	Accreditation Specification	Notes GPIT	Notes Vendors	Point Accreditated	Points marked with a star in column A are not tested until integration is complete, integration with state bodies will not occur until all other fields have been tested and passed
	Pre Test				
*	The contract between Vendor and GP-Defining support maintenance and training				
*	Statement on Vendor's Approach to Confidentiality				
*	Procedure on access to patient data and business of the practice				
*	Signed Undertaking to do available training for all system functions in RFC 2022				
*	Partnership agreement for training for signature by both supplier and the practice and how training to be carried out				
*	Licence for any drug database to be used				
*	A contract binding to supply users updates to drug databases				
*	An Escrow setting out the source code, data structure and documentation is to be available to users				
*	Evidence of registration as a company				

*	Evidence of current business insurance and professional indemnity insurance			
*	Tax clearance certificate			
*	Document to respect role as data processor			
*	Copy of data sharing agreement between Vendor and GP			
*	Methods to ensure ongoing quality of work development for analysis, coding and testing			
	Self assessment of testing against RFC 2022, identifying improvements, timelines and priorities for development			
	Testing			
	Tested on three networked computers	Not for cloud based software		
	Preloaded with 200 patients			
	Networked with printer			
	Support Contract			
*	Procedures for dealing with support and maintenance calls			
*	Clause to protect the confidentiality of all data relating to patients and practice business			
*	Provide documentation, including users manuals			
*	Suppliers undertaking to provide training to GPs and support staff			
*	Include a contract to give updates for ICD 10 or drug databases			

*	Escrow specifying the third party to hold all system source code and documentation versions, if no longer commercially viable	Understanding needed for pre-accreditation, contract in place for full accreditation		
	Help Desk			
*	Help desk available between 9-17:30 on weekdays			
*	System for logging calls outside operational hours			
*	Facility for supporting remotely			
*	Provide documentation on known faults, with plans to correct faults and release dates for corrections			
*	Provide online FAQ and user manuals			
	User Manuals			
*	General overview of the product			
*	Detailed functions of all modules			
*	Describe instillation, backup and audit			
*	Provide quick reference guides to carry out essential functions			
	Patient Record			
	Create a single record for each patient			
	Allow storing more than one identifier for each patient			
	Assoc key identifiers with each patient record			
	Uniquely identify a patient and tie the record to a single patient			
	Provide availability to link or merge patient records if more than one created for a patient			
	Ability to mark an accidental clinical entry			

	Provide the ability to match the information if incorrect to the correct patient file			
	Allow retrieval using other identifiers like GMS number			
	Ability to inactivate a patients record where applicable			
	Provide means to enter a consultation after the system is offline			
	Mandate the minimum registration data			
	Minimum Data- First/Family name/ DOB/Gender/2 lines of address/registered doctor			
	Manage Demographics			
	Capture demographics as part of the patient record			
	Store and retrieve demographics as discrete fields			
	Retrieve demographics as part of the patient record			
	Ability to update demographics			
	Present a set of identifying information at each interaction with the patient record			
	Collect the data range shown in Patient demographic data P27			
	Collect NOK data as specified on P28			
	Collect Carer data as specified on P28			
	Collect Eircode as part of the address			
	Collect PPS numbers			
	Capture all information defined in the HIQA standard demographic dataset			

	Data from external sources			
	Capture external data and documentation			
*	Receive and store the full range of healthcare messages from Healthlink in HL7XMLV2.4			
*	Display all HL7 messages received			
*	Integrate messages into the individual patient record			
*	Facilitate manual integration of HL7 messages			
*	Ability to correct matching errors in HL7 messages			
	Ability to receive, store and display scanned documents as images			
*	Incorporate Healthmail functionality into patient records			
	Capable of interacting with web services			
*	Create and consume structured messages in compliance with HIQA messaging standard			
	Summary Record of Care			
	Present summarised views of the patient's EHR			
	Present the patient's smoking and drinking status			
	Patient History			
	Ability to capture, update and present patient history			
	Capture pertinant family history			
	Indicate if condition is active or not			

