

Livewell Southwest

SystemOne Operational Policy

Version No.1

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

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SystemOne Operational Policy

1. Introduction

- 1.1 The Department of Health (DOH) in 2000 set out a national programme for Information Technology and the delivery of that programme was handed over to the government agency Connecting for Health (CFH). The CFH agency acting on behalf of the NHS assigned implementation to local IM&T teams with support from consulting Accenture.
- 1.2 The chosen clinical software for Livewell Southwest (LSW) is The Phoenix Partnership (TPP) SystemOne Community Modules and Mental Health Module, widely known as TPP or S1. This will be replacing the ePEX service user information system. The need to replace the ePEX System (which has been in place for 23 years) creates an opportunity to put in place a single integrated information system. Its aim is to replace the mix of paper and computer-based recording with a holistic information system that integrates between disciplines. The ability to gain immediate access to clinical data means healthcare professionals from a variety of services can work seamlessly together to deliver the best patient care.
- 1.3 The implementation process will be approximately eighteen months from when the initial services go-live.
- 1.4 This Policy will be reviewed regularly and updated in accordance with any policies and procedures that are referred to and as they are updated too. It is the responsibility of service leads to update any local operational policy to reflect the implementation of SystemOne.
- 1.5 The first area of deployment was the Minor Injuries Unit which went live on 9th December 2013. Since then SystemOne has been deployed through the majority of LSW services. The final stages of the roll-out will see SystemOne deployed to the newly acquired services in South Hams & West Devon and Adult Social Care.
- 1.6 SystemOne will not replace ePEX for those Services that have NOT gone live yet. The functionalities and processes stay the same for those staff within the organisation until they go live.
- 1.7 The project implementation and subsequent rollout programme, with the assistance of a Clinical Change Lead, will define the end of ePEX functionality other than 'Read-Only' and Alert/Warning sharing on both systems.
- 1.8 A data migration of information from ePEX to SystemOne took place on the 7th of July 2014 for mental health and LD services (including CAMHs) and for Orthotics, Prosthetics, Long Term Conditions (LTC) and Adult Speech and Language Therapy (SLT) in November 2014. All migrated data should be checked against original data held in ePEX to check the accuracy/validity particularly in relation to waiting list entries caseloads and staff roles.

1.9 Any information that needs to be collated for Serious investigations/ court proceedings / complaints or death may need historical information to be taken from ePEX rather than SystmOne.

2. Purpose

2.1 The purpose of this framework is to provide all staff with consistent guidance and rules that will help improve the following: patient care, data quality, recording principles, measurement of Referral to Treatment times (RTT), the capture of clinical activity and provide evidence to improve income streams and link with the Payment by Results (PBR). It will also highlight some issues that users of SystmOne should be aware of regarding the quality of data that can be seen in SystmOne.

3. Duties

3.1 Governance Group

The policy will be monitored and reviewed by the SystmOne Governance Group. The group consists of SystmOne administrators, information governance representation and community services representation. Use of the system will be audited and monitored, particularly in relation to data quality, record-keeping and use of such functionalities as tasks and reports. The group will also provide any updates required/requested on SystmOne and govern any rule changes for recording SystmOne codes. Any requests for specific code changes should be agreed within the service and then submitted by a designated lead to the SystmOne Governance Group by an email to the Chair of the meeting.

3.2 Staff

Staff are responsible for following this policy and highlighting to Team Leaders and Service Managers any difficulties.

4. Training

4.1 Getting Started

4.1.1 Before using SystmOne, all staff are required to be issued with a Smartcard and undertake the formal End User Training (EUT) programme for that service and to be deemed to be competent in the use of the system.

4.2 Smartcards

4.2.1 Smartcards are about the size of a credit card and have an integrated chip, which makes sure that SystmOne users have the appropriate access to the information they require to carry out their job. Access to SystmOne is gained when the Smartcard is inserted into a reader and a PIN is entered. Each service has a specific template of access rights applied to it and the workgroup (unit) access rights.

4.2.2 Process during Community implementation

- Staff in the services being rolled out will be contacted by the Registration Authority (RA) to arrange the appropriate forms for registration.
- RA will ask Service Manager's/Team Leads to nominate a sponsor who will be able to 'unlock' cards (See section 18).
- Staff will either visit RA on-site at Mount Gould Hospital Admin building or RA will set up sessions for that service to complete the paperwork.
- The RAO1 form is completed which Line Managers are required to sign.
- After initial go-live, further rollout services going live will be given the Smartcard at the training session.
- New users to services' already gone live will be issues with smartcards only after training.

