



## 1.1 Online Electronic Health Record (EHR) Access system

Your practice has agreed to become involved in a project to allow patients to view their medical record via the internet. This document introduces some of the issues surrounding access to medical information and gives some advice on how to manage and administer this access.

### 1.1.1 What is the Online EHR Access system?

The online EHR access system allows patients to view the contents of their GP electronic medical record from any internet enabled PC using a web browser. Authenticated access to the record will be securely controlled using passwords and PINs issued to the patient specifically to allow them to view this information. During the course of this pilot, we shall be introducing an additional level of security called a 'one time use authentication token'. Once this becomes available, practices will be able to trial this as well, if they wish.

The patients will be able to view:

- A summary that gives them the most important and recent entries in their health record (e.g. allergies, current medications, active problems)
- Consultations including: date, practitioner seen, reason for visit, history, examination, outcome, investigations, etc. There is a facility to enable practices to start access to consultations from a date of their choosing.
- Medical Record showing diagnoses, investigations, and procedures.
- Patient Information Leaflets linked from the diagnoses in the consultation and medical record section.
- Results showing investigations such as blood results, liver tests, blood pressure, x-rays etc, with links to information leaflets .
- Vaccinations and medications.
- Letters to and from the GP.

The information is presented in a format that is easy to navigate and offers links to resources such as patient information leaflets about diseases, tests, investigations, support groups and medications etc. There are also links to websites such as NHS Direct Online and Patient.co.uk where patients can find additional information to help them understand and educate themselves about what they read in their health record.

In this initial phase of the project patients will only be able to view their information - they will not be able to add or change what they see in any way via the online system.

The Online EHR Access System Patient Information Leaflet gives more detailed information from the patient's perspective and should be read in conjunction with this document. The Patient Information Leaflet is a template and can be altered by the practice. The 'contract' is between the individual practice and the patient and therefore the practice has to be happy with the wording of the PIL and the consent form

### 1.1.2 Feedback from the Online EHR Access system

An important aspect of this project will be the feedback from the patients and staff at the various practices involved. The attached documentation will be useful to the clinical leads to organise this feedback.

## 1.2 Managing patients' access to the Online EHR system.

### 1.2.1 EMIS Clinical System

In the EMISaccess area of your EMIS clinical system you will be able to sign up patients for the Online EHR. This will issue the required PINs and passwords to allow access.

### 1.2.2 Patient Requirements

To use EMISaccess and the Online EHR system patients will require a PC with internet access and a suitable web browser (e.g. Internet Explorer version 6 or later). They will also have to have registered to use the system, consented and been given the required passwords and PINs.

## 1.3 Advice for registering Patients to use the Online EHR System

- Confirm patient has read and understood the Patient Information Leaflet (PIL). **Appendix 2**
- Confirm patient identity by asking name, address and date of birth and obtaining proof of identification (i.e. passport or driving licence) if necessary.
- Ask them to fill in and sign PATIENT CONSENT FORM. **(Appendix 3)**
- You may find it helpful to offer patients the document written by a patient who has successfully used the system for some time. **(Appendix 5)**
- The above approach is one suggestion. Alternatives are available. One is clearly described in a free DVD created by [amir.hannan@nhs.net](mailto:amir.hannan@nhs.net). Please contact him for details.

## Enrol a Patient

1. From the main menu, [select the patient as the current patient](#).
2. [Print the patient's login details](#). (Detail shown in Appendix 4)

Tip: You can customise the login details template for your practice stationery, provided that you do not change the mail merge fields containing the login details.

3. Give the document to the patient and tell them to visit the EMIS Access website and select Create Your Account on the main page.
4. On the website, the patient must enter the following information, in exactly the same format as on the registration form:
  - PIN number . This is only valid for one sign-up.
  - Practice ID. This is your EMIS practice number.
  - Access ID. This is the patient's user number on the EMIS Access system.
  - NHS number.
5. For extra security, the patient must enter the following information on an additional screen:
  - First name as shown on the registration form.

