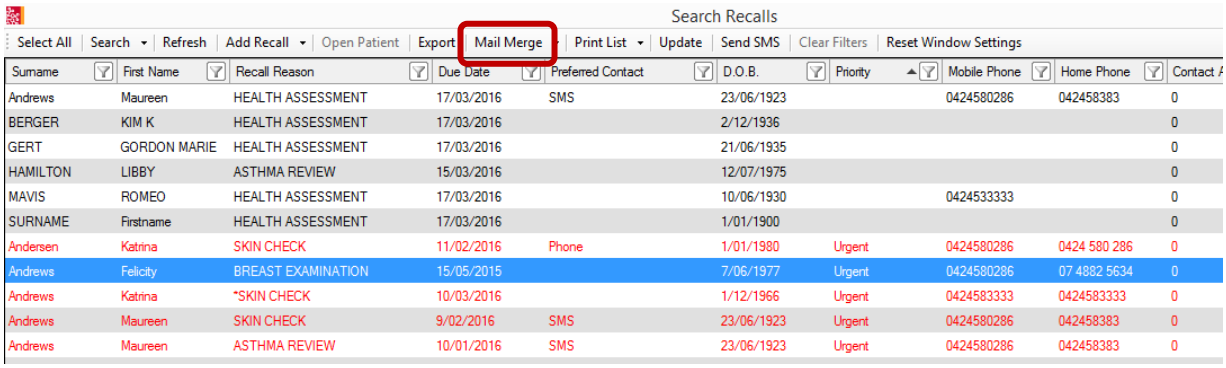
Medical Director will display a message indicating how many SMS messages were successfully sent.

Mail-merge follow-up - generating recall & reminder letters

1 To Mail Merge recall letters, generate the recall list (Search > Recall), enter the search parameters and select **Search**.

2 Select the recalls from the list that you want to Mail Merge to a letter template. (you can hold the Control key down while clicking to select multiple reasons from the list).

3 Select **Mail Merge** button.

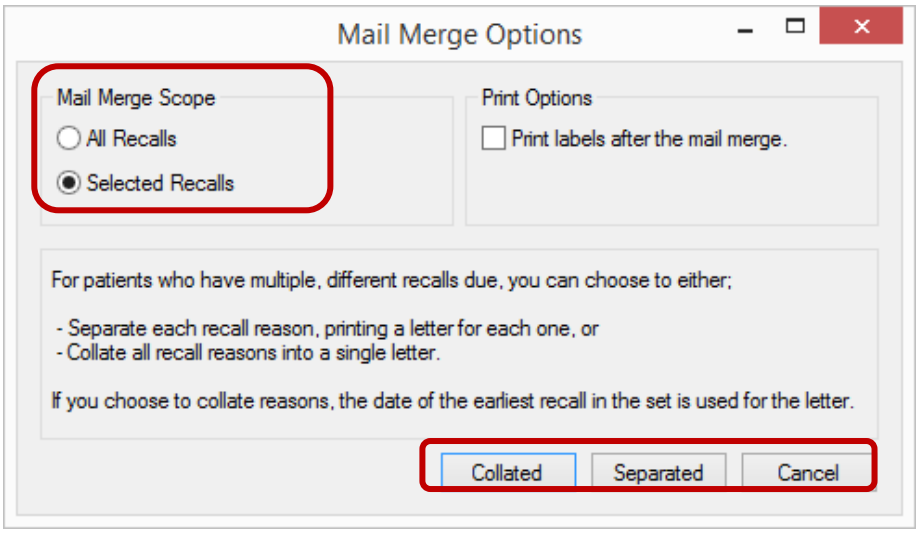


Surname	First Name	Recall Reason	Due Date	Preferred Contact	D.O.B.	Priority	Mobile Phone	Home Phone	Contact A
Andrews	Maureen	HEALTH ASSESSMENT	17/03/2016	SMS	23/06/1923		0424580286	042458383	0
BERGER	KIM K	HEALTH ASSESSMENT	17/03/2016		2/12/1936				0
GERT	GORDON MARIE	HEALTH ASSESSMENT	17/03/2016		21/06/1935				0
HAMILTON	LIBBY	ASTHMA REVIEW	15/03/2016		12/07/1975				0
MAVIS	ROMEO	HEALTH ASSESSMENT	17/03/2016		10/06/1930		0424533333		0
SURNAME	Firstname	HEALTH ASSESSMENT	17/03/2016		1/01/1900				0
Andersen	Katrina	SKIN CHECK	11/02/2016	Phone	1/01/1980	Urgent	0424580286	0424 580 286	0
Andrews	Felicity	BREAST EXAMINATION	15/05/2015		7/06/1977	Urgent	0424580286	07 4882 5634	0
Andrews	Katrina	*SKIN CHECK	10/03/2016		1/12/1966	Urgent	0424583333	0424583333	0
Andrews	Maureen	SKIN CHECK	9/02/2016	SMS	23/06/1923	Urgent	0424580286	042458383	0
Andrews	Maureen	ASTHMA REVIEW	10/01/2016	SMS	23/06/1923	Urgent	0424580286	042458383	0

When you choose to **Mail Merge** the mail merge Options will appear.

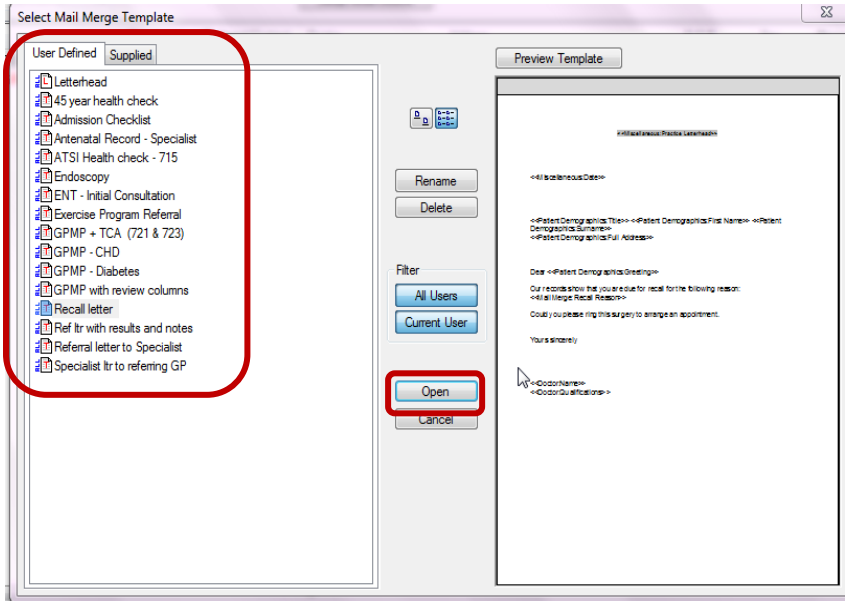
4 Choose **Selected Recalls** if you have already highlighted the ones you want from your list.

5 Choose collated if your patients have more than one recall and this will collate multiple recalls for a single patient on the one letter instead of separating them into multiple letters for the same patient.



6 **Select the template** from your User Defined list then select **Open**.

7 Click **OK** and the letters will created and sent to the printer.





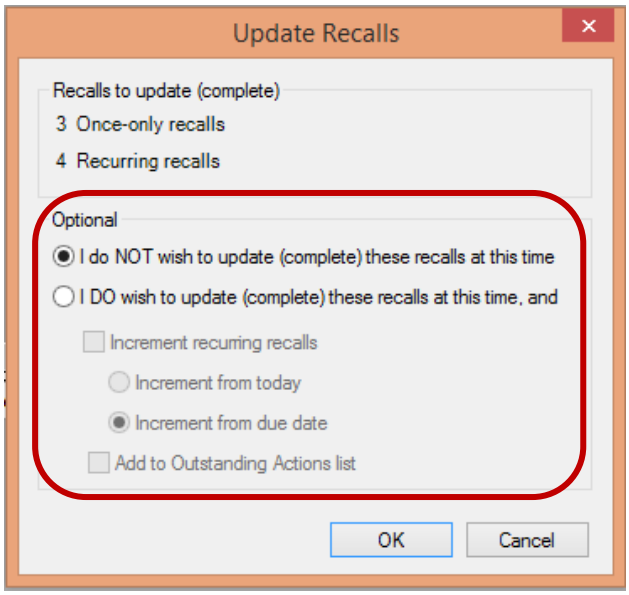
Note: When a mail merge is performed, a copy of the letter that is generated is **saved** into the individual patient's Letters tab in the patient record.

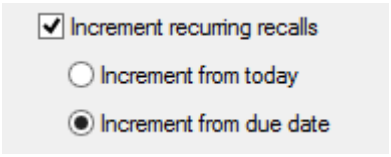
To Update/Remove the Recall or Cancel (and retain the recall)?

Once you have sent patients a recall letter, SMS message or telephoned your patients you will be prompted with this 'Update Recalls' screen and will now need to decide which of the two options is more appropriate:

1 If you choose '**I do NOT wish to update…'** the recall will remain as is and will continue to appear on your recall list with the same original recall date set. The telephone will continue to ring in the patient record if the recall is due in the next 30 days.

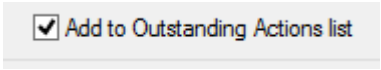
2 If you choose **'I DO wish to update…'** this will delete the recalls from appearing in future (the telephone will not ring any more).





If you also choose **to Increment recurring recalls** you will need to specify whether to increment from todays date or the due date.

If you also tick the **'Add to Outstanding Actions list'** tickbox, the 'recall' will be removed and an 'Action' **added** to the patient record. This action will then pop-up when the patient record is opened and it will appear on the Outstanding Actions list.