	Capture patient preferences of language, religion and culture			
	Capture patient consentand authority for treatments			
	Capture that patient has withdrawn consent			
	If patient unable to consent then name those giving consent			
	Allergies			
	Capture true allergy, intolerance and adverse reaction, to drugs and other triggers			
	Capture the reaction type			
	Capture NKDA for patients			
	Enable deactivating allergies and reason why			
	Capture date allergy was recorded			
	Medication Lists			
	Ability to capture, display and report patient specific medication lists			
	Capture date, dose, route, quantity of prescribed medication			
	Enable capture of medications not prescribed from the software			
	Present the prescriber			
	Mark a prescription done in error			
	Enable a medications list to be printed for the patient			
	Signal that a medication list exceeds the viewed screen or printed list	Not relevant as not printing GMS prescriptions		
	Medications orderd directly from the medication list			
	Manage Problem Lists			

	Capture display and report all active problems			
	Capture, display and report a past history of all problems			
	Capture the onset date of the problem			
	Capture the source, date and time of all updates to problem list			
	Provide ability to deactivate a problem			
	Provide ability to display inactive or resolved problems			
	Immunisations			
	Capture, display and report all patient immunisations			
	Include date, type, batch number, manufacturer, exp date, site given, method of admin and dose			
	Prepare a report of patients immunisation history			
	Manage Assesments			
	Provide ability to create assesments			
	Use standardised assesments where they exist			
	Ability to doccument using standard assesments			
	Ability to capture data relavent to the standard assesment			
	Present Guidelines and Protocols for planning care			
	Ability to present current guidelines to clinicians creating plans for treatment and care			
	Manage Patient Specific Care and Rx plans			

	Ability to capture patient specific plans of care			
	Provide ability to use previously developed care plans to create new care plans			
	Ability to track updates to a plan of care			
	Provide ability to transfer care plans to other care providers			
	Manage Prescriptions			
	Provide ability to generate prescriptions			
	Generate GMS and private scripts for once off and repeat prescriptions on different needed stationary			
	For under 12 the childs age in years and months will be displayed on the prescription			
	Capture user and date stamps for all prescription-related events			
	Have ability to update the medication list			
	Ability to search for both brand and generic name and include both in the results, must include Irish Generic products			
	Maintain a descrete list of orderable medications			
	Utilise a recognised and established drug database and update at least every quarter			
	Provide ability to reorder a script without having to re-enter all the data			

	Confirm check and report allergies, drug/drug interactions to drug interaction tracking,			
	Provide patient specific dosing and warnings when new medications are added to existing			
	For repeat scripts, alert prescriber maximum number of repeat scripts issued or review date has been met			
	Provide a facility to record hand written scripts			
	Support practice-specific formularies			
	Allow searching for brand name and generic medications			
	Must include prescribers Medical Council registration number			
	No advertising for medications permitted			
	Manage Orders for Diagnostic Tests			
	Provide ability to capture orders for diagnostic tests			
	Provide matching of outgoing requests with incoming results			
	Enable printing labels for request forms and specimen bottles			
*	Provide the ability of generating a HL7 2.4XML order message			
*	Provide a placer order numberwhen communicating to the lab fulfiling the order			
*	View active orders for a patient either rad/lab, and all orders			

*	Ability to display outstanding orders for multiple patients			
	Manage Referrals			
	Allow capture and communication referrals to other providers both internal and external to the organisation			
	Capture clinical details as needed for the referral			
	Capture insurance information for the referral			
	Present captured referral information			
	Support referral templates including HIQA/ICGP template			
*	Track electronic referrals and generate alerts for referrals that have not been acknowleged			
*	Generate a structured HL7XML v2.4 referral message			
*	Generate and send an ack message after the hospital sends the referral response message			
	Provide a view of referrals by the practice or individual GP, to see an overview of referrals for a patient			
	Medication Administration			
	Present a list of medications to be administered			
	Display timing, admin route and dosing of all medication on the list			

	Capture medication administration details include timestamps, observations and reasons why a medication was not given			
	Immunisation Administration			
	Provide ability to recommend immunisations based on immunisation guidelines			
	Check for potential adverse or allergic reactions for immunisations when they are given			
	Capture the immunisation administration details			
	Record as descrete data elements data associated with any immunisation			
	Capture and update the immunisation schedule produced by NIAC			
	Provide an immunisation report of those given			
	Enable a printed return for fee claim			
	Hold a list of vaccines avaliable to the practice, including type, manufacturer, batch number and expiry date			
	Ability to inactivate a vaccine when expiry date has passed			
	If expired vaccine given, the event should be tracked with a warning so appropriate action can be taken			
	Capture consent and objection to vaccination			
	Manage Electronic Results			