Note: This is not their calling name.

- Surname (last name) as shown on the registration form.
- Date of birth.
- Password. The patient needs a password to log on to EMIS Access. The patient should remember their password and keep it secret.
- Security question. The patient must select a question from the droplist and then enter their answer to the selected question. They may be asked to answer this question when they contact the practice with a query about their EMIS Access account.

When the patient has registered, they can use [internet appointments](#) and [patient messaging](#).

#### **1.3.1 See also:**

- [Enrolling Patients](#)
- [Managing Patients](#)

### **1.4 Information and advice for clinicians, practitioners and practices using the Online EHR System**

#### **1.4.1 Background**

The NHS Plan laid down the idea that patients should have access to their electronic health records and this has been reinforced recently. In addition, if we want patients to exercise more choice over their dealings with the NHS, then they need information about what is happening to them. Record access is a pre-requisite to empowerment.

A related initiative by the government is called Copying Notes to Patients, a process which the whole NHS was meant to embrace by April 2004. This access approach can circumvent the actual copying of letters.

#### **1.4.2 Evidence**

We have been showing patients their records on paper for many years, at Wells Park Practice. Our published experience, easiest to see at [www.icmcc.org](http://www.icmcc.org) which includes investigating the reactions of patients with cancer to seeing their records, suggests the following conclusions, so long as simple safety procedures are carried out, as described later:

- It enhances communication between clinician and patient.
- It increases the onus on the clinician to tell the truth
- It increases patient satisfaction
- It enables patients to correct data errors, the commonest ones being demographic data, but the errors can also be about clinical process and outcomes.
- Patients feel better informed and almost always reassured, even when they read bad news.
- Patients feel they understand about 70% of what they read.

#### **1.4.3 Safety Issues and recommended actions**

Our experience has been that these simple precautions avoid much risk. It does mean that whoever reads the letters or results needs to see them from a lay point of view.

- **Third party information:** The identity of the provider of third party information must remain concealed from the patient. The data that a third party provides can be seen by the patient. (For instance, if a wife reports the drinking of the husband but does not want herself to be identified) but the identity of the giver of that information must be kept away from the patient reading the record.

**We recommend that records are checked for third party information before access is enabled.** A common source of third party information is the child protection case conference (which is often full of third party information) and can be filed in the records of those who participated in the case conference who are patients of the practice. We suggest that the covering sheet of the case conference be placed in the index child's record, not the full record. This is open to discussion.

The system enables a practice to start allowing patients to see consultations only from a date set by the practice. Practices can thus ensure that they have safe recording methods in place to prevent patients' access to data that they do not have a right to see. **For further information, see Appendix 1**

- **Serious test results and potentially frightening letters** should probably be excluded until a face-to-face meeting. When reading letters or checking results, look for new frightening information that you feel patients should not be expected to see on their own without discussion and putting into context.

**We recommend that the practice should ensure that clinicians read letters and results before they are included in the records.** If this is not possible, the practice will be enabling patients to see information before it can be put into context by the practice.

- **Children.** There are no legal precedents that cover this area, except for the usual "Gillick competence" approach. It is essential that children's records are only seen by the parents/carers with the child's permission. Different surgeries have developed different policies. The simplest is that record access is only allowed for children over a certain age, say 10 years old. We recommend that access should be disabled when a child reaches 10. We shall be consulting on the best approach to this issue over the next few months.