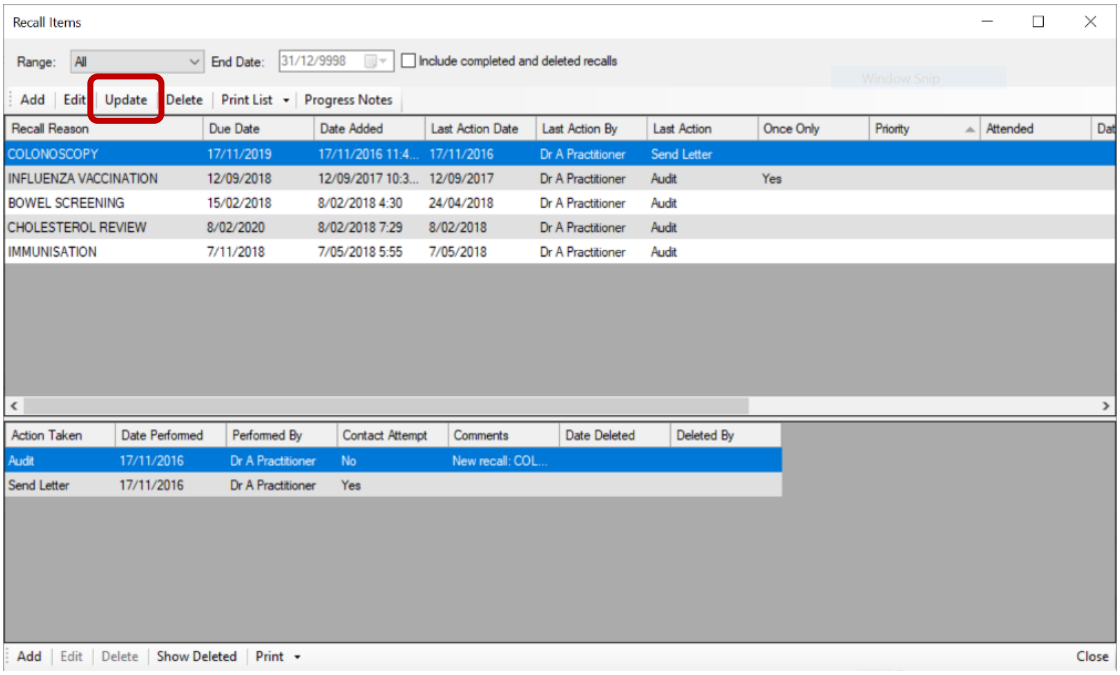


Marking the recall as performed

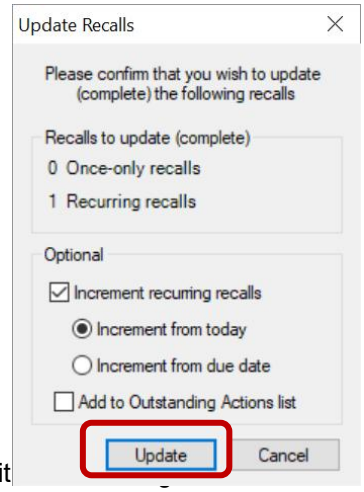
If there is a ringing phone in the patient record, check to see which recalls are due in the next 30 days for the current patient.



Once the service (recall reason) has been provided to the patient, the recall should be marked as performed so the patient wont continue to be followed up.



To mark the recall as performed:



1. Open the patient record (F2).
2. Select the Recalls button.
3. Select the recall to be completed.
4. Select the Update button.
5. Select Update button again.

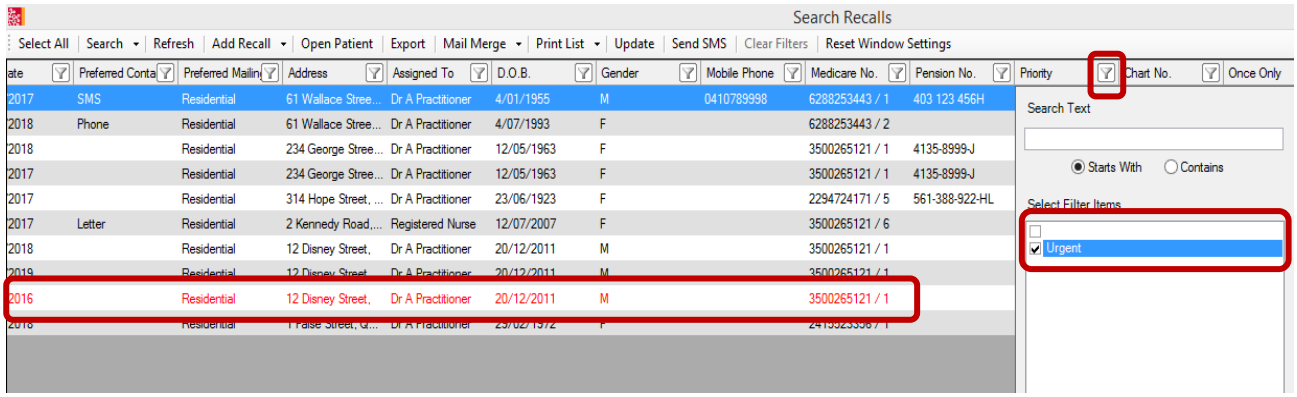
A pop-up will appear advising ‘Update Successful’.

If the recall is marked as ‘once-only’, it ill be marked as completed. If it interval is added to the date so that it becomes due again into the future.

Following Up Recalls Marked 'Urgent'

If clinically significant recalls are **ticked** as '**Return Urgently'** when created you will be able to generate a list of only those marked as urgent.

Tip: Generate a regular list of only those recalls marked as 'Return Urgently' by filtering on 'Priority' on the Search Recalls screen (and select all doctors to ensure these have been followed up).



Viewing Recall Actions (Notes) from the Patient Record

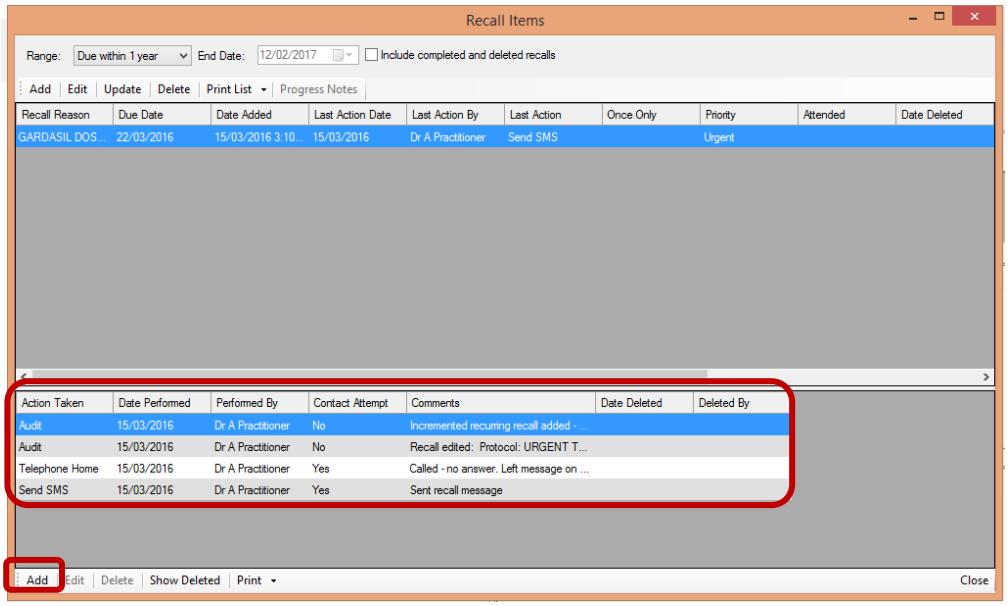
'Recall Actions' can also be **added** and **viewed** directly through the patient record.

After **open**ing the patient record:

1 Click on Recalls

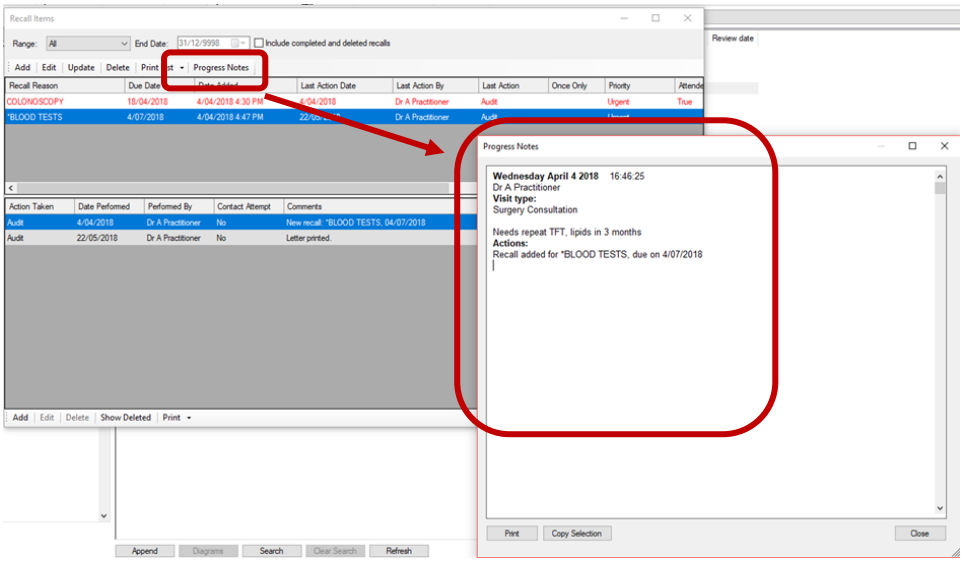
2 **Highlight** the Recall reason at the top of the screen (urgent recalls will be in red)

3 **Recall Actions** relating to the selected recall will display in the lower section of the screen.



Use the **Add** button at the bottom of this screen to add a recall action, to document follow up attempts with the patient.

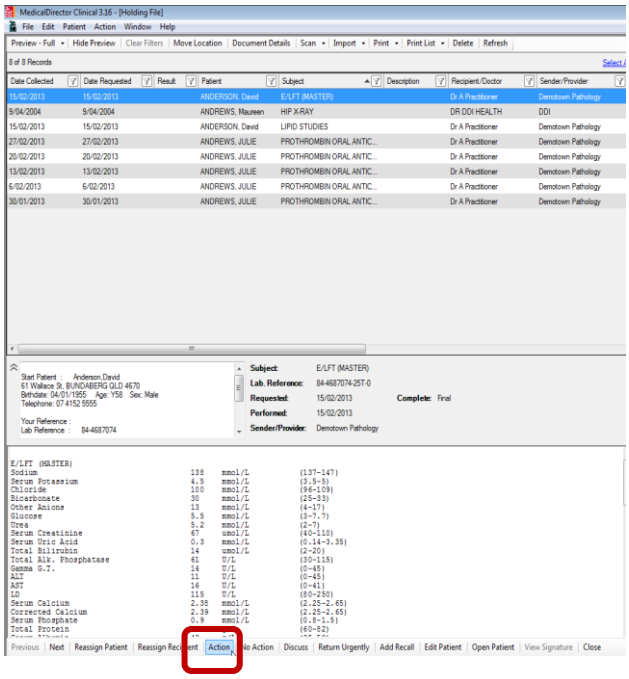
When viewing a recall, note the availability of the 'Progress Notes' tab at the top of the screen that can be used to see notes made by the doctor on the date the recall was added to the patient record. This can be used to further explain the chosen recall reason so it is clear why the patient is to be recalled. Eg the type of blood tests required.