4.2.3 Proof of identity must be provided for the RAO1 form to be completed, this is made up of the following:

- Photo ID – for example photo card Driving License or passport.
- Active in the community document – for example bills or bank statement.

4.3 EUT

4.3.1 Appropriate End User Training (EUT) for that service group will be provided by Professional Training and Development. The training starts with ensuring staff that require training have the appropriate IT skills. This is important because it enables the staff that will use the system to be confident and to be in line with others in the system training. EUT will only be provided, once a Training Needs Analysis (TNA) has been completed. TNA involves the basic IT skills and also provides a clear indication of the modules that are required for each group of staff.

4.3.2 For services in the implementation process, the training team will deliver a pilot delivery to appropriate staff which will be a 'road-test' of the training and materials. Training materials are module specific, area to area. The training team will work with the service lead to develop a training schedule that supports the service that is going to use the system.

4.3.3 Training will be delivered in the IT training rooms at Beauchamp Centre. Bookings for training will be made with the Professional Training and Development Department. Only those indicated for training will be allowed to book training.

4.3.4 All training is evaluated by training attendees which is reported back to the training lead.

5. Procedure

5.1 Data Quality

The data contained in SystemOne is only as efficient as the information recorded by clinical staff. Therefore the information should be relevant, clear, timely and accurate. To enable accurate reporting required by LSW, all service user's registered, must be matched to the spine with their relevant NHS number.

5.2 Minimum Data Entry

All clinical staff working within the community that have had SystemOne implemented must record the following details:

5.2.1 For Clinical Activity

- All service users must be registered.
- All referrals must be entered for all clinically relevant events except for 'one-off' contacts eg. Duty tel.'calls and MHA Assessments'.
- Allergies recorded.
- Contacts (events recorded).

5.2.2 For Reporting Purposes

- All service users must be registered and discharged in a timely manner.
- All referrals must be recorded.
- 18 week Referral to Treatment (RTT) guidelines to be adhered to. See 5.5.4 below.

5.3 Record keeping Standards

All data entered onto SystemOne should adhere to LSW's Records Management Policy.

5.3.1 Best practice principles of recording information are :

- The need to protect confidentiality.
- To assist service users make informed decisions.
- To demonstrate clinical effectiveness.
- To communicate information that is timely, accurate and complete.
- To support standard setting and provide an audit trail.

5.3.2 All data regarding service user care/intervention should be recorded as soon as possible, following the event.

5.3.3 Abbreviations should be avoided where possible (as per professional regulatory body guidance) or wherever used, as per locally agreed service list.

5.3.4 If data is recorded retrospectively, the date will need to be adjusted within the system, prior to the completion of consultation notes, using the details button on the main toolbar. This will ensure that consultations appear in chronological order within the new journal in SystemOne.

5.4 Risk Markers

5.4.1 If a service user represents a potential risk to a staff member, then an incident form must be completed as soon as possible, and then a Special Note to be completed on the Special Notes Node. See Appendix A.

5.5 Referral

5.5.1 Referrals should be recorded at the point of registration.

5.5.2 Within the referral process, the following fields must be completed:

- Service offered
- Referral source
- Referral date
- Reason for referral
- Date of action
- Outcome
- Referral status
- Default contact location
- Caseload (except MH and LD Unit and Children's SLT)
- Waiting List
- RTT if applicable.

5.5.3 In order to enable reporting and consistency within each team, it is essential that a set of standard options are utilised in each field and that all staff members are fully aware and kept up to date with these options.

5.6 Referral to Treatment (RTT)

RTT measures the whole patient pathway from the date the referral is received until the first definitive treatment has been provided. This period of time can include diagnostic testing. This information is captured on the waiting list and referral screen in SystemOne.

It will be made clear for those services included in the RTT reporting framework that this policy must be read alongside the Community Services Referral to Treatment Rulebook and the Referral to Treatment and Access Policy.

No patient or service user should wait longer than 18 weeks from initial referral to their first definitive treatment.

Where services are included in the RTT reporting framework, the referrals to the services must be added to the SystmOne waiting list and not removed until a first definitive treatment has been provided. If a patient or service user is transferred from one waiting list to another, the date the referral was received – “clock start” –will migrate with the patient or service user onto the new list.