#### 1.4.4 Changes in style and culture that may be needed.

- It would be helpful to write notes in as clear a style as possible. However, patients reading handwritten records say that they understand 70% of what they read.
- Derogatory comments are always unacceptable.
- All clinicians should be writing anyway as if patients can see whatever they write. Patients can obtain access to records on request, though GPs are allowed to charge for this access. Doctors can only censure access if:
  - may cause serious harm to the physical or mental health, or condition of the patient or any other person
  - may relate to or be provided by a third person who had not consented to the disclosure.
- Third party information given to clinicians needs to be handled carefully, for instance when a mother tells you about her son's behaviour and asks you to intervene without revealing your source. (See above and Appendix 1)
- Recording speculative differential diagnoses is only a problem if they have not been discussed with the patient.
- Do not write anything you don't want the patient to see. This open style does put a premium on honesty. It is best to explain that a colonoscopy is looking for cancer rather than write notes to yourself that a patient may see in the future.
- It is worth every member of the practice obtaining a reasonable understanding of the PAERS system in order to answer patient queries.

#### **1.4.5 Ways by which the system can save time**

- Patients can look at their results on computer (if you get your results by electronic links) without contacting reception.
- Patients can look at their immunisations on computer without contacting reception.
- Patients can arrive themselves without queuing at reception.
- Patients can read their letters without contacting a clinician.
- Patients can share information with family, carers and other healthcare professionals, reducing the requests for clinical information from the practice.

#### **Will there be an increase in consultation time?**

There may be concerns that patients will want more explanation and ask more questions. Our experience is that access appears to be time-neutral. Some patients do take longer, but research also shows that:

- access is used by patients to keep consultations short. They do this by looking at the data beforehand and only asking about things they need to ask
- one paper showed that there was no increase in time taken.
- The practice will save time when people can look up their information without consulting anyone at the practice: allergies, immunisations – for forms etc

#### **1.4.6 Increases in complaints?**

When patients see the thinking behind some of the decisions. There is no evidence for an increase in litigation as a result of access.

On the contrary, the evidence is good that relationships are improved

#### **1.4.7 Are patients made anxious?**

A small minority are, most are reassured. The group of patients who have the most difficulties are patients with psychiatric problems. Research suggests that this group is still pleased to have seen the information even if it upset them. Upset can be therapeutic.

#### **1.4.8 What if patients see errors in the records?**

Research suggests that, at the moment, if patients see errors, they tell no-one. We see access as improving record-keeping. Patients should be encouraged to report errors. The commonest are simple demographic errors (evidence suggests that most practices have 10% demographic errors). If patients can tell us about them (accurate mobile numbers for instance) that can help practices significantly.

If there are mistakes in diagnoses, they obviously need changing. The commonest is that a diagnosis is reported which turns out later to have been inaccurate, but the original Read code has not been deleted. That needs rectifying.

Sometimes people feel that the description of a discussion either with GP or consultant does not represent their recollection of the exchange. In that case, it seems quite legitimate to add a comment by the patient to that effect. We would never eliminate comments from the record (unless there is an incorrect diagnosis as discussed above)

#### **1.4.9 Is the record secure?**

The main risk to security in the current system is that an attacker might guess or steal a patient's account log-in information and use it to log-in themselves. This risk is higher if patients use weak passwords, fail to keep their passwords secret, use public computers or do not keep their home systems patched up to date and protected from viral and trojan software. Token based two factor authentication will mitigate much of this risk.

A simple study conducted in two surgeries suggests that about 3/4 of patients are content with a pin and password, while a quarter would prefer 2 factor authentication.

It is possible that members of the family, for instance, will be able to see records, perhaps by glancing over patients' shoulders or by coercing them. As with internet banking and other protected sites, once the record has been delivered, we can assume that the patient becomes fully responsible for its security.

**1.4.10 Collaboration with other practices**

It may be useful for practices involved in record access to encourage their PCT to create a committee that oversees the development of the process across the PCT. In Thameside and Glossop PCT, there is a Local Care Record Board that supports GPs who offer record access. In addition, it helps solve ethical or practical problems that arise. A useful contact is [amir.hannan@nhs.net](mailto:amir.hannan@nhs.net)

In general, there are an increasing number of practices involved in record access. EMIS can always put you in touch with others if you need advice or want to share any difficulties.

**PRACTICE CONFIRMATION BY SENIOR PARTNER**

I confirm that the practice as a whole has read and understood the contents of this guidance.