Managing Recalls from the Holding File

The Holding File should be checked regularly (F5) and all correspondence actioned.

The process of 'Actioning' removes the correspondence from the Holding File and stores it in the patient record and also adds it to the 'Actioned Items' list for follow-up by staff if required.



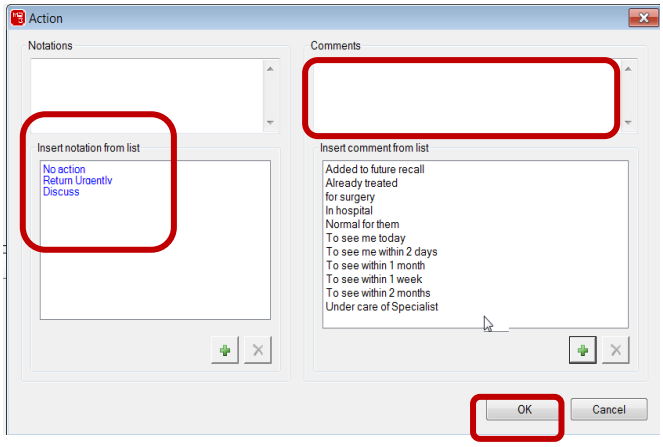
1 From the Main Menu or Patient Record click on Correspondence>Check Holding File (F5)

2 Select Practitioner name from the list.

3 Highlight a result and select 'Action' from the bottom of the screen.

4 Double click to choose a Notation from the list on the left.

5 Double click to choose from the list of Comments previously saved as required Add an Individualised Comment by free test typing into the Comments box (top right).



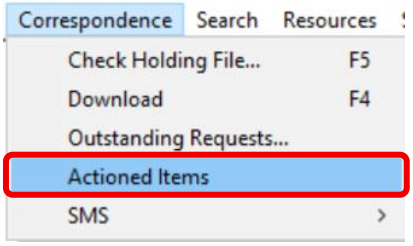
6 Click OK to activate filing of document in the patient record.

Tip: Use the Comments area to clarify action if required or highlight an important clinical aspect.

Managing Incoming Results / correspondence

Following up Results/Documents

Depending on the practice protocol for following up results, lists of documents marked Return Urgently, Discuss etc. may need to be generated for follow-up by practice staff.

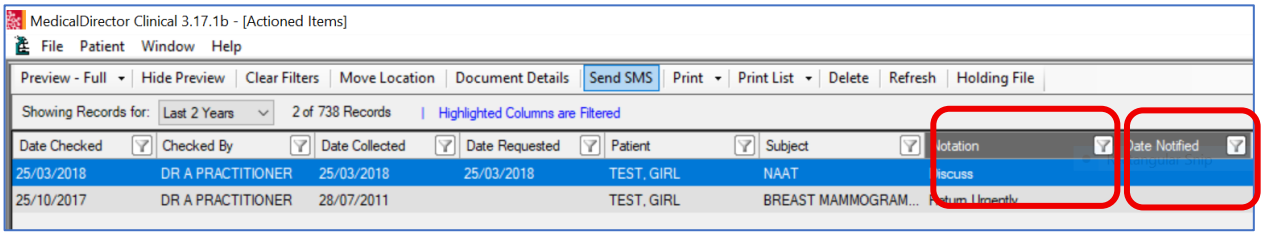


From the Main Screen:

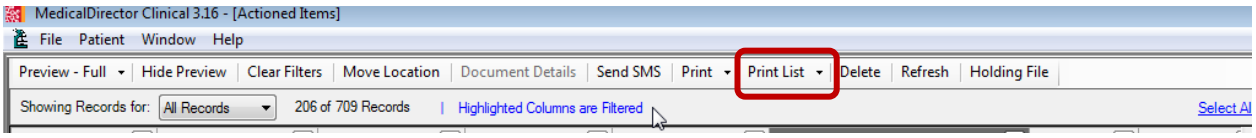
1. **Click** on the **Correspondence** drop-down menu
2. **Click** on **Actioned Items**.
3. **Use the column filters** to display the list in the required format eg filter the 'Notation' column to show only documents the doctor has marked as 'Return Urgently' or 'Discuss'.



4. Filter the '**Date Notified'** column so that only BLANK dates are included in the filtered list of results. This will show only results where follow up activities have not been finalised.

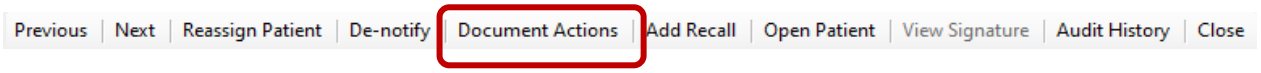


5. To print the filtered list **click** on '**Select All'** and then **Print List** from the top of the screen.



6. To send text messages to selected patients on the list, click on '**Send SMS'.** Then follow the steps on Page 15 to select a template and send the SMS messages.

Contact attempts can be recorded by selecting the '**Document Actions'** button at the bottom of the screen. Select '**Add'** to record telephone calls, letters and SMS messages sent to patients to follow up.

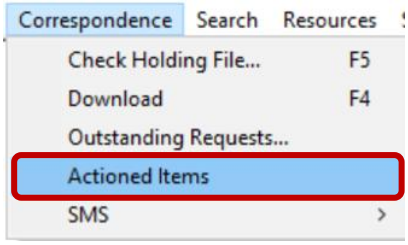


Accessing and Notifying Results from the Main Screen

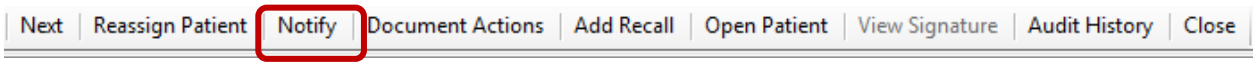
Results can be marked as 'notified' from the Main Screen (Actioned Items) or within the patient record. As a clear medico-legal audit trail it is important that results are marked as 'notified' in MedicalDirector when they are given to the patient. If they are not marked as notified when the result has been given, staff will potentially be contacting patients to return only to find out the patient has already been notified.

To notify results from the Main Screen:

1. **Select** the dropdown menu **Correspondence**.
2. Select **Actioned Items**.
3. **Click** to **highlight** relevant result.
4. Select '**Notified'** from bottom of screen.



This will insert a notation into today's progress note.



Accessing and Notifying Results within the Patient Record

To notify results from the Patient Record:

1. **Open** patient record.
2. Select the **Results** tab.
3. **Highlight** relevant result and **click** on '**Notify**' button at the bottom of screen. This will insert a notation into today's progress note and stamp the result as notified with the current date.

Topic 4 – Letters and templates

Generating and sending letters

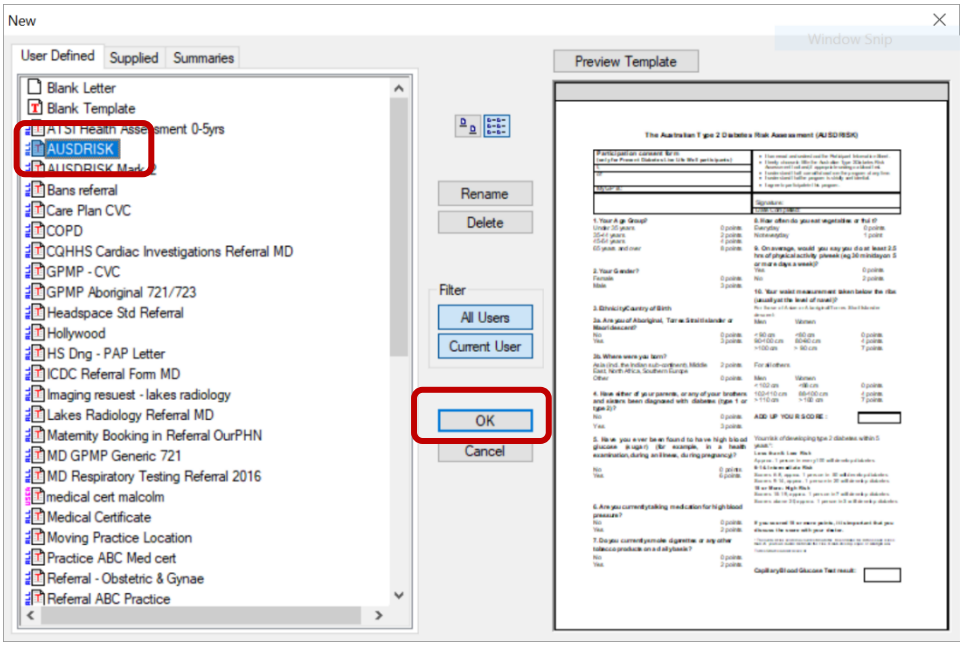
Generate a letter

1 Select the **Letter icon** within a patient record.

2 Select **File > New** from the drop-down menu.

3 **Select the required template** from the list and select **'OK'**.

4 **Respond to any prompts for information**



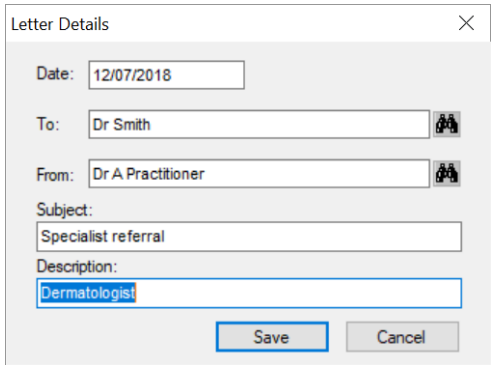
5 Check the completed letter or document and make any changes required.

6 **Save the letter** in the patients record by selecting **File > Save** from the Menu or clicking the Save icon on the Toolbar.

7 To print the letter, select **File > Print** from the drop-down menu, or click the Print icon on the Toolbar.

8 Complete or modify the **Letter Details**

9 **Save** from the drop-down menu, or click the Save icon.