5.6.1 RTT Coding

RTT periods within SystmOne are monitored by the use of RTT codes that need to be entered at the relevant points along a patient’s RTT pathway. If a service is within the RTT reporting framework, it is essential that the codes for patients on the RTT pathway in SystmOne are updated accordingly. As an organisation we are monitored on our services waiting times and the RTT process allows that to happen.

Below is the full list of RTT codes that can be used within SystmOne, along with a description of how and when to use each code and a mapping from the codes previously used in ePEX.

The list of available RTT codes can be found in Appendix C.

5.6.2 Urgency of referral

Emergency-within 4 hours

Urgent- within 24 hours

High-2-7 days

Routine 28 days

5.6.3 Waiting List

A waiting list is a chronological record of patients waiting for an appointment/admission based on clinical priority. This includes new GP referrals, Choose and Book and Sentinal/DRSS referrals, and internal referrals. The organisation of the waiting list helps the regular review and assessment of patients waiting for an appointment. The waiting list must be held in the waiting list module SystmOne for LSW who have implemented SystmOne.

5.6.4 The agreed structure for SystmOne contact methods

The notes/consultation section within the tabbed journal must be used to record clinically significant information passed on during telephone calls i.e. serious risk / threats / concerns raised about mental health by others / vast deterioration / urgent / specific advice / information.

5.7 Responsibilities

- 5.7.1** All clinicians are responsible for entering their clinical activity onto SystmOne either themselves or delegating an admin person to do this. It is essential to record the plan of action, who is involved and contact details. This will enable out of hours services to access up to date and accurate information.

An admin member of staff can set the Date and Time which can be set to when the consultation took place. The Event done by field is really important as this is where the admin member of staff can record the consultant's name that completed the event. The Authorised field can also be used to record the consultant's name. Contact method can be Face to Face – As the consultant would have been face to face with the patient.

The admin staff can then add admin activity this will need to show how long the consultant took whilst doing the consultation and another activity added to show how long it took the Admin member of staff to add the information into the system.

- 5.7.2** SystemOne will force an activity to be recorded after every saved contact with the patient/client. By recording this activity she/he will be evidencing the activity in full – which will assist with caseload weighting exercises and Payment by Results funding to Clinical Commissioning Groups (PBR). It is important at this stage to also enter how long an activity took for reporting purposes.

It is the responsibility of the person making the telephone call to another professional to record the event and agreed action.

5.7.3 Calculating travel time (only if agreed to do so by the services)

Where is it not possible to allocate specific time for travel i.e. when staff visit more than one client before returning to base – staff should add up the total travel time for the day, divide this time by the number of clients seen and apportion the time equally to each client.

- 5.7.4** All clinical activities must be entered onto SystemOne within 24 hours, a record in the notes should be made if the record is updated after this period.

- 5.7.5** Under exceptional circumstances i.e. if there is a serious risk or incident – all activity must be entered with immediate effect, ensuring the Special notes Screen is also completed, as appropriate – this should also include the free text screen to record details.

- 5.7.6** Each line on the Event screen must be completed and **all** relevant information must be entered into SystemOne. When staff enter their data they are responsible for the accuracy of data. If there is a deviation from the norm, the notes sections must be used to record significant information.

5.8 Transfers of care

- 5.8.1** For MH&LD services, the new worker should open an episode on the Episode screen, indicating whether they will be the named nurse, lead care professional or care coordinator if relevant.

- 5.8.2** For all other services, the caseload holder should be reassigned to the appropriate

caseload holder.

5.9 Unlinked contact without a referral (previously known as Single Contacts)

5.9.1 It is not acceptable to have an unlinked referral when having contact with the same client for more than 3 'face to face' appointments within a calendar month. A client seen after 3 initial 'face to face' assessments which were recorded face to face contacts **must** be opened to staff by being referred into that service. However, within the service there may need to be some agreed exceptions to this rule and staff will need to consult their own service Practice Policies for clarification.

5.9.2 Unlinked referrals would usually only be used as by duty workers when not able to link a phone call etc. to a referral. It is not acceptable to record clinical activity as an admin event to work around not having to create a referral.

5.10 Staff working across areas

Staff **must** have different user codes to record the activity they do for different teams where staff work in more than one team. These will be activated via their smartcard access rights and the unit the staff member accesses when recording information.

5.10.1 The new SystemOne policy will help to feature the definition of the code to ensure staff are clear about which code to use as this has changed from codes previously utilised in ePEX.

5.11 Activity

This field should be used for codes that are required for financial purposes, but practitioners should refer to their SystemOne Coding Manual for their own service.