NAME:.....

SIGNATURE .....

PRACTICE NAME , ADDRESS, TELEPHONE  
NUMBER:.....

.....

.....

.....

EMIS CUSTOMER NUMBER .....

Please return this section of the form to:  
Rob Murgatroyd  
EMIS  
Fulford Grange  
Micklefield Lane  
Rawdon  
Leeds LS19 6BA  
.....

SUGGESTED GUIDELINES FOR RESPONDING TO THIRD PARTY INFORMATION AND RECORD ACCESS
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### **Definition**

3rd party info in this context means: "information about the index patient given to the clinician by a non-clinician".

### **Legal background**

The clinician has a duty to keep confidential the identity of the person providing the 3<sup>rd</sup> party information.

The clinician has a duty to put the data provided by the 3<sup>rd</sup> party in the index patient's record, ensuring that the identity of the giver of that information is kept out of the record.

### **Current practice in handling incoming letters**

Practices will continue to file 3rd party information arriving in letter form and it is important that they do so, as they may contain important data relevant to the patient's health.

Some practices file letters before having been read by the clinician, some file them after.

If letters are filed before being seen by the clinician, it is difficult to eliminate data that would identify the providers of any third party information.

A clinician seeing the letters first enables safeguards to be put in place, as well as being able to anticipate issues for the patient such as a change in medication.

### **Record Access creates a new situation**

If patients and practices without patient record access follow the current access law, there is time for the practice to examine the records for 3<sup>rd</sup> party information. Instant access means that admin systems need to ensure that what a patient sees is within the current legal framework.

### **Managing a 3<sup>rd</sup> party encounter face to face or on the phone**

For the majority of instances, it is sufficient to explain to the person giving you the information that the person to whom this information refers will be able to see it but the identity of the provider will be protected. Usually the giver of information will be content.

If that is not the case, then it may be possible to encourage honest discussion between the provider of the information and the index patient.

If that is not possible, explaining that it is the clinician's duty to record the information and protect the identity of the provider of information is usually sufficient.

### **Managing 3<sup>rd</sup> party information in an incoming letter**

If the practice reads letters before scanning them, 3<sup>rd</sup> party information can be handled by:

- Censoring the identity of the giver of information
- Keeping the letter out of the system, while ensuring that the clinician knows the letter exists, ensuring that the data is transmitted to the next practice when the patient moves.
- Writing to the giver of info perhaps to get permission for sharing.

It remains a risk to the practice if the practice scans letters without reading them first so that patients would be able to read letters before the clinician could make them safe.

### **IT solutions**

A cut-off date. Patients can see their summary record going back, but can only see detailed data after a certain date that can be set individually by each practice. This enables practices to reconfigure their administrative processes to ensure safety.

# Online Electronic Health Record (EHR) Viewing System

## Patient Information Leaflet and Consent Form

### Online Health Record Viewing System (EHR)

Our surgery is piloting a system that allows you to view your medical record using a personal computer (PC) and the internet. Before you can begin using the Online Electronic Health Record (EHR) viewing system we require you to register and consent to use the system.

### What is the Online EHR Viewing System?

The system is a website that allows you to view your medical record over the internet from a PC. It allows you to easily and quickly view the electronic medical information held about you by the surgery.

The information is presented to you in a format that is easy to navigate and offers you links to resources such as patient information leaflets about diseases, tests, investigations, support groups and medications etc. There are also links to websites such as NHS Direct Online and Patinet.co.uk where you can find additional information to help you understand and educate yourself about what you read in your health record.

### Registering and consenting to use the EHR viewing system

To be able to use the system you must have a PC with a web browser such Internet Explorer (version 6 or later) and have a connection to the internet.

You must also register with the practice and sign a consent form before you start using the system. Before you sign the consent form you should be happy that you understand what the system does, what your responsibilities are and how your data is stored. When you have had enough time to understand this you should consent by signature and hand the consent form to your GP receptionist.