*	Provide the ability to present numerical and non-numerical current and historical test results to the appropriate provider			
*	Provide the ability to filter the results			
*	Filter abnormal results where an abnormalresult flag is displayed in the message			
*	Facilitate the management of tasks by providers associated with resultssuch as: seen, signed off, delegate to named GP or Practice Nurse, phone patient, write to the patient, visit patient etc			
*	Facilitate patient communication of results, such as information by phone, letter, SMS text or email, that result is: normal, needs repeat,needs review appointment			
*	Provide the ability to filter results for a unique patient			
*	Provide the ability to filter results by factors that support results management,such as type of test and date range			
*	Allow group tests done on the same day			
*	If the system containsthe electronic order, THEN the results SHALL be linked to a specific order			
*	Provide the ability for providersto make notes on a result			
*	A note must be clearly identified as originating from a defined user and not a part of the original result			

	system SHALL NOT allow a user to overwrite original data in a result			
	Manage Display of results			
*	The Vendors SHALL work with the laboratory to attain this standard defined in regional laboritories.			
*	Provide an initial display of messages before integrating them into theindividual patient record			
*	The initial display SHALL be of the data provided in the message according to the display guidelines or XML stylesheet provided by the message sender.			
*	The system SHALL indicate normal and abnormal results based on data supplied from the original source			
*	Flag results have been received but have not been reviewed			
	Manage Patient Clinical Measurements			
	Capture patient vital signs such as blood pressure, temperature, heart rate, respiratory rate, and severity of pain as discrete elements of structured or unstructured data			
	Compute and display percentile values when data with normative distributions are entered			
	Display height and weight in Imperial and S.I. units, configurable by the user			
	Manage Clinical Documents and Notes			

	Provide the ability to capture clinical documentation including original, update by an amendment to correct, and addenda			
	Provide the ability to capture free-text documentation			
	Provide the ability to view other documentation within the patient'slogical record while creating documentation			
	Provide the ability to update documentation before finalising it			
	Provide the ability to finalise a document or note			
	Provide the ability to attribute,record and display the identity of all users contributing o or finalising a document or note, including the date and time of entry			
	Manage Antinatal and postnatal care			
	Provide the ability to capture all data relevant to ante-natal and post-natal care			
*	Integrate with the hospital MN-CMS IT system			
	Capture user and date stamps for all assessments and interventions			
*	Capture all medication prescribed/discontinued and vaccinations given in the past year			
	Generate the required output for antenatal and postnatal care, particularly the maternity claim form			

	Generate and Record Patient Specific Instructions			
	Provide the ability to generate instructions pertinent to the patient for standardised procedures			
	Provide the ability to generate instructions pertinent to the patient based on clinical judgment			
	Provide the ability to include details on further care such as follow up, return visits and appropriate timing of additional care			
	Provide the ability to record that instructions were given to the patient			
	Provide the ability to record the actual instructions given to the patient or reference the document(s) containing those instructions			
	Clinical Decision Support			
	Document the standard assessment in the patient record			
	Provide access to health standards and practice appropriate to the EHR user's scope of practice			
	Provide the ability to access health assessment data in the patient record			
	Use national immunisation guidelines to manage immunisation administration as part of planned care and opportunistically			

	Provide the ability to access care and treatment plans that are sensitive to the context of patient data and assessments			
	Identify patients eligible for healthcare management protocols based on criteria specified within the protocol.			
	Allow including or excluding a patient from an existing healthcare management protocol group			
	Provide the ability to audit compliance of selected populations and groups that are the subjects of healthcare management protocols			
	Identify patients who are on a specific drug in the event of a drug recall			
	Provide the ability to present protocols for patients enrolled in research studies			
	Provide the ability to maintain research study protocols			
	Provide the ability to present patient guidance and reminders appropriate for self-management of clinical conditions			
	Provide the ability to manage and develop patient guidance and reminders related to specific clinical conditions			
	Medication and Immunisation Management			