6. Assessment Templates, Questionnaires and Care Plans.

6.1 Each team will have an agreed suite of assessment templates, questionnaires and care plans made available to them on their default clinical tree within their unit.

6.2 If clinical teams require new templates, questionnaires and/or care plans to be added to their clinical tree or created, they should raise with the SystemOne Governance Group.

NB: Due to potential clinical risk issues, individuals must not create assessment templates outside of the process of the SystemOne Governance Group.

7. Allergies

7.1 All clinical staff should record sensitivities/allergies relating to each individual service user using the sensitivities and allergies option on the clinical tree.

8. Service User Discharge

- 8.1** In order to enable accurate reporting and effective caseload management, all service users should be discharged from the system as soon as possible after completion of treatment.

9. Service User Death.

- 9.1** In the discharged field, the drop down list should be completed as 'discharged' and then the 'reason for discharge' as death. Clinicians should carry out usual processes and inform GP of death. GPs put the information on their GP systems and this is updated to the 'spine'.

10. Clinical Trees

- 10.1** Each unit will have an agreed clinical tree set up within their unit.

11. Tasks

- 11.1** Tasks will appear for each group, and Service Leaders will need to ensure a process is in place to manage and reassign tasks when required.
- 11.2** Where appropriate, system generated tasks will be assigned to a Business Intelligence group to be dealt with by system administration.
- 11.3** It is the responsibility of the staff member sending the task to also telephone the receiving team to ensure that the task is picked up in a timely manner.

12. Updating Address

- 12.1** If a service user has a new permanent address this should be updated in TPP. The information will update the national spine, and the GP will be notified. However, if an address is known to be temporary it should be marked as such, as this will not update the national spine, but will ensure that the letters from the clinical services are sent to the correct current address.

13. Sharing Records

- 13.1** SystemOne enables accurate and timely service user information to be shared, as required, across NHS care environments. This will assist communication, in order to improve the service user's journey/experience. For further guidance on this, please refer to LSW's Confidentiality Policy.
- 13.2** Informed consent is from the user which is recorded within the system for each client. The default position of SystemOne, is that the record is defaulted to share in which means a user can view any part of the shared record (patient has agreed to share out

from other units), but the record is not shared out by default (implied dissent) until consent has been obtained and recorded.

Children under the age of 11 will have their record shared both in and out by default.

13.3 The judgment to share the information is the responsibility of the service user.

13.4 There are three privacy markers, which are as follows:

- Part shared record service users can choose not to share a particular episode of care.
- Record is private; a service user can decline to share all episodes of care.
- Safeguarding relevant.

13.5 If a service user dissents to information being shared, there is an option to override the dissent in three areas:

- Access in the public interest.
- Access required by statute.
- Access required by court order.

13.6 As record sharing consent is key to providing joined up care, regular audits will be run by Business Intelligence to ensure that the patient's record sharing preference is being recorded.

14. Safety and security information

14.1 The Smartcard regulates the level of access to health care information. The duty of the Smartcard holder is to keep service user information secure and confidential.

14.2 A Smartcard holder is responsible for:

- Carrying the card when access is required to the NHS care record service.
- Keeping the Smartcard safe and secure.
- Never sharing the PIN number.
- Never allowing the Smartcard to be used by someone else (audit checks will be randomly made).
- The card holder will be held responsible for all service user data recorded and accessed using that card.

15. Starters and Leavers

It is the responsibility of the Line Manager to ensure that the following occurs:

15.1 Starters

- Are booked onto a SystemOne training programme.
- Are issued with a Smartcard only after training.

- Change forms include a section to denote SystemOne access level changes.

15.2 Leavers

- Manager to inform Registration Authority (RA) within HR.
- RA to cancel access rights according to a member of staff's leaving date.
- If member of staff is not continuing in the NHS, the manager is to retrieve the Smartcard and return to RA.

16. The creation of New Clinical Tools

16.1 To help consistency throughout LSW, the following process for development of new clinical tools has been agreed as follows:

16.2 Clinical templates

- The Business Intelligence Team will work with clinicians to either identify existing or create a range of discipline/service specific clinical templates that will be used within TPP SystemOne. They will be added to the default clinical tree of the relevant clinical teams by the IM&T business change team.

16.3 Process for new clinical templates

- Due to potential clinical risk, individual clinicians do not write clinical templates in isolation.
- All new clinical templates requests should be submitted to the SystemOne Governance Team.