Once you have consented you will be issued with a series of numbers that you must remember to allow you to access the system from any PC.

Any data held by the practice concerning you is subject to the regulations laid down in the Data Protection Act (1998). The consent is between you and your surgery.

### How do I use the Online EHR Viewing System?

Using your PC web browser enter the web address [yoursurgerywebaddress](#) and click the link "How To Register" for full illustrated instructions to setting up EMISaccess on your HOME PC.

Once you have signed into EMISaccess you must select the 'View Medical Record' section which will further prompt you to enter the password specifically assigned to allow you to view your online EHR.

When you have been correctly identified the system will allow you to view the parts of your medical record as described below. Use the menu and links to view each area of your medical record. There is an online help section to help you use the system.

### **What can I see on the Online EHR viewing system?**

The system allows you to view the following areas of your medical record:

- A summary that gives you the most important and recent entries in your health record.
- Consultations including: date, practitioner seen, reason for visit, history, examination, outcome, investigations, etc. Your practice may allow all patients access to this information only after a certain date. This is because they want to ensure that you cannot have access to information that you do not have a legal right to see. This is third party information – information given by someone else about you. It is very unlikely that the practice holds such information about you, but they may not want to take the risk and so will ensure procedures are in place to safeguard both you and third parties.
- Medical Record showing diagnoses, investigations, and procedures
- Allergies.
- Patient Information Leaflets linked from the diagnoses in the medical record section.
- Results showing all investigations such as blood results, liver tests, blood pressure etc.
- Vaccinations.
- Medications.
- Letters to and from the GP.

The system also allows you to send messages to your practice using a system in EMISaccess (if your practice has enabled this).

### **Why have an Online EHR viewing system?**

There are many reasons to provide you with access to your medical information. A few of them are listed below:

'We want to develop a culture of openness, honesty and trust; to ensure that patients have the information they need to make informed choices; and to enable patients to become equal partners with health care professionals in making decisions about treatment and care.' This is the response to the Department of Health from the enquiry into the Bristol Royal Infirmary Enquiry.

'Patients have the right to see their medical records, though in practice much communication between professionals is not available to the patient concerned. Patients often do not know why they are being referred, or what is being said about them' The NHS Plan. This practice believes that it is important for improved patient care and education that you are involved in your healthcare as much as possible

### **Advantages to you, the patient:**

- No queuing to get results
- You can check the accuracy of your medical record
- It empowers you to become more involved in your medical care

### **Where is my confidential medical information held whilst I am viewing my online EHR and who has access to it?**

The information you view on the online system comes from the clinical system at your surgery. Portions of this information are encrypted (this means it is very difficult for someone else to intercept and read the information) and securely sent from the GP practice system to your PC web browser.

None of the medical information that is shown on the online system is held permanently on any computer except the computer which holds the original data in your surgery.

When you log off from the online system or if a problem occurs with your computer, for instance a power failure, all your confidential medical information is cleared from the system.

Using the online system does not allow any extra people to view your medical information other than the people who would normally have access to it in the GP practice.

**How will other people be prohibited from seeing my record?**

To view your online EHR you have to identify yourself with passwords and PINs that only you know. Unless you reveal this information to someone else you will be the only person able to access your medical record via the online system

**What if I find an error in my medical record or if I see someone else's medical information?**

If you find any errors or missing information in your medical record you must inform the practice immediately.or discuss it with your GP. If you see someone else's medical information you should immediately exit from the system and inform the practice.

**Are there any risks for me?**

There may be something in your history you don't want any family members to see. It might be information you had put to the back of your mind and are now confronted with.

The record is designed to be used by doctors for doctors. There will be abbreviations and technical terms. However, most patients understand most of what they read and the information linked with problem titles offer detailed explanations. Please ask if you do not understand

Results can be difficult to understand. Results may be abnormal and cause you to worry. The system includes information about tests to help you.