	Check for and alert providersto interactions between prescribed drugs and medications on the current medication list			
	Relate medication allergies to medications to facilitate allergy checking decision support for medication orders			
	Provide the ability to prescribe a medication despite alerts for interactions or allergies			
	Provide the ability to identify an appropriate drug dosage range, specific for each known patient condition and parameter at the time of medication orders			
	Provide the ability to automatically alert the provider if contraindicationsto the ordered dosage range are identified			
	Provide the provider's ability to override a drug dosage warning			
	Alert the user while prescribing when the dosage exceeds the recommended dosage for the indication or any indication			
	Present alternative medications treatments based on practice standards, cost, formularies, or protocols			
	Orders Results, Referrals and Care Management			
*	Alert for a result outside of a standard value range			

	Provide the ability to include clinical and administrative data (e.g. insurance information) as part of the referral process			
*	Provide the ability to include test and procedure results with a referral			
	Health Maintainance: Preventitive care and Wellness			
	Establish criteria for dentifying preventive care and wellness services based on patient demographics (e.g. age, gender). For example, recommend required immunisations based on patient profile and risk factors, including age, time since last vaccination (e.g. pneumococcal) and risk groups for influenza vaccination			
	Present alerts to the provider of all patient-specific preventive services that are due			
	Provide an alert or prompt when smoking statusis not recorded in the patient record or was recorded more than a year ago			
	Operation Management and Communication			
	Provide the ability for users to create manual clinical tasks			
	Provide the ability to automate clinical task creation			

	Provide the ability to modify and update task status manually (e.g. created, performed, held, cancelled, pended, denied, and resolved)			
	Provide the ability to prioritise tasks based on urgency assigned to the task			
	Provide the ability to link a clinical task to the component of the EHR required to complete the task			
	Provide a link between a patient’s record and any outstanding tasks for that patient.			
	Provide the ability to track the status of tasks. This includes attributessuch as completed, outstanding, assigned and unassigned			
	Provide the ability to notify providers of the status of tasks			
	System is used to enter, modify, or exchange data, guarantee that the sources and receivers of data cannot deny that they entered/sent/received the data			
	Provide the ability to document, in text format, in the patient record verbal/telephone communication between providers			
	Incorporate scanned documents from external providers into the patient record			
*	Provide the ability to share clinical information (e.g.referrals) via secure email or other electronic means			

*	Electronically communicate orders between the prescriber, provider and pharmacy, as necessary, to initiate, change, or renew a medication order			
*	Receive any acknowledgements, prior authorizations, renewals, inquiries and fill notifications provided by the pharmacy or other participants in the electronic prescription and make it available for entry in the patient record			
*	Provide the ability to collect accurate electronic data from medical devices according to realm specific applicable regulations or requirements			
	Provider Access Levels			
	Provide a registry or directory of all personnel who currently use or access the system			
	Contain the legal identifiersrequired for care delivery, such as the doctor's medical council number and the nurse's registration number with An Bord Altranais			
	Provide the ability to add, update, and inactivate entriesin the directory so that it is current			
	Contain the data items shown in the Provider Data table below in the provider access directory or staff database			
	Practice Locations			
	Contain the information shown in the Practice Data table			

	Contain information necessary to identify primary and secondary practice locations or offices of providersto support communication and access			
	Provide the ability to add, update and archive information on the provider's primary and secondary practice locations or offices			
	Provide the ability to add, update and archive information on related organisations			
	De-Identifying Data			
	Conform to IN.1.9 (Patient Privacy and Confidentiality) and provide de-identified data views per scope of practice, organisational policy and legislation			
	Conform to IN.2.4 (Extraction of Health Record Information), Conformance Criteria #2 (The system SHALL provide the ability to de-identify extracted information)			
	Manage Appointments			
	Possible for users to define session types and locations			
	Be possible to browse the appointments slots to find a free slot to make patient appointments when browsing			
	Indicate as a minimum free slot (and available to be booked): those which are booked and those which have a booking availability constraint in effect			

	Allow multiple or partial slots to be booked for a patient			
	Allow an appointment to be booked for a patient that is not fully registered with the practice			
	Allow a previously booked appointment to be cancelled			
	Be possible to mark an appointment as ‘patient Did Not Attend’ (DNA)			
	Not allow a booking to be made to an appointment list that has been cancelled			
	Provide facilities to track a patient’s status throughout their appointment from arrival to departure			
	Be possible for the performer to make new appointments and amend or cancel existing appointments for the patient being seen			
	Allow reporting and printing appointment lists for one or more performersfor a user-specified range of dates			
	Possible to identify all patients who have DNA’d within a date range and have DNA’d more than a user-defined number of times			
	Manage Scanned Doccuments			
	Scanned doccuments be linked to an entry in the electronic patient record			