17. Where to go for help.

Any ongoing help/advice/support should initially be requested through the Systems Helpdesk, contact telephone number 01752 (4)35000 or e-mail LSWcic.systems-helpdesk@nhs.net

18. Unable to log on with Smartcard.

If you cannot log in with your Smartcard because it is locked after 3 failed attempts to log in or you cannot remember your password. Then you must contact dedicated 'unlockers' to unlock your Smartcard. Names are published on LSW's SystemOne web pages.

19. Change to Role or Unit Access

19.1 If a member of staff changes role which necessitates a change to the roles held on your Smartcard, a change form should be completed and the appropriate change

identified. The systems helpdesk will be notified of this change by HR and will authorise the appropriate access level change to the user's smartcard.

19.2 Where staff change the team / service they work the local SystemOne help desk **must** be informed immediately by the staff member, as a new staff user code will be required in order that the contact activity can be recorded to the new team the staff member is working for. This will be done by changing the access rights on their smartcards.

19.3 It is the responsibility of the practitioner to close / transfer their own episodes / caseload when leaving/changing posts, (remember not to close the referral unless discharging the patient/client from the service).

20. Sharing Information - Monitoring Compliance and Effectiveness

20.1 Monitoring Compliance and Effectiveness is the responsibility of the team or ward manager. There is an audit tool attached to this policy to use. See **Appendix B**.

20.2 The team manager as evidence that the policy has been regularly audited will hold the completed audit tool. This will be monitored and accessed by the clinical audit facilitator and outcomes discussed as a regular standing item at the ePEX/SystemOne Governance Group, feeding into the review of the SystemOne operational policy.

20.3 Quarterly audit cycle is recommended to be carried out by all clinical teams:

- **Referrals**
Ensure that clients discharged / closed / have their referral on SystemOne closed down (remember to refer on before closing referral if client remaining within LSW services).
- **Episodes (MH&LD Only)**
Ensure all service users/clients/patients on caseload have current episode and care co-ordinator/lead professional/named nurse information recorded.

Ensure that service users/clients/patients discharged / closed / transferred have their episode on SystemOne closed down.
- **Caseloads (Excl. MH&LD)**
Ensure that service users/clients/patients discharged / closed / transferred have been removed from caseload.
- **Events (Contact methods)**
An audit by the business intelligence team will take place to ensure the Face to Face events recording does not deviate from the guidance of recording referrals appropriately.
- **Episode Screen**
Ensure that the Care Co-ordinator/Lead professional/Named nurse has been ticked and that the patient/client has an identified Care Co-ordinator on

SystemOne.

- **Tasks**
Ensure that tasks are dealt with appropriately and in a timely manner. All tasks are expected to be completed within 1 month.
- **Waiting List**
The waiting list screen must be closed when a RTT code of **10** or above has been applied to the patient; as laid down by the Department of Health (DoH) guidelines.

21. Where to find this policy

This policy is available on:

<http://pchnet.derriford.phnt.swest.nhs.uk/Documents/Policies,PGDsandProtocols.aspx>

It will be the manager's responsibility to bring to the notice of all currently registered users within their area, the contents of this policy. All information must be handled in strict accordance with the Data Protection Act 1998.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Finance

Date: 19th January 2016

APPENDIX A - Special Notes – Staff Safety Guidance

Introduction

1. This guidance has been written to help staff manage immediate levels of risk that may be presented to them whilst being involved with that persons care. All Special Note Warnings must have a review date recorded on SystemOne. These should be reviewed from when the last care package review took place – a minimum of every 6 months for CPA, or yearly for non CPA unless the warning is to remain permanent. Warnings that are to remain permanent should have 99y inserted next to the special note.

2. Purpose of the guidance

This guidance is about recording Special notes on patient records on SystemOne, when there is a potential danger to staff. For staff who only use ePEX to create warnings who have causes for concern need to make sure this information is communicated, to other areas involved in that patients care either by sending a copy of the entry or a letter in a timely way and asking for confirmation of receipt.

The safety of the patient should be identified in the patient's care plan, a risk assessment should also be completed as per the CPA Policy.

3. Scope of the guidance

This guidance applies to all staff who are authorised to use SystemOne.

It is fundamental to this guidance that warning information is on all systems, whenever patients are registered on ePEX live or SystemOne.