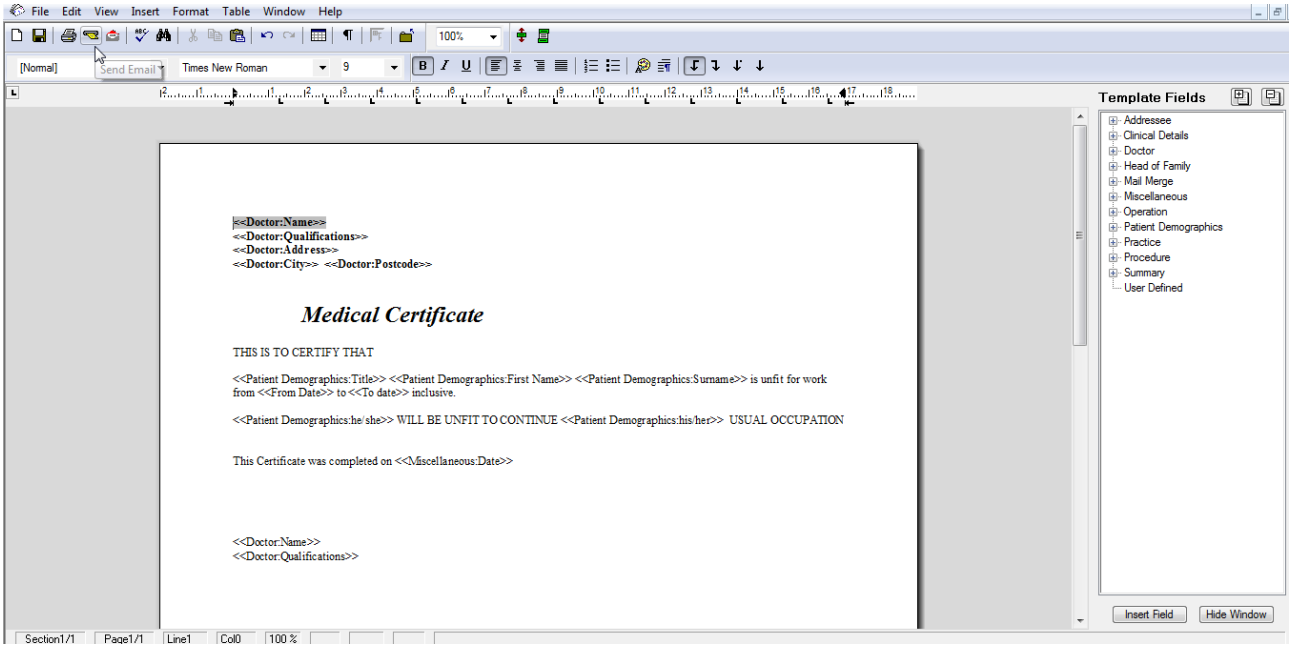


The saved letter will be available in the Letters tab on the patient file.

Working with templates

Modify Templates

1. **Open** the patient record and **click** on the **Letters tab**.
2. **Click** on the **File** drop-down menu.
3. **Click** on **Modify Template**.
4. **Click** on the relevant Tab (e.g. User-defined, Supplied or Summary) to find the template you wish to modify. Select and **Double-click** to **open** the template. The template will now open in edit mode. All the template fields (ie fields with brackets around them) are displayed.



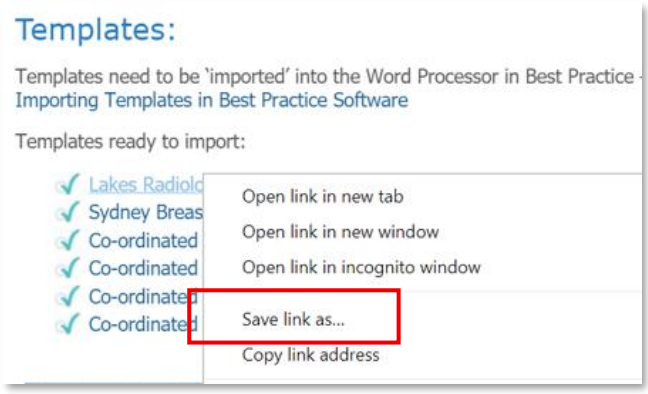
There should also be a list of **Template Fields** displayed on the right hand side of the screen. If this is not displayed **click** on the **Data Toolbar** icon and the list will appear.

5. **Edit** the template.
6. Select **File>Save** to save the changes made to the template.

Importing Templates

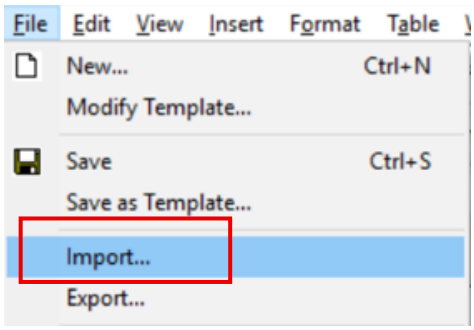
Step One - Download the template

1 Right-mouse click on the file link to the template and select **Save Link As**. Navigate to the folder or location on the hard drive of the computer where you want to save the file (eg desktop) and select **Save**. Do not Open it once saved, it must be **imported** into Medical Director.



Do not open the template, instead:

Step Two – Import the template into Medical Director.



1 **Open** Letter Writer from either the main screen or a patient record (F8).

2 **Click** on the File > New.

3 Select **Blank Template** from the User Defined tab**.**

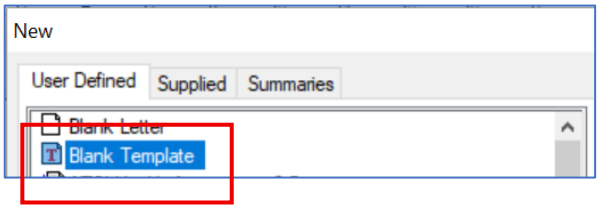
4 Select **OK** button.

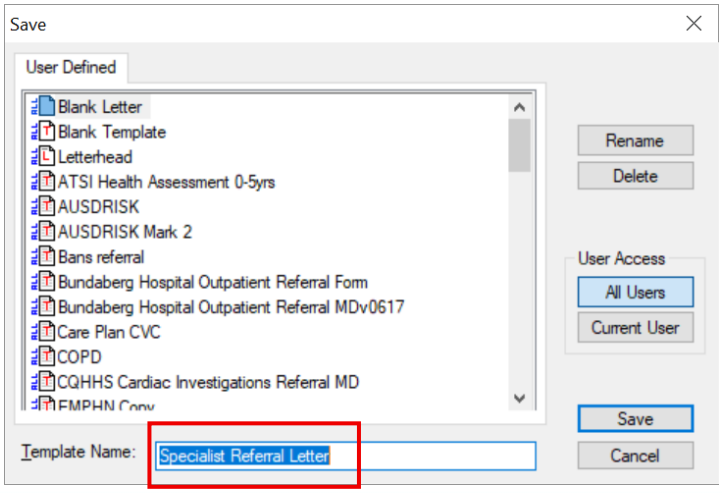
5 Select **File > Import**.

6 Navigate to where you have saved the template (e.g. desktop) and **doubleclick** on template.

7 **Click** on the **File** drop down menu and select **Save as Template**.

8 **Type** a name for your template and **Save**.





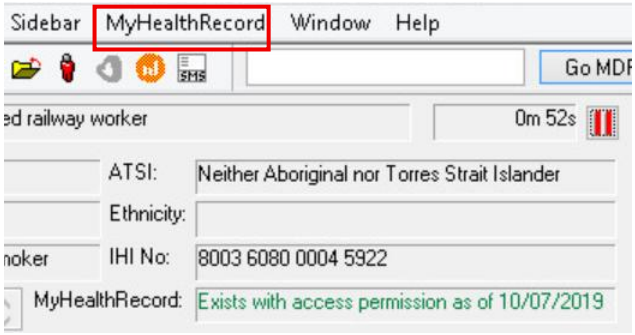
Topic 5 – Digital Health

My Health Record

Accessing My Health Record & Adjusting Filters

If your patient has a My Health Record this should be indicated in green in the demographics section of your patient record.

1 To access, click on the **My Health Record dropdown menu.**

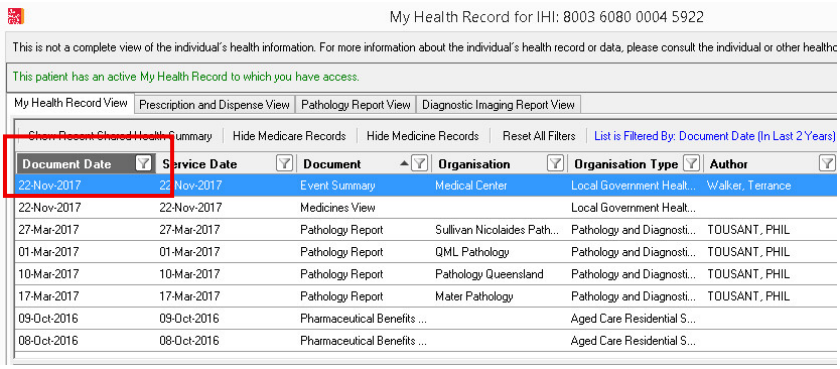


2 To enable faster retrieval of relevant documents you can change the filters. Click on the **filter icons**

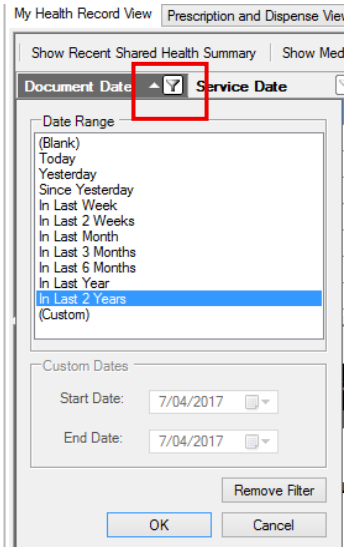


3 Select your preferred view. Default 'My Health Record View' will be set to 'In Last 3 Months'.

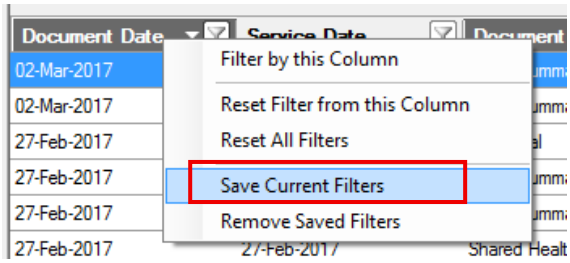
You can change the defaults: date range, document type, organisation etc to your preferred view.