	Show the date, type of scan letter, Consultant name, Institution and Identity of the person doing the scanning			
	Store the image file in an appropriate file format, such as Tag Image File Format (TIFF) or Joint Photographic Experts Group (JPEG)			
	If (OCR) is used, the system SHALL facilitate storing the original scanned image file	Unlikely to be used anymore		
	Maintain a comprehensive audit trail of the scanned image			
	Measurement, Analysis Research Reports			
	Export or retrieve data collected overspecified time intervals required to evaluate patient outcomes			
	Provide data detailed by GP, practice nurse or other selection criteria			
	Define outcome measuresfor specific patient diagnoses			
	Provide the ability to export or retrieve data required to assess health care quality, performance and accountability			
	Produce an anonymous report for all patients diagnosed in a specified timeframe.			

	support: Anonymous data (de-identified); Practice level reporting (all consultations); The ability to custom report in terms of dates covered and diagnoses (all or specify); The ability to select data fields for inclusion or require a minimum dataset			
	Minimum dataset SHALL include the following variables: ID, age, sex, GMS status, county/postcode, date of consultation, diagnosis code and text			
	Allow the following additional data to be selected for inclusion: Symptoms, reason for encounter, medications prescribed, procedures, treatments, investigations,referrals, tests ordered			
	Report Generation			
	Provide the ability to generate reports consisting of all and part of an individual patient's record			
	Generate structured clinical and administrative data reports using internal or external reporting tools			
	Provide the ability to export reports generated			
	Provide the ability to specify report parameters based on patient demographic and clinical data, which would allow sorting and filtering of the data			

	Provide the ability to support the processing of ad hoc queries and reports of structured clinical and administrative data through either internal or external reporting tools			
	Disease Coding			
	Provide the ability to access pertinent patient information needed to support coding of diagnosis, procedures and outcomes			
	Entry Authentication			
	Authenticate principals before accessing an EHR-S application or EHR-S data.			
	Prevent access to EHR-S applications or EHR-S data to all nonauthenticated principals			
	Provide the ability to create and update sets of access-control permissions granted to principals			
	Provide EHR-S security administrators with the ability to grant authorisations to principals according to the scope of practice, organisational policy, or jurisdictional law.			
	Provide EHR-S security administrators with the ability to grant authorisations for roles according to the scope of practice, organisational policy, or jurisdictional law			
	Define system and data access rules			

	Enforce system and data access rules for all EHR-S resources (at component, application, or user level, either local or remote)			
	Timestamp initial entry, modification, or data exchange and identify the actor/principal taking action required by users' scope of practice, organisational policy, or legislation			
	Provide additional non-repudiation functionalityrequired by users' scope of practice, organisational policy, or legislation			
	Secure all modes of EHR data exchange over which it has control			
	Secure Data Routing			
*	Automatically route electronically exchanged EHR data only from and to known sources and destinations and only over secure networks			
	Provide the ability to associate any attestable content added or changed to an EHR with the content's author (for example, by conforming to function IN.2.2 (Auditable Records)			
	Provide the ability for attestation of attestable EHR content by the content's author			
	Indicate the status of attestable data which has not been attested			
	Patient Privacy and Confidentiality			

	Fully comply with patient privacy and confidentiality requirements according to a user's scope of practice, organisational policy, or legislation			
	Provide the ability to maintain varying levels of confidentiality according to users' scope of practice, organisational policy, or legislation			
	Provide the ability to mask parts of the electronic health record (e.g. medications, conditions, sensitive documents) from disclosure according to the scope of practice, organisational policy or legislation			
	Provide the ability to override a mask in an emergency or other specific situations according to the scope of practice, organisational policy or legislation			
	Back Up			
	Have the capacity to backup data. This includes patient data and associated information such as templates, guidelines, protocols and configuration information	Not relavent to cloud based systems		
	Initiate backup as part of a semi-automatic or automatic routine			
	Provide documentation to assist a user in doing a test restore			
	Health Record Management			
	Allow storing and retrieving health record data and clinical documents for the legally prescribed time			