Adding New Special Notes and Safeguarding Information:

1. Only information as outlined in the list below should be recorded in a SystemOne record.
2. Only Clinical Staff should be entering Special Notes and Safeguarding Information except from the administrators in the Safeguarding team.
3. Information already entered by one member of staff in the record (for example in the tabbed journal) should not be copied by another member of staff into Special Notes or Safeguarding Information. If you have reason to think that this should be done then you must contact the member of staff concerned to discuss your (proposed action) opinion.
4. If any member of staff remains unsure as to whether some information constitutes a Special Notes or Safeguarding Information they must seek advice from their service lead, Or line/team manager.

Categories that are appropriate to use Special Notes for are:

- Advance Decisions.
- Violence & Aggression including use of weapons to ensure the safety of staff.
- Significant other issues i.e. vicious/dangerous dogs in the home.
- Incomplete/lack of records.
- MAPPA (Multi-Agency Public Protection Arrangements) and MARAC (Multi-Agency Risk Assessment Conference) warnings and safeguarding children vulnerable adult concerns. 121a information can be entered into the tabbed journal unless anything of particular risk to others is noted.
- Adult at risk to Children is to be entered in the adults name as a public protection issue under the special note heading.
- Information relating to missing persons including missing antenatal mothers should be entered under special notes with note indicating that it is a missing person.
- Yellow and red card warnings and those under the violent patient scheme.

Previous warnings in ePEX no longer within Special note Warnings

- Drug warnings e.g. allergies and sensitivities will be entered or migrated into the sensitivities and allergies node within the clinical tree.
- Concerns about relatives, taping of conversations, this is no longer considered a warning by LSW.
- Child protection issues for children or vulnerable adult concerns should be added to the safeguarding screen on SystemOne.
- **Warnings that were previously entered under the category of warnings in ePEX are now being migrated into reminders within SystemOne this will need to be reviewed and if appropriate re-entered as a special note and the reminder ended.**
- Safeguarding adults should be entered as a high priority reminder in SystemOne.
- This guidance requires that all users of SystemOne strictly adhere to the procedures set out below for their own safety and for the safety of their colleagues.

4. Organisational settings

If a special note has been entered onto a patient record there will be a scroll icon in the patients' demographic box. The first patient view of the record will be the warning screen which will show all current special notes, high priority reminders and drug sensitivities and allergies. Historical special notes can be seen by checking on the scroll icon in the clinical tree.

5. Responsibilities of ePEX and SystemOne users

All users must be aware that the main two are electronic databases being used within LSW; ePEX and SystemOne. Patients may be known to more than one service and therefore may be registered on both systems. If so, warnings must be recorded on both ePEX and SystemOne.

SystemOne is currently being rolled out across the organisation. Any area that has gone live with SystemOne are responsible for registering patients on SystemOne but also will need to check ePEX for previous warnings or child protection issues. Any new warnings that need to be entered, should be entered onto SystemOne as a Special Note

warning and must also be entered onto ePEX, until all areas within the organisation have migrated over to SystemOne.

Once migration is complete, records may still require checking in ePEX for previous warning screens.

This is to ensure that all staff have access to warning information that is essential to know, for their personal safety.

When entering referrals onto the system the warning screens should be reviewed to see if there has been any previous warning. Following assessment of a client if a new warning screen needs to be entered this should be entered onto ePEX. If a patient is registered onto SystemOne for the first time and the patient information hasn't already been migrated over to SystemOne from ePEX the member of staff must enter a special note warning on SystemOne as well as ePEX.

If the member of staff finds a warning on ePEX but that there is no equivalent special note on SystemOne, then it is their responsibility to add the Special Note to the patient record immediately. This will ensure the safety of staff and patients.

It is the responsibility of all staff to refer to the warning screen on SystemOne.

6. How to enter a warning on SystemOne

- Retrieve patient record.
- Click on clinical tree special note.
- Right click on mouse to enter new special note including reasons for the entry.
- Select safe haven for violent patients.
- Select special note for all other entries.
- Frequent caller heading should only be entered after an MDT has agreed this.
- Enter a recall of special note either 6 months or 12 months to make sure this special note warning is reviewed.
- A duplicate entry will then need to be made on ePEX