You might want to tell the doctor something about your spouse/partner/child etc in confidence.

1. If the doctor records the information and the patient then sees this it could cause problems.
2. If the doctor doesn't vital information may get lost or forgotten
3. The information may be malicious and again cause problems

**What if I don't want to register to use the PAERS System?**

If you do not want to register to use the PAERS System you can still use all the practices' services exactly as before. Your decision not to register will not affect your treatment or your relationship with your GP practice in any way.

**REMEMEBER TO LOGOUT FROM THE SYSTEM WHEN YOU ARE FINISHED.**

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**Patient Pass Phrase:**

Please complete the consent slip below and enter a patient pass phrase which must be 8 characters long – alphanumeric (contains letters and numbers). This is needed, in order for you to access your medical records. PLEASE NOTE: this is an additional password and is only used for viewing your medical records.

.....**Cut Along This Line**.....

**Online EHR Viewing System**

**Consent Form**

I have read and understood the information leaflet about the Online EHR Viewing System and subject to the information in that leaflet, I consent to Wells Park Practice enabling me access to my electronic health record via the internet.

I further agree to use the system in a responsible manner in accordance with all instructions given to me by Wells Park Practice and to immediately report any errors I encounter whilst using the system. If I see any patient data which does not relate to me I will immediately log out and report the matter to Wells Park Practice.

Patient Pass Phrase..... (Note: Must be 8 characters – alphanumeric).

Signed.....

Print Name.....

Date of Birth.....

Date.....

## Guide to registering patients in EMISaccess V1.2 (12/12/2006)

### Registering Patients in EMISaccess

- STEP 1:**     **\*\*Ask for identification, i.e. driver's license, passport, utility bill...\*\***
- STEP 2:**     Ask patient for his or her name and D.O.B, and bring up in EMIS.  
(It's important you have the right patient up in EMIS before proceeding to the next step!)
- STEP 3:**     Type **EA** and then **E** to 'enroll patient'.
- STEP 4:**     **Print** the document.
- STEP 5:**     Click the button '**Save in patients record**', **un-tick 'Link to Consultation'** and click **Save**. You will see a message box appear that says, 'Document Saved. Exit MS Word back to EMIS', click **Yes**.

Hand the form over to the patient, just highlighting with your finger the important section which explains about '**Enabling Session Cookies**', as the patient needs to do this before they can use EMISaccess.

Go to Tools >> **Internet Options** >> **Privacy** >> **Sites** >> and type the following [www.e-mis.co.uk](http://www.e-mis.co.uk) click **allow** and **ok** then close explorer.

### Enabling Medical Record Viewing

If the patient expresses an interest in viewing their medical records, they have to read and sign the EHR Consent Form. After they have read and signed the EHR document and you have seen their identification (Above, Step 1), or if they've already signed-up for EMISaccess and they've answered their security question correctly, you may proceed;

- STEP 6:**     Type **EA** (EMIS access) and then **N** (Manage Patients).  
*If you've just registered the patient, he/she will probably be the last one in the list. If the patient has registered already on a previous date, you'll have to find them by following step 7.*
- STEP 7:**     Type **F** (Find Patient), and enter the patient name. Find the patient in the usual way.
- STEP 8:**     Type **D** and move your cursor down to '**Medical Record Viewer**', and change the status to **Y**.
- STEP 9:**     **F1** back and type **P** (Patient Pass Phrase). **Type in the 8 digit alphanumeric pass phrase** the patient chose on their consent form and hit **Enter**.
- Step 10:**     Write the patient pass phrase on the EHR Leaflet. (Not the consent slip you tore off).

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**THE PATIENT CAN NOW ACCESS THEIR MEDICAL RECORDS ONLINE.**

## 1.5 Registering to use the Internet Appointment Booking Facility

To use the Internet appointment booking facility you need to register at [https://access.e-mis.co.uk/signup/signup\\_a.asp](https://access.e-mis.co.uk/signup/signup_a.asp)

### IMPORTANT!

When first trying to setup an account and access EMISaccess, you may be prompted to enable **SESSION COOKIES**.

