SIDeR Shared Care Record User Guide

By using this guide you will be able to use the Somerset Integrated Digital electronic Record to view real-time health and social care data for your patient.

You will only be able to view client data if the patient has not opted out at an organisational level for external health and care staff to have access to their record. Patients can object by informing the relevant organisation.
For example, if the patient has opted out of sharing their mental health record via Somerset FT, you will NOT be able to view their mental health record at all. The patient would have to go back to Somerset FT and remove their objection before this can be made visible to you. There is nothing you can do locally to override this, even if the patient is with you and has changed their mind.

All user activity on SIDeR is audited, you cannot edit or delete audit trail entries.
While in your care and viewing the patient's record in your own EMIS system, open Pyrusium in a new window or tab. You will need to log in the first time, then your credentials will be remembered on subsequent occasions.
The **SIDeR record** will open for the current patient you are viewing in EMIS; read the disclaimer and acknowledge that you are using SIDeR for direct care purposes:

The summary screen is now displayed:
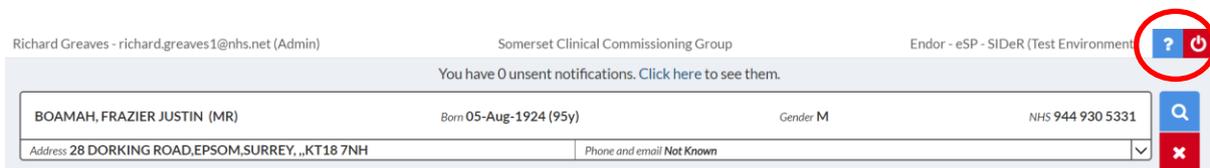
At the top of the page you can see your details, your organisation and the close icon.

Underneath there is a notification if an End of Life record has been created for your patient.

The patient banner bar contains patient demographic information pulled from the national spine, with the NHS number as the primary patient identifier used by SIDeR.

The summary screen shows **acute** and **repeat medications**.

Encounters show all contacts for this person across all Somerset health and care organisations connected to SIDeR. A colour coded graph enables you to quickly see their encounter history and identify a patient who frequently visits for support and care services.

Key **allergies** and **problems** (which include conditions) are also displayed.

Note: the summary screen only displays key **allergies**. To see ALL recorded **allergies** you will need to look in the relevant organisation tabs:

Hover over the end of the line on the colour coded strip and it will reveal which organisation provided the data (the colour matches the relevant organisation colour on their tab above):

Morphine sulfate 10mg/5ml oral solution. 300 ml. 21-Feb-2019	2.5ml - 5ml up to qds for extra pain relief. watch for constipation	GP System
Monuril 3g granules sachets (Profile Pharma Ltd). 1 sachet. 14-Feb-2019	As Directed	

The **alerts** tab contains patient alerts deemed important by health and care professionals

To see more detail from each organisation, click on the relevant organisation tab.
Please note that as of 1st April 2020 SomPar and TST merged to form Somerset NHS Foundation Trust; however on SIDeR they will maintain two tabs as they have different clinical systems.

GP Record   SMH = St Margaret's Hospice
YDH = Yeovil District Hospital
SCC = Somerset County Council (will be sharing data from April 2021)
SFT = Somerset Foundation Trust (SFT Acute was formerly TST, SFT Comm & MH was formerly Somerset Partnership) – data from Somerset FT will be shared soon.

Note: If no information exists, that organisation's tab will be greyed out and crossed out.
Glossary:

Acute Medication = single prescriptions of medication issued in the past 28 days

Repeat medication = ongoing medication repeated at regular intervals

Problems = conditions including previous events (e.g. MI, stroke and procedures)

Encounters = contacts/appointments/attendances