4 Click **OK**

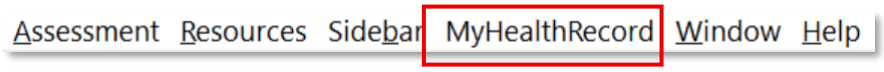


5 Save your preferred default filter by right clicking on the column heading and selecting '**Save Current Filters'**.



Accessing and saving documents in My Health Record

When Medical Director has been configured for eHealth ie all certificates and health identifiers loaded, you will be able to access documents that may have been uploaded to your patient's My Health Record directly from their patient record if they have ever created a My Health Record and have allowed access.



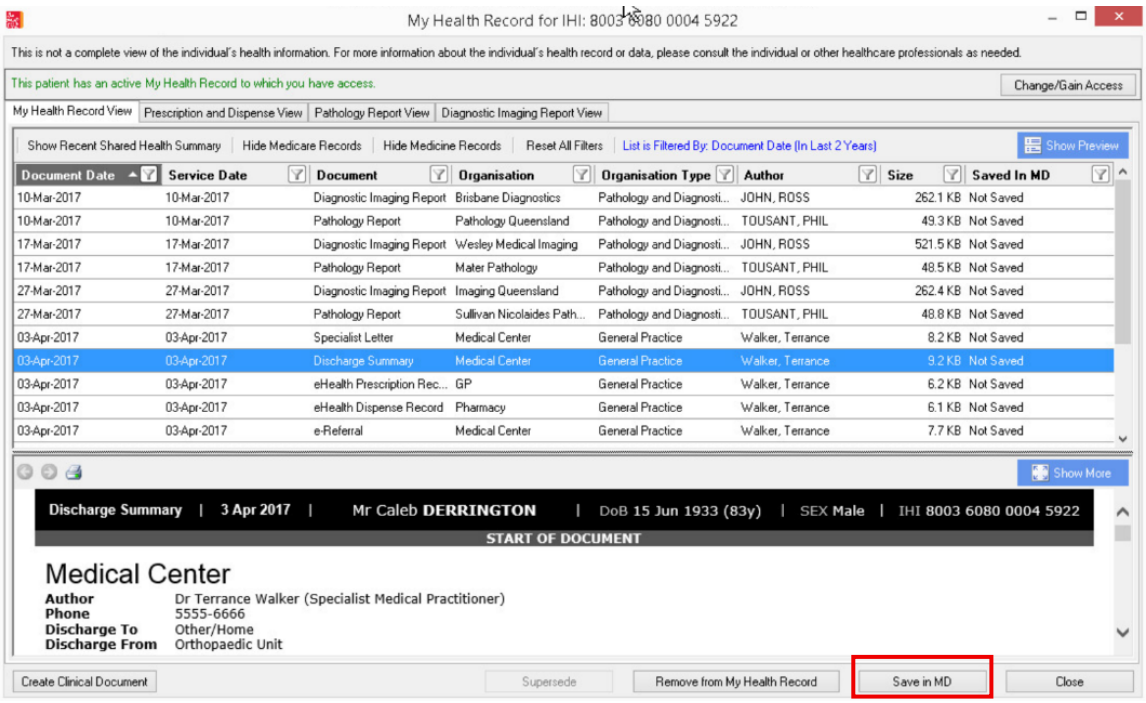
In order to view a My Health Record the patient's Individual Health Identifier (IHI) must be imported into their file (see section on IHI). This is often done when the patient record is created however MD will automatically search when you click on the My Health Record dropdown menu. You can also see if a patient has a valid IHI.

On the patient screen the MyHealth Record status will display as follows:

- **Exists requires access code as of DD/MM/YYYY**: The patient has a My Health Record record but it requires an access code. The patient has setup the access code for his/her My Health Record.
- **Exists with access permission as of DD/MM/YYYY**: The patient has a My Health Record record and you may access the patient's My Health Record.
- **Does not exist or not disclosed as of DD/MM/YYYY**: The patient either does not have a My Health Record or the My Health Record record is hidden.
- **IHI not recorded as of DD/MM/YYYY**: The patient does not have an IHI recorded.

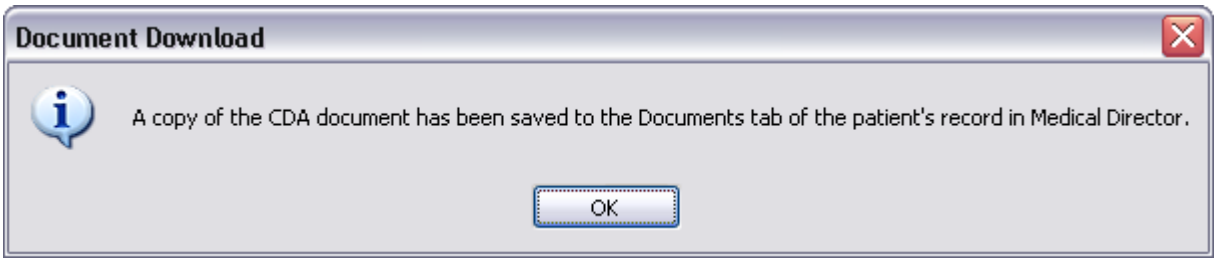
To view the patient's My Health Record:

1. Click on the dropdown menu **My Health Record**.
2. A list of documents the patient has had uploaded will appear including who they are from (Authorising Organisation and Author).
3. Find the required document in the list eg. Latest Shared Health Summary and **doubleclick to display the document.**



4 If you would like a copy of the viewed document select Save in MD.

This will be saved in the Documents section of the patient record.



Uploading documents to My Health Record

Preparing a Shared Health Summary

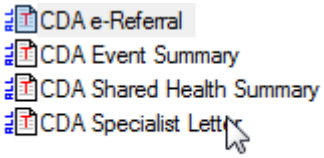
1 Open **Letter Writer (F8)**

2 Select **File > New Document**

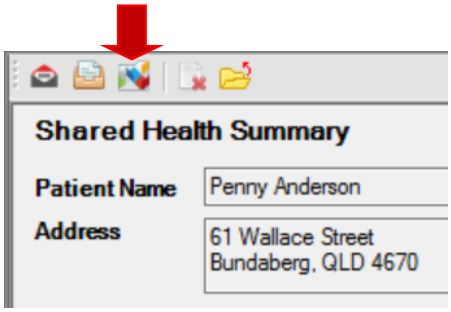
3 Double-click on **CDA Shared Health Summary** from the eHealth tab.

4 **Select the template** by double-clicking or clicking once then OK.

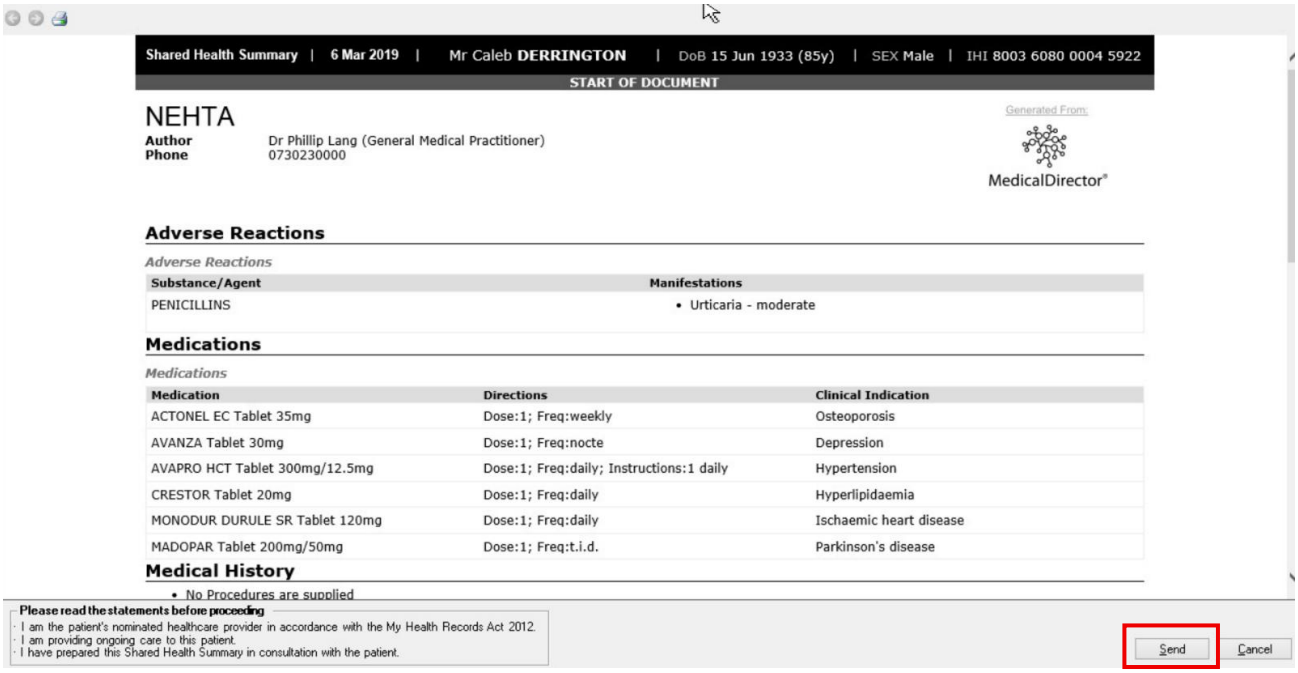
5 Edit the document as required.



Uploading Shared Health Summaries to the My Health Record



6 Once you have generated the patient's Shared Health Summary (or Event Summary etc) click on the **Send to My Health Record** icon (shown above). The document will display in full screen preview (shown below).



7 Click on **Send** button to upload to the patient's My Health Record.



8 Click **OK** and a copy of the Shared Health Summary you uploaded will be saved in the Letters section of the patient record.

eHealth/CDA Documents can also be sent electronically to other health practitioners via Secure Messaging eg. MD Exchange, Healthlink, Argus etc.