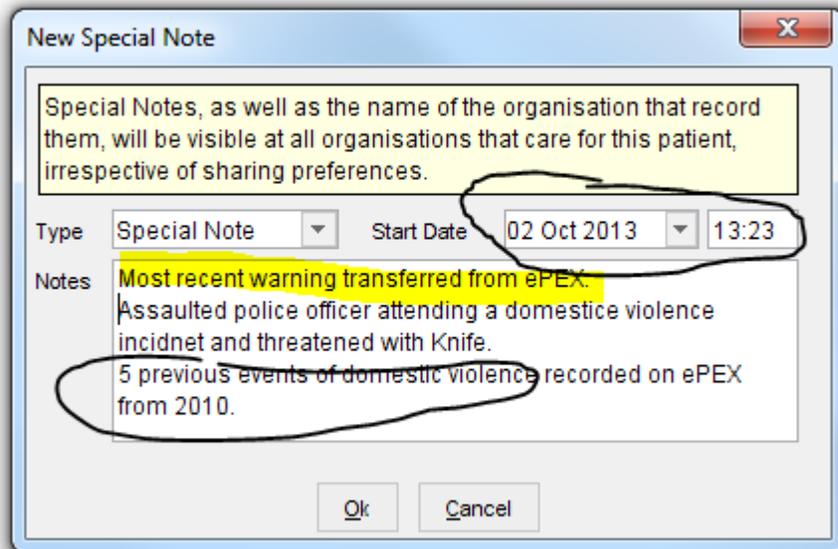
7. How to view a special note (warning) on SystemOne

- Retrieve patient record.
- Click on clinical tree select special note.

- The special note will tell the member of staff what the presenting issue is.
- Also take note of the reminder as the warning from ePEX may have been migrated into this area all are visible in the warning screen.
- Don't forget to also check ePEX at this point if your service has not migrated its data prior to going live with SystemOne.

Transferring Historical Information from ePEX to SystemOne:

1. Only information that is currently recorded as a Warning in ePEX should be considered as a potential for Special Notes or Safeguarding Information in SystemOne.
2. If there is a Warning in ePEX due consideration must be given as to whether it merits transferring to SystemOne (if this is a non-migrated service) as the use of Warnings in ePEX have not been regularly reviewed.
3. If there are multiple entries of a similar nature, please record the most recent event with date summarising the list the remaining.
4. Any information that is transferred across should have the original date recorded against the Special note.



5. If any member of staff remains unsure as to what should be transferred over from ePEX they must seek advice from their service lead/ line/team manager.
6. Any other information that is seen in ePEX but is not classified as a Warning should NOT be entered as a Special Notes or Safeguarding Child Information. If you consider the information relevant to the episode of care it should be recorded in the narrative record (e.g. Family History) or considered in the assessment or in a 'Notes & Activities' template.

9. Permanent warning categories

- All drug allergies should remain and would not be reviewed unless new information came to light in which case the allergy can be ended.
- Serious levels of aggression or Violence, Use of Weapons.
- Mental Capacity Act – Advanced Decisions. This information can be recorded on the special note screen entitle it as Advanced Decision. Comments can be recorded in the notes box of the special notes warning screen. Information in the comments box will need to reflect the Advanced Decision details and where documentation

relating to this can be accessed.

10. The procedure to follow out of hours to ensure a warning is recorded on both SystemOne and or ePEX

Until SystemOne has been rolled out across the organisation

This is a critical part of this policy. It is the procedure that must follow to ensure that warnings are available to users of both ePEX/ePEX LD and SystemOne. **Remember** this is for the safety of all staff out of normal working hours.

To view information available to ePEX LD, staff should contact Lee Mill.

To view information available to Mental Health system users staff should contact Glenbourne unit coordinator.

11. New users of SystemOne

11.1 On application for access to SystemOne, a paragraph will be added to the Data Protection Agreement that currently goes out to applicants, making sure they are aware of this policy and advising them how to access a copy. This will be sent out by the Informatics Team and the signed agreement will be retained by them. Access will not be granted to any staff without the agreement being signed.

11.2 Management of warnings will be included in the basic training Package.

11.3 For services that carry out in-house training, it will be their responsibility to ensure the management of warnings is passed on to all their new staff.

12. Review of Special note warning

12.1 It is important that information related to Special note Warning is regularly reviewed so the Warning can be closed as soon as it no longer applies.

12.2 All warnings will have a review date recorded. Currently SystemOne special notes can have an expiry date added but a report would need to be run to see when they need to be reviewed.

12.3 When warnings are reviewed on the SystemOne system this will necessitate a review of the clients risk assessment.

12.4 Warnings should be reviewed when a review takes place – a minimum of every 6 months for patients on CPA and 12 months for non-CPA.

13. Review and monitoring

13.1 It is the responsibility of the Team Manager to audit Special Note Warning screens for clients with open episodes with the team on a three monthly basis.

This can be done by selecting reporting on the large tool bar and running a report of the appropriate recall.