From Internet explorer, follow the procedure below;

Go to Tools >> **Internet Options** >> **Privacy** >> **Sites** and type the following **www.e-mis.co.uk** click **allow** and **ok** then close explorer. (Internet Explorer 4 upwards).

There are two registration screens. The information you enter on the first screen enables the system to check your identity when you log on. On the second screen you enter a password and security details that no-one else will know.

The information you need to complete the registration screens is shown below. Look after this form carefully until you register, and destroy it afterwards. If this form is lost or stolen before you have entered your password and security details, contact the practice straight away, by telephone or in person.

Remember to enter the information exactly as it appears on this form, or your registration will not be accepted. When you log on after registering you must also enter all details in exactly the same format.

Screen 1	
PIN	~[PIN]
Practice Number	~[CDB]
Access ID	~[Access_Id]
NHS Number	~[NHS Number]
Screen 2	
First Name	~[Forename]
Last Name	~[Surname]
Enter the other information yourself. Remember your password and security information, but do not write them down in identifiable form.	

After registering, you will be notified of successful sign-up and then automatically redirected to

<https://access.e-mis.co.uk> for you to sign-in and take advantage of our online facilities.

## APPENDIX 5

### A patient's guide to record access

This has been written by a patient who has record access in Manchester.

#### Advantages ☺ (A patient's perspective)

- GP/Healthcare** The patient has an active role in their own healthcare and develops a good relationship with their GP and Practice.
- Access abroad** You may be in another country and taken ill. You may decide to allow the doctor access to your records (a personal decision). It might be that you forgot to order your repeat prescription and need it to be ready on your return. You can do this by using an internet café.
- Casualty or outpatients** If you are going to see a healthcare professional in hospital you can allow them to see your records online if there is a computer in the room or print out the relevant information and take it with you. This can be very helpful to the consultant.
- Relatives having access** *Only if you wish* you could share all your records with relatives or just part by printing the part you wish to share.
- Saving Time** Blood results, x-rays or letters can be checked. If they are normal it saves you time not having to travel to the surgery. It also leaves a free appointment allowing the doctor to see someone who is in need of an appointment.
- Information for Forms** If you need to know when you had your immunisations or what allergies you have, you can look them up.
- Better understanding** If you did not understand the conversation with the doctor or nurse, you can look at the record of that consultation. Patients have found that that makes the discussion easier to understand and remember. You will also find that the information buttons explain technical terms for you. This can be extremely helpful.
- Medication Information** You can easily check information about any medication prescribed by clicking on the **blue 'i'** button listed next to your medication in the list. This also includes information on how to take the medication. You can check what results mean or check a condition and some help guidelines. There are links to support groups e.g. Diabetes UK.
- Security** It's as safe as internet banking ***IF*** you keep your passwords secure. You wouldn't leave your bankers card and pin numbers lying around (particularly at work) and then wonder how someone managed to withdraw money from your account. Don't leave your passwords where they can be found. This may also include at home if you don't want family members to view your records. Don't use obvious ones such as names, birthdays or anniversaries etc.

#### Disadvantages ☹

- Forgotten History** There may be something in your history you don't want any family members to see. It might be information you had put to the back of your mind and are now confronted with it!

**Complex information**

The record is designed to be used by doctors for doctors. There will be abbreviations and technical terms. However, most patients understand most of what they read and the information buttons linked with problem titles offer detailed explanations. Please ask if you do not understand

**Test Results**

Results can be difficult to understand. Results may be abnormal and cause you to worry

**3<sup>rd</sup> Party Info**

You might want to tell the doctor something about your spouse/partner/child etc in confidence.

4. If the doctor records the information and the patient then sees this it could cause problems.
5. If the doctor doesn't vital information may get lost or forgotten
6. The information may be malicious and again cause problems