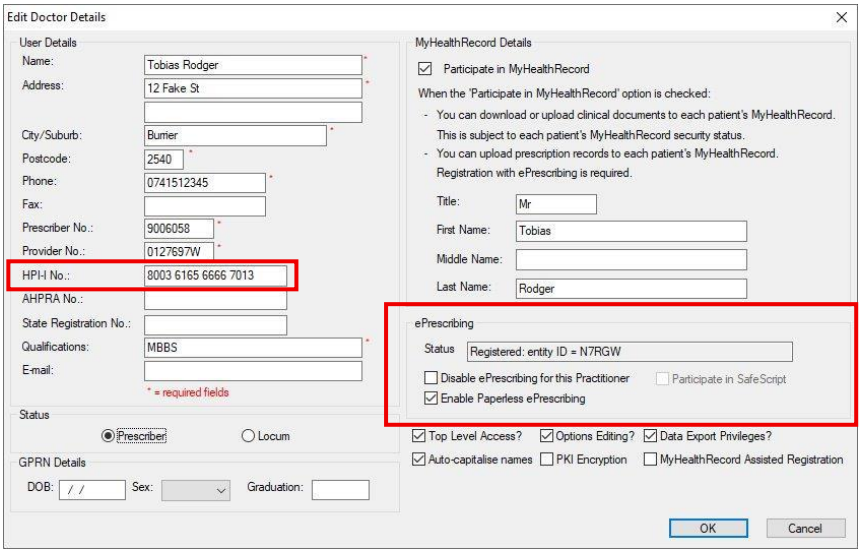
With MDExchange and Healthlink you can also upload to the patient's My Health Record at the same time if that is requested.

ePrescribing

Generate ePrescriptions

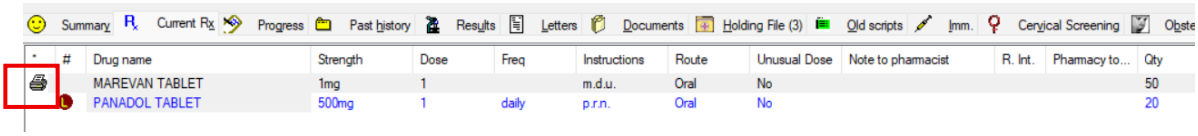
In addition to printing a paper prescription, it is possible to send an eScript from MedicalDirector.

MedicalDirector must to be configured for ePrescribing and each doctor set up with their Health Provider Identifier number (HPI-I) entered and Paperless ePrescribing ‘enabled’



Send an eScript

1 **Create a prescription as usual** – the medication/s will have a printer symbol to indicate they have not yet been printed/sent.



2 Select **Print** (printer icon at top of screen)

3 **Select the prescription delivery method**

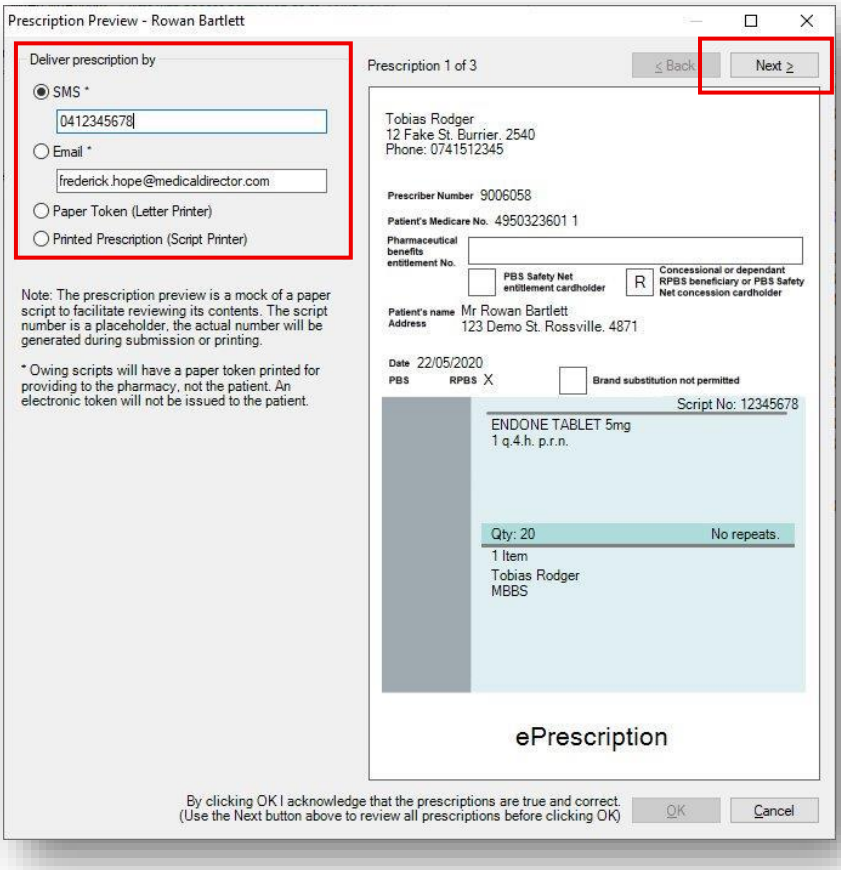
A suggested delivery method will be preselected for you. This selection is determined by information recorded on the patient's demographic as follows:



- If a mobile number is recorded, SMS will be preselected
- If no SMS but an email address is recorded, email will be preselected
- If neither mobile nor email is recorded, Paper token/Printed Prescription will be preselected.

4 Select **Next** to scroll through to the next script to be printed (if more than one script) in the list.

5 Select **OK.**



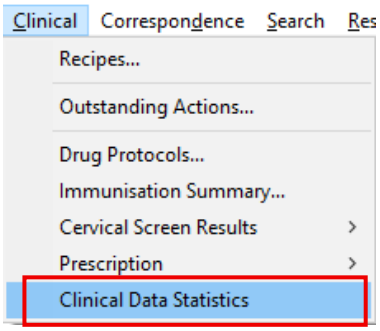
Topic 6 – Quality improvements

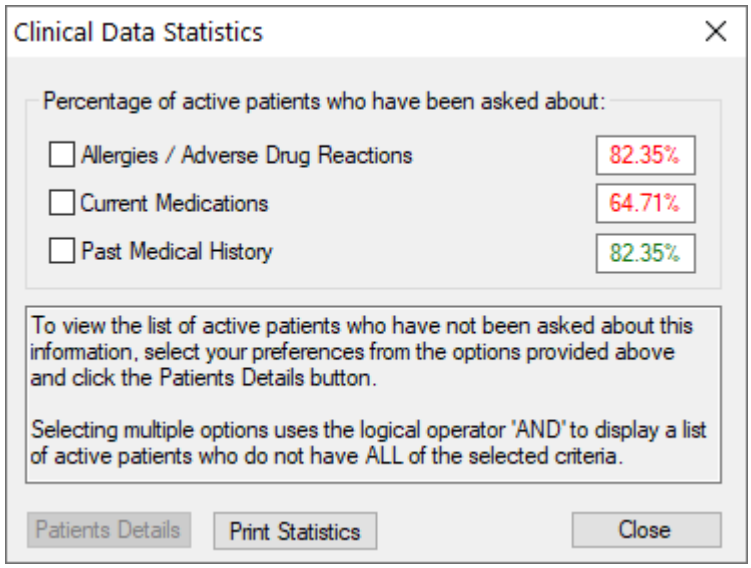
Using data for improvement

Regular data quality measurements

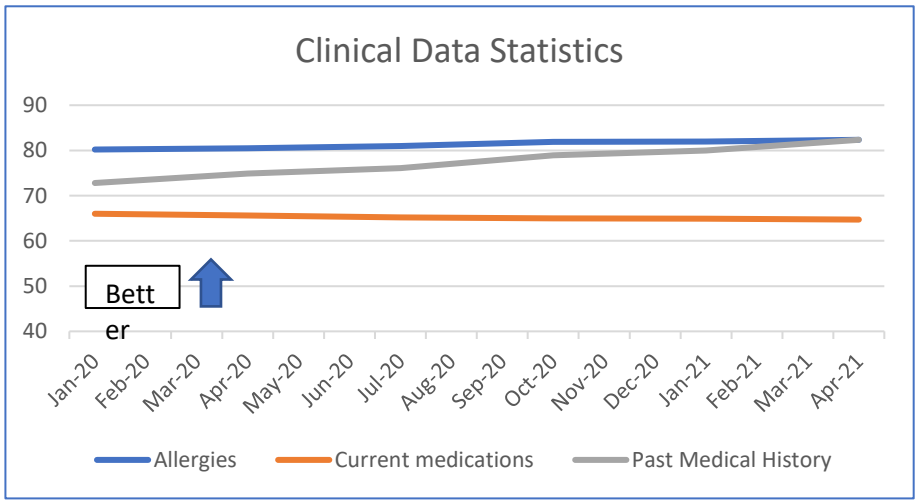
Regular measuring, monitoring and analysis of key metrics is important to helping you understand whether your practice improvement activities are working successfully.

MedicalDirector has an inbuilt tool (Clinical Data Statistics) that is accessible from the Clinical drop down menu. It provides a snapshot of the data quality and can be used to measure the percentage of patients that have been asked about Allergies, Current medications and Past Medical History. This can then be used to baseline data, monitor progress and improve these measures over time.





Sample 1 – Monitoring key metrics over time (including baseline)



Database searches

nKPIs & baseline data using database searches

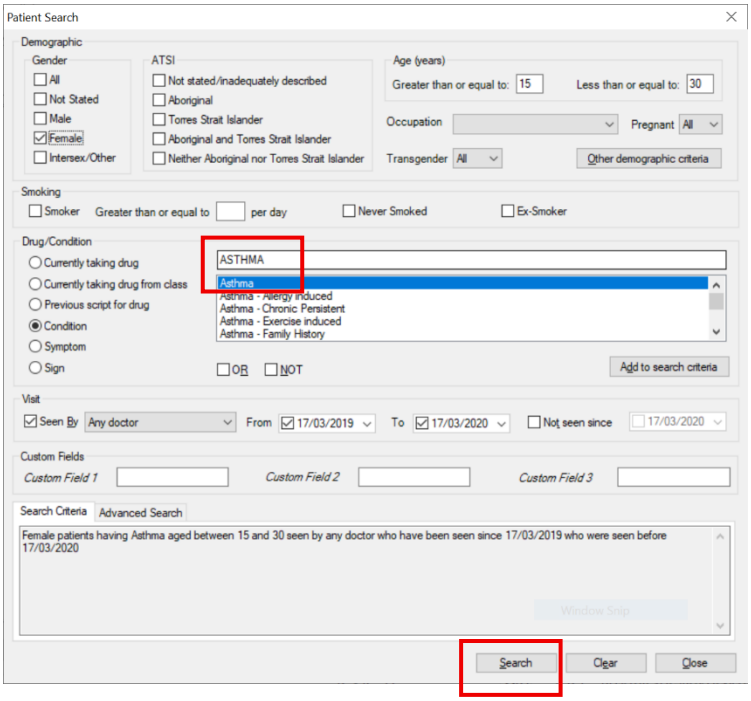
The **search** function in MD has enormous capability however this is a section where it is important that as much clinical data as possible is **entered** to enable advanced **search**ing.