APPENDIX B - SystmOne Operational Policy Audit Tool

Team/Unit Date of Audit..... Name of

Auditor.....

Ref	Standard	Met (Y)	Not Met (N)	If Standard not met, please note why not. (If not, why not)
1.	Referrals - All patients who have been discharged, allocated or who are not for follow up must have their referral screen ended. (Remember to refer on if patient still having input by LSW).			
2.	Caseloads - All client/patients on caseload have a current caseload entry on SystmOne.			
3.	Caseload (or referral allocation) Screen – all clients/patients have the care co-ordinator box, Lead professional or named nurse ticked and the care coordinator/Care Manager is identified on SystmOne (Applicable to all Mental Health, Learning Disabilities and CAMHS staff).			
4.	All clients/patients discharged/closed/transferred have their caseload (or referral allocation) on SystmOne closed down.			
5.	Contingency and crisis plans – this information has been entered onto eCPA for each client/patient on caseload. (Not applicable for Community & Rehabilitation and Children & Families Directorate Staff).			
6.	Waiting list –The waiting list screen has been closed			

	for each referral when appropriate action was taken.			
7.	Special notes Screen - All warnings have been reviewed within a CPA review or yearly and an entry made into the tabbed journal.			
8.	On the date of review of the Special note warning the client/patient risk assessment was reviewed.			

This completed audit form needs to be kept by Team/Unit Manager to evidence use of policy

APPENDIX C - Referral to Treatment Codes

Codes to indicate treatment not given. <u>Clock still ticking</u>		
Code	Definition	Description
RTT(10)	First Activity- first activity in a Referral to Treatment period Awaiting first treatment	This code will start the clock following an <u>external</u> referral. Clock start ePEX equivalent = Waiting for Assessment
RTT(11)	Active monitoring ended	First activity at the start of a new Referral to treatment period following Active Monitoring. Clock start ePEX equivalent = Was not used in ePEX
RTT(12)	Referral from consultant	This code will start the clock following an <u>internal</u> referral. Clock start ePEX equivalent = Was not used in ePEX
RTT(20)	Subsequent activity	Subsequent Activity during a referral to Treatment period, further activities anticipated <i>i.e.</i> ongoing assessment prior to first definitive treatment. Clock still ticking. ePEX equivalent = RTT01
RTT(21)	Transfer to another Health Care Provider	<u>DO NOT USE - CURRENTLY UNDER REVIEW</u>

Activity that ends the Referral to Treatment Period. Clock stopped		
Code	Definition	Description
RTT(30)	Start of 1 st Definitive treatment.	Where the first treatment is provided and the patient is discharged at the same appointment 1 st Definitive treatment. Taken onto caseload/episode of care opened. Admitted. <u>Clock Stops</u> ePEX equivalent = RTT10 & RTT11
RTT (31)	Start of Active Monitoring	Initiated by the Patient. <u>Clock stops</u> ePEX equivalent = RTT18
RTT (32)	Start of Active Monitoring	Initiated by the Care Professional. <u>Clock Stops</u> ePEX equivalent = RTT18
RTT (33)	Did not attend	The Patient did not attend an appointment whilst the clock is still running. <u>Clock Stops</u> <u>Very important:</u> If it's in the patients best interest/safeguarding not to discharge on the same date restart the clock with RTT10 immediately ePEX equivalent = RTT14
RTT (34)	Decision not to treat	Decision not to treat made or no further contact required. <u>Clock Stops</u> ePEX equivalent = RTT12
RTT (35)	Patient declined offer of Treatment	<u>Clock Stops</u> ePEX equivalent = RTT15
RTT (36)	Patient died before treatment	<u>Clock Stops</u> ePEX equivalent = DIED

	Activity that is not part of the Referral to treatment period – Not to be used where a clock is ticking...	!!!Description!!! – There were no equivalent RTT codes of any of these activities within ePEX
RTT(90)	Activity after RTT period	First Definitive Treatment occurred previously (e.g. admitted as an emergency from A&E or the Activity is after the start of treatment).
RTT (91)	Active Monitoring	Care activity during active monitoring.
RTT(92)	Patient is not referred	Not yet referred for treatment, undergoing diagnostic test by GP before referral.
RTT(98)	Not applicable to RTT	Not applicable to referral to Treatment Periods.
RTT(99)	RTT not yet known	The status is treated as if the Activity is a subsequent Activity during a RTT Period. In this case the RTT Period Status should be corrected once it is possible to determine the correct value.