	Provide the ability to retain inbound data or documents (related to health records) as received. Initially (unaltered, inclusive of the method received). The legally organisationally prescribed time per users' scope practice, organisational policy, or jurisdictional law			
	Retain the inbound data content (related to health records) originally received for the legally prescribed time			
	Audit Capabilities			
	Provide audit capabilities for recording access and usage of systems, data, and organisational resources			
	Provide audit capabilities indicating the time stamp for an object or data creation, modification and extraction			
	Provide audit capabilities indicating the time stamp for an object or data exchange			
	Provide audit capabilitiesindicating the time stamp for an object or data view			
	Provide audit capabilities indicating the time stamp for an object or data deletion			
	Provide audit capabilities indicating the author of a change.			
	Provide audit capabilitiesindicating the viewer of a data set			
	Provide audit capabilities indicating the data value before a change			

	Provide the ability to generate an audit report			
	Provide the ability to view change history for a particular record or data set according to users' scope of practice, organisational policy, or legislation			
	Maintain a comprehensive audit trail of scanned image files to facilitate the shredding of documents by practices			
	Extraction of Health Record Information			
	Provide the ability to extract health record information			
	Provide the ability to de-identify extracted information			
	Data Portability			
	The system SHALL have the facility to allow export of patient-related information into: A text file, and A "CSV" type file where the field lengths, separators, content, column headings, definitions etc., that are used are fully described in the documentation			
	Contain all data stored in the system either for a selected individual patient or the entire practice population at the user's discretion			
	Include the audit trail,scanned documents and attached documents			
	Standard Terminologies			

	Provide the ability to use ICPC-2 and either SNOMED CT or ICD-10 to code consultations and clinical care elements (Need ICD10 for sick certs)			
	Provide a user-friendly interface to facilitate coding with ICPC-2and either SNOMED CT or ICD-10			
	Where appropriate codes are not available, the system SHALL provide facilities to enter a local or temporary code			
	Provide the ability to use different versions of terminology standards			
	Provide the ability to update terminology standards			
	Allow cascade terminology changes where coded terminology content is embedded in clinical models (for example, templates and custom formularies) when the cascaded terminology changes can be accomplished unambiguously			
	Changes in terminology SHALL be applied to all new clinical content (via templates, custom formularies, etc.)			
	Standards Based Interoperability			
*	Provide the ability to use interchange standards as required by realm-specific and local profiles, such as laboratory messaging and out-of-hours messaging			
*	Use interchange agreement descriptions when exchanging information with partners			

	Business Rules Management			
	Provide the ability to manage business rules, pull data from different sections			
	Data Returns U6			
*	Interface, via web services, with PCRS to check patient registration before data return			
*	Provide an efficient and user-friendly method for the GP or all practise staff to input the whole dataset as part of periodic assessments or cycle of care consultations. In particular, there SHALL NOT be a need for double entry or transcribing of data by staff			
*	Only allow data returns to the schedule agreed in the contract			
*	NOT allow partial returns of data to PCRS			
	Implement data validation for height and weight entries to prevent GP or practice nurse data input errors			
*	automatically include Relevant laboratory results in the data returns for the diabetes care cycle			
*	Support real-time and batch data returns for periodic assessments and cycles of care			
*	Receive and process an ACK message for each patient data return submitted			
*	Display error messages from ACK messages and support the system user in interpreting and resolving these errors			

*	Support identifying and recalling patients due the periodic assessments or cycle of care reviews			
	MNCMS			
*	Display discharge summary messages from MN-CMS using the Healthlink style sheet			
	Support the HIQA 'National Standard for Patient Discharge Summary Information' (03/07/2013)			
*	Display the patient identifiers contained in the discharge summary messages from MN-CMS			
*	Display, in a readable format, the free-text comments contained in the discharge summary messages from MN-CMS			
	IHI			
*	Import the modified GMS panel list from PCRS			
*	Decrypt the IHI number			
*	Validate the IHI number (position 17 modulus 11 check digit and position 18 GS1 check digit)			
*	IHI number (18 digits) SHALL be stored in a single field in the GP practice software management system database			
*	Sending electronically to other information systems, for example, in an eReferral or barcode, the GP system SHOULD transmit the complete decrypted IHI number, that is, the entire 18 digits			