Tip: Only information entered into the correct fields of MD will be searchable. For example code diagnoses in the Past History section. Also, enter 'signs' and 'symptoms' under the Examination tab in Progress Notes if you want to search for them.

There are specific inbuilt **search**es available from the main screen under the **search** drop down menu. The available menu options are: Patient, My Health Record Audit, Asthma, Diabetes Register, Immunisation, Cervical Screen Results, Pregnancy, Prescription, Recall, Influenza 'at risk', Pneumovax 'at risk'.

Customised Patient Searches

1. From the main menu, **click** on **Search**.
2. **Click** on Patient.
3. **Click** on fields relevant to your **search** e.g. age range, sex, smoker etc.
4. Select Add to Search Criteria
5. Select **Search.**

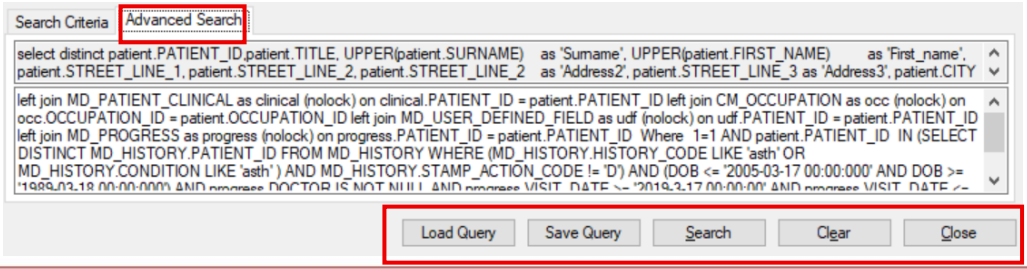


A list of patients matching the search criteria will be displayed on the screen.

Advanced Searches (SQL searches)

Select the Advanced Search tab to use the following options:

Load Query: to load and re-use a previously saved query from your computer
Save Query: to Save the current SQL query to your computer to use again. Name the query and save.
Search: Run the current query
Clear: Remove all SQL search details from the current window.



Sample QI Activities/PDSAs



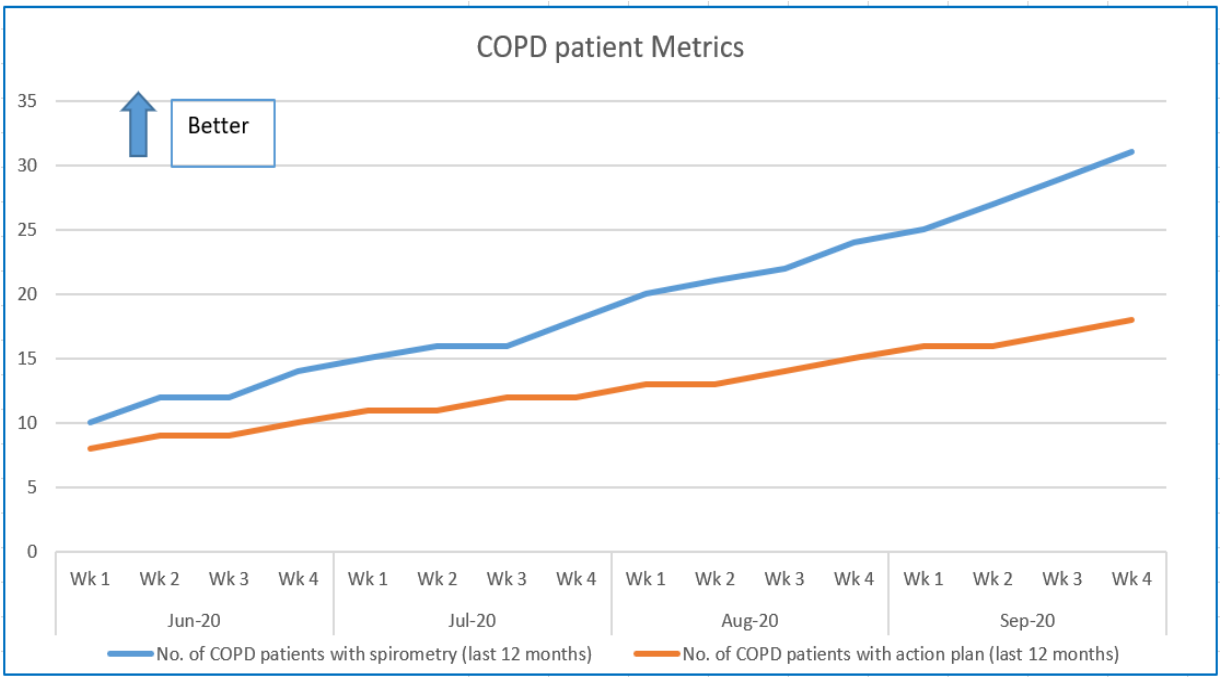
Sample 1 - COPD Quality Improvement Activity/PDSA

1. What is our goal?

Improve the ongoing management of patients with COPD through a patient centred, team-based approach.

2. How will we measure our progress?

1. Increase the number of patients with COPD who have an action plan by 25% by end of 2020.
2. Increase the number of patients with COPD who have recorded spirometry results by 40% within 6 months.



Next steps:	Team members:
• Build a register of patients with COPD (look for indicated diagnosis). • Implement spirometry recording integration in clinical software. • Source a suitable COPD action plan template for clinical software. • Recall patients with COPD and no action plan / spirometry recorded for last 12 months	Data collection/reporting: Recall Management: Spirometry Integration: Templates:

Sample 2 - Data Quality – Recording allergies and adverse reactions

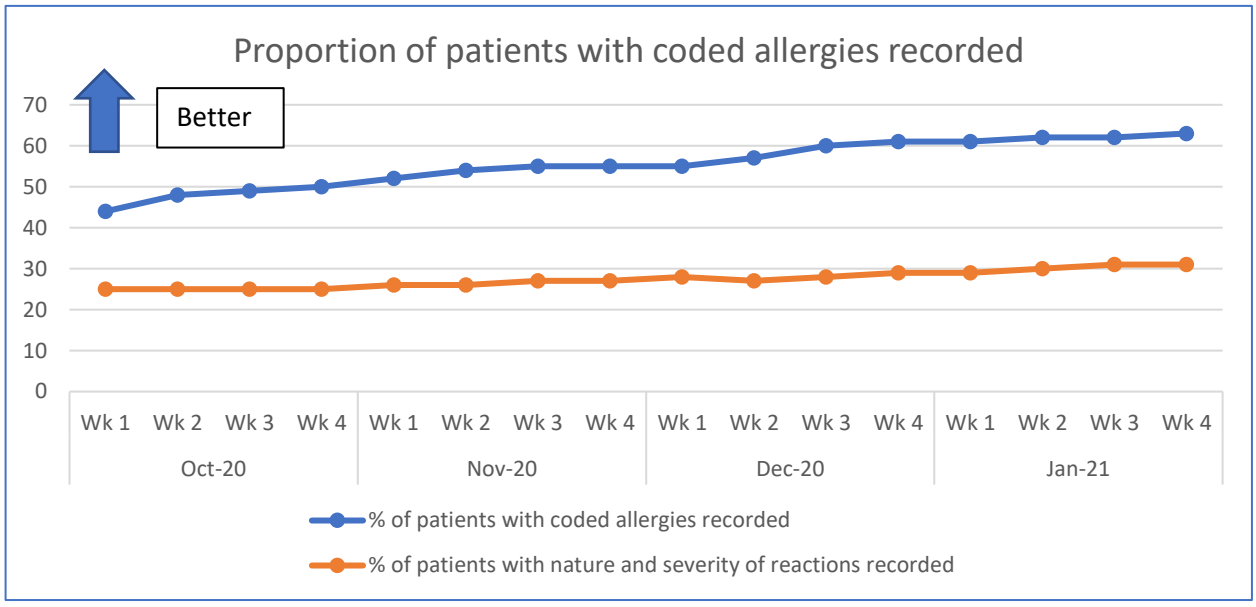
1. What is our goal?

Improve the recording of 'allergies and adverse reactions' in clinical software. Benefits:

- Improved safety for patients when prescribing medications (when coding is used and nature / severity of the reaction is included).
- Better compliance with RACGP accreditation standards (data quality).
- Improved comprehensibility of the patient record for other clinicians with whom the record is shared for ongoing treatment.
- Improved ability to search for patients with specific allergies, no known allergies and nothing recorded.

2. How will we measure progress?

1. Improve measure – proportion of patients with either coded 'allergy' or 'adverse reaction' data recorded or 'Nil known' checked will increase significantly in 3 months – date to be specified.
2. Quality measure – proportion of patients with 'nature' and 'severity' of reaction recorded will increase by 10% by DATE.



Ideas currently being trialled:

- Print a health summary for patients when they next present to check and update their allergy information.
- Provide training to clinical staff to record essential clinical data items for every consultation including the benefits of coding allergies.
- Print a list of all patients with No Allergies recorded and add an action to their record to flag when they next attend.
- Prepare a checklist of essential clinical data to be displayed in front of each clinician.

Team members –

Recording Metrics:

Determine baseline - current level of recording of coded allergies.

1. Consider tracking % of patients with no allergies recorded and Nil known not checked.
2. Track progress over time by measuring each month and tracking on a chart/graph.

