SystmOne
COMMUNITY OPERATIONAL GUIDELINES

Guidelines IM&T 11
Date: August 2007
**Document Management**

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| Description       | This document aims to provide guidance and direction for all community staff using SystmOne within Northamptonshire PCT. The main purpose is to:  
  · Provide better information for patient care, wherever and whenever it is available.  
  · Improve communication between community teams.  
  · Improve flow and transition through patient pathways.  
  · Meet record-keeping standards at a local and national level.  
  
  This document supports the delivery of the Trusts underlying principles of continuous quality improvement, minimising