*	Displaying the IHI on-screen or printing a document, the GP system SHALL show the decrypted core number, i.e. nine digits plus modulus 11 check digit in positions 8 to 17 of the complete IHI number in the format 3-3-4.			
	Be consistently displayed at all times with the GP system			
*	Have the capacity to purge or clear out all IHI numbers seeded to GPs in a practice.			
	eReferrals			
*	Support electronic cancer referrals for breast, lung, ovarian and prostate cancer			
*	Support general electronic referrals			
*	Support specialist referrals using the integrated browser technology. These include pigmented skin lesions, endoscopy and ophthalmology referrals, COVID Hub/Swab referrals			
*	Integrate eReferrals and associated structured messages into the individual patient electronic record			
*	Conform to the Healthlink message specifications for Cancer, General and Specialist referrals.			
	Healthmail Integration			

*	Enable a link to a general practitioners/practice Healthmail account. The sign-in details will be automated at subsequent attempts to send Healthmail messages when the clinician is signed in			
*	When software is used to transmit an electronic prescription, sending the email SHALL only be possible with licensed staff to prescribe medication, i.e. the GPs and Nurse prescribing staff			
*	Provide an auditable trace of who was logged into a workstation when a Healthmail message is sent			
*	Link to a Healthmail account and the logged-in user SHALL only be made when the user clinician is signed into the practice management software			
*	Be a function of attaching files like letters, photographs, ECGs, etc to Helathmail messages			
	Electronic Prescription Transfer			
*	Ensure that only Healthmail can be used for electronic prescription transfer			
*	Enable a link to a general practitioners/practice Healthmail account. The sign-in details will be automated at subsequent attempts to send Healthmail electronic prescriptions when signed in			
*	Only be possible with staff licensed to prescribe medication, i.e. the GPs and Nurse Prescribers			

*	Provide an auditable trace of who was logged into a workstation when a Healthmail prescription is sent			
*	Prescriptions generated for electronic prescription transfer MUST display the patient's date, name, address, and GMS number (if applicable)			
*	Display the quantity and dosing rate			
*	Contain the name, address and IMC number of the prescriber			
	Opiate Substitution Treatment prescriptions can not be generated through ePrescription transfer. They need to be completed on their proper prescription pads but can then be scanned and emailed to the pharmacy using Healthmail.			
	Social Welfare sickness certs			
*	Enable sickness certification messaging to the DEASP through HL7_V2.4 messages			
*	Allow the user to select the time of illness in the number of weeks			
*	Record a log of sickness certificates given out to include the clinician, certification dates and the illnessin the patient clinical notes			
	Chronic Disease Management Program			
*	Interface, via web services, with PCRS to check the registration status before data return			

*	Collect the data fields required for the CDM returns and send the data as HL7 V2.4 message through Healthlink. Two parallel messages will be automatically generated containing the demographic data to the PCRS to stimulate GP reimbursement. The anonymised clinical data will go to an HSE data repository			
*	Ensure that agreed clinical fields be collected from the patient's baseline details to populate the CDM message automatically			
*	Relevant blood tests have been recorded in the previous six months, their results be populated in the investigation fields of the CDM message.			
*	Message SHALL NOT be transmitted until all agreed clinical fields have been captured			
*	Build an individual patient care plan that can be reviewed/updated and printed off for the patient			
*	Incorporate relevant clinical calculators, like QRISK, CHADsVASC2 etc. and auto-populate, where possible, any data fields within the calculators			
*	Receive and process an ACK message for each patient data return submitted			

*	Display error messages from ACK messages and support the system user in interpreting and resolving these errors			
*	Maintain a log of what messages have been submitted and accepted or rejected			
	COVID Vaccination Messaging/ Reimbursable flu and pneumonia vaccinations			
*	Capture the PPS number for contracted payments and improve the IHI matching			
*	Patients with no designated PPS number, there SHALL be the option of alerting in the message the patient has no PPS number			
*	Enable capture of the mRNA vaccine's use-by dates and the vials batch number and expiration dates			
*	Dose number SHALL be captured and differentiated if an increased number of vaccines are required to attain primary immunity instead of follow-up booster doses			
*	Collect either a mobile phone number for the patient or an email address to facilitate Department of Health distrubiting COVID vaccine passports			