Appendix 7

List of Electronic Areas where patient information is held within the patient's folders on RiO / IAPTus.

RiO CHECKLIST

NTW SOT Initial response team folder
NTW IRT Telephone triage
NTW IRT Rapid response triage form
NTW SOTW Street triage form – phone
SOTW Street triage form – face to face
SOTW Street triage form – follow up

Core Clinical Documents Folder

- Core document assessment
- Medication, allergies and sensitivities form
- Audit tool
- Consent status screen
- FACE risk profile
  - Adult
  - Addictions
  - CYPS
  - LD (Child and Adolescent)
  - Learning Disability
  - Neuro Disability
  - Neuro Psychiatry
  - Older People
  - Perinatal
  - Forensic
  - Narrative risk assessment
- Lead professional care plan/review
- Community care coordinator care/risk management plan
- Care coordination reviews
- Employment and accommodation
  - Employment and accommodation form
  - CYPS Living arrangements
- Getting to know you process
- Inpatient care coordination care/risk management plan (IP)
  - Care coordination care/risk management plan (IP)
  - IP core clinical doc care plan
- Inpatient Documentation
  - Inpatient arrangements
- Keeping children safe assessment
- GP Blood pressure check
- Physical health monitoring
  - Core physical health monitoring record

    - ~ BP & TPR chart
    - ~ Height and weight chart
    - ~ IP Rapid tranquiller chart
- ~ Nutrition screening tool
- ~ Falls risk assessment tool
- ~ Mental health discharge summary

PCP Core Clinical Documents Folder

- ~ Core documents
    - ~ MDT trigger tool
    - ~ DNA reason form
- ~ Consent
    - ~ Service user preference details

Read Only Files Folder

- ~ Adults read only
    - ~ Inpatient care plans
    - ~ IP risk management and contingency plan
    - ~ IP care plan agreement
- ~ WAA assessment (all sections)
- ~ Sainsbury risk too (all sections)
- ~ Care plan documentation
- ~ Crisis and risk management plan
- ~ Care plan agreement
- ~ Service user consent to share information
    - ~ Bolt documents
- ~ Care plan review
- ~ Carer form
    - ~ Carer details
- ~ LD read only
    - ~ Care coordination assessment (all sections)
    - ~ Care plan documentation
    - ~ Risk management plan
    - ~ Lead professional care plan/reviews
    - ~ Nurse led clinic care plan/reviews
    - ~ Additional care plan information
    - ~ Care plan agreement
    - ~ Formulation and summery of assessment
    - ~ Care coordination review
- ~ FACE risk profile
    - ~ All sections
- ~ Older Peoples read only
- ~ Service users consent to share information - both sections
- ~ Registration details
    - ~ Additional demographics

    - Carer contact details
- Older peoples assessment documentation – all sections
- Older peoples care plan documentation
    - Care plan agreement
    - Risk management and crisis plan
- Care plan review
    - Inpatient multidisciplinary review
    - Formulation, progress and summery
    - Link to enhanced care plan review
- Face risk profile – all sections
    - Nutrition screening tool
    - OP specialist assessment
    - CPR decision form
- CYPS (read only)
    - Care plan documentation
    - Crisis plan
    - Risk management plan
    - Care plan agreement
    - Non enhanced care plan review
- Care coordination assessment – all sections
- CYPS care plan review
    - Children and young people's care plan review
- CYPS consent to share
    - CYPS consent to share information and copy of letters
    - Notional screen tool
- CYPS face risk profile – All 5 sections
- CYPS LD face risk profile – All 5 sections
- CAMHS outcome measures
    - CAMHS SDQ – Parents
    - CAMHS SDQ – Teacher
    - CAMHS SDQ – Young person
- Specialist services read only – RECS equipment
- Pharmacy read only
    - Antipsychotics in dementia intervention plan
    - Antipsychotics in dementia review plan
    - Pharmacy print form
- IAPT (read only)
    - IAPT read only
    - Patient experience questionnaire
- Forensic (read only)
    - Forensic Face Risk profile
    - Background history
    - Static forensic history
    - Index offence
    - Risk factors and warning signs
    - Risk formulation

- Consent to letters (read only)
  - Consent to share information documents
  - Consent form – sharing letters with service user
  - Consent form sharing letters with carers
- Addictions (read only)
  - Addictions face risk profile
  - Addictions risk factors and warning signs
  - Addictions risk management/crisis contingency
- Medication (read only)
- Physical treatment (read only)
- Mental capacity act documentation (read only)
  - Advance statement
  - Children dependent and home
  - Additional information
  - MCA additional information for registration
  - Record of a decision about the best interests
  - Record a decision
  - Advice for relevant advocates and professionals
  - Advice of IMCA or local advocacy service
  - Final decision
- Core clinical (read only)
  - Discharge summary
  - Physical heath monitoring form
- Service specific files
  - Adults
  - Registration documentation
  - Additional demographics
  - Crisis triage
  - North of Tyne info
  - Crisis critical indicator and EDP
  - Inpatient admission property procedure
  - Inpatient weekly diet sheet
  - Inpatient medical certificates issued
  - Inpatient 1:1 sessions with therapy
  - Inpatient diabetic chart
  - Inpatient phlebotomy record
  - Inpatient 24 hour sleep chart
  - Inpatient fluid balance chart
  - Moving and handling assessment
  - Moving and handling care plan
- Acute day services
  - Acute day services admission checklist
  - Acute day services discharge planning checklist
  - Acute day services weekly MDT review record sheet
- Sunderland Rehab and recovery
  - Cognitive assessment of voices
  - Social functioning scale

  - Early warning signs self-management
  - Early signs chart
- Recovery star
  - Recovery star
- Exercise therapy
  - Activity index
  - Exercise therapy referral
  - Pre-activity questionnaire
  - Psychological services
  - GAD 7
  - PHQ 9
- Addictions
  - Addictions alcohol
  - Severity of alcohol dependence questionnaire
  - Alcohol/Benzodiazepine physical withdrawal chart
- Opiate assessment tools
  - Opiate physical withdrawal chart
- Veteran service
  - Veteran service minimum data set
  - Trauma screening questionnaire
  - Core 10 screening measure
- Older peoples
  - Older peoples assessment
  - Ward admission checklist
  - Supported MMSE and CDT
- Care plan documents
  - Leave care plan
  - Intermittent obs
  - Arm's length obs
  - Eyesight obs
  - Wad initial care plan
- Older people's specialist assessments
  - Ward risk of absconding care plan
  - Assessment of suicide risk
  - Framework for risk of suicide/self-harm
  - Weight chart
  - Fluid balance
  - Oral fluid balance
  - Moving and handling assessment
  - Moving and handling care plan
  - Weekly sleep chart
  - B.M chart
- MPS assessment
  - MPS provisional coding form

IAPTUS CHECKLIST

PATIENT

- EPISODE Click on all episode individually (there may be multiple)

Episode Summary

- Options – Print Summery **all sections with one click**

ASSESSMENT

- Assessment (if referral date is before May 2014 the assessment will be on Rio but check assessment tab on IAPTus as data may have been imported, anything from May 2014 the assessment will be in the assessment tab of IAPTus)

DOCUMENTS

- Letters

Uploads