Sample 3 – Uploading My HR Health summaries for vulnerable patients

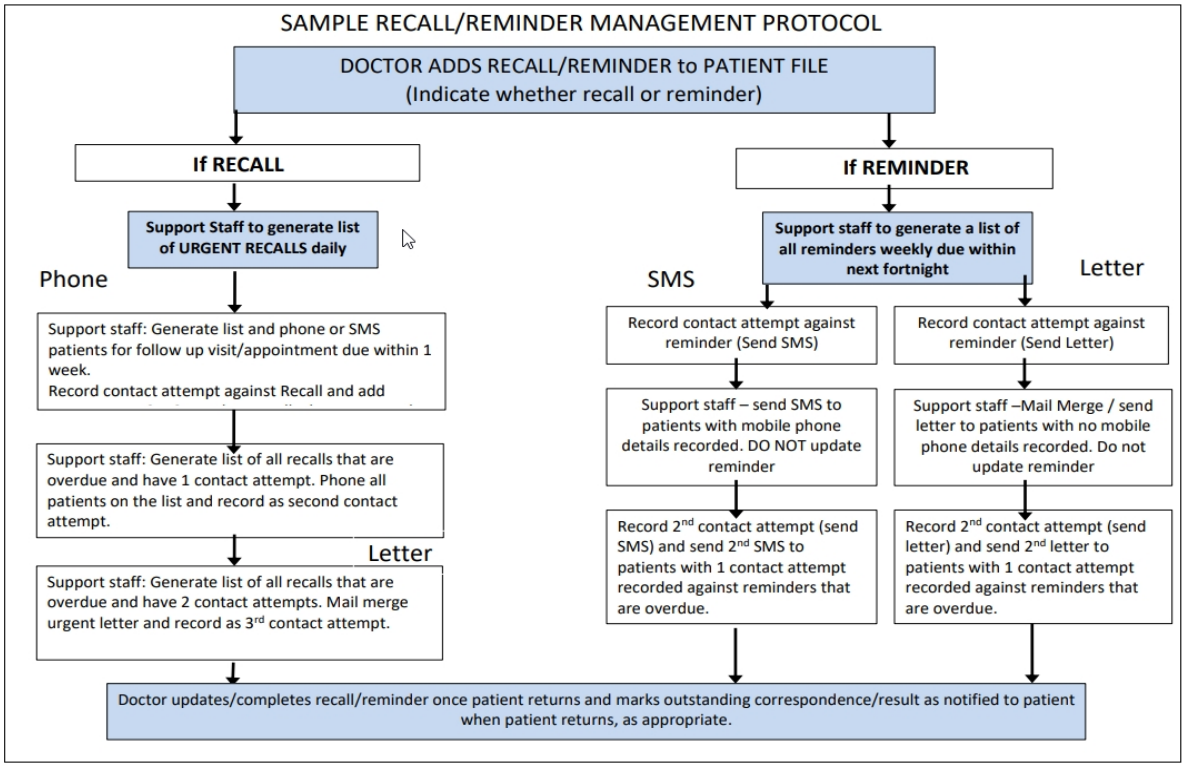
Step 1. The 3 Fundamental Questions

1. What are we trying to accomplish? **(By answering this question you will develop your goal for improvement)**
Improve the management of vulnerable patients through the use of digital health and in particular the use of My Health Record (as a method to share information) with a focus on vulnerable patients.
2. How will we know that a change is an improvement? **(By answering this question you will develop measures to track the achievement of your goal)**
The total number of Shared Health Summaries for 'vulnerable patients' uploaded to My health Record will increase by 10% each month for the next 6 months.
3. What changes can we make that can lead to an improvement? – list your ideas for change **(By answering this question you will develop the ideas you would like to test to achieve your goal)**
Idea 1 – Team meeting to define 'vulnerable' patients by agreeing criteria we will use to identify and flag patients in our software and to develop a plan of action. Idea 2 – Establish a register of 'vulnerable' patients Idea 3 – Review the register and check whether patients have registered for My Health Record and have a recent Shared Health Summary uploaded. Idea 4 – Retrain clinical staff on use of My Health Record Idea 5 - Book a telehealth consultation with GP and each vulnerable patient on the register Idea 6 – Upload a Shared Health Summary (as required) to ensure the most up-to-date information is available to other healthcare providers. Idea 7 – For patients that have opted out, ask if they would like to opt in and explain the benefits. Idea 8 – If GPMP in place, RN/AHW to follow up by telehealth to check on patients welfare periodically and upload new SHS as health summary information changes.

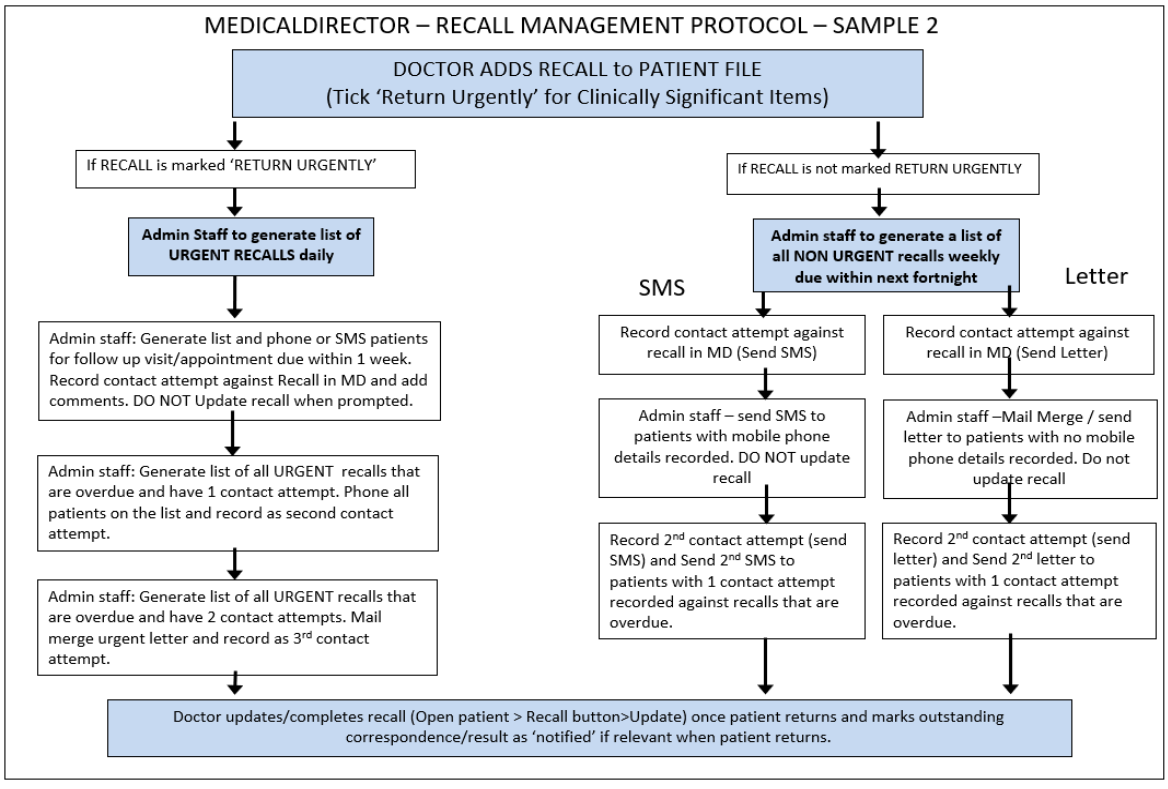
One Improvement idea I will share / trial

Appendix

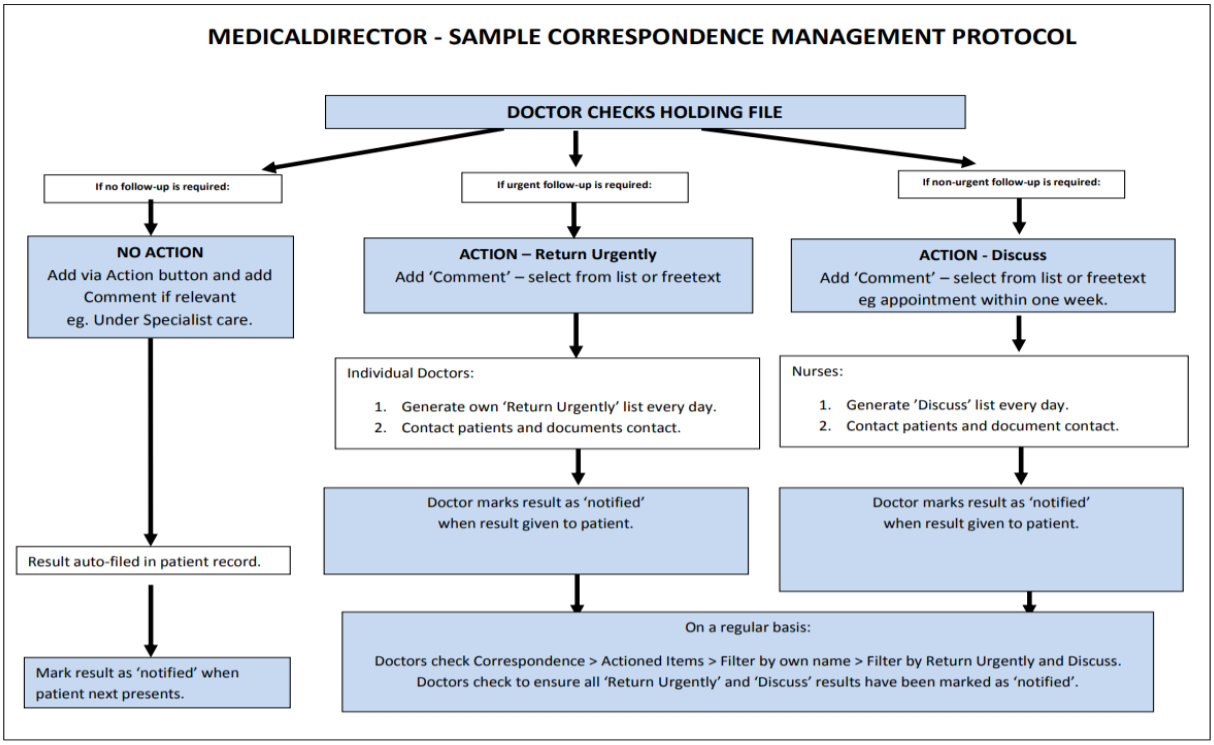
Sample 1 – Reminder Management Protocol



Sample 2 – Reminder Management Protocol



Sample 3 - Correspondence Management Protocol



Sample 4 – Correspondence Management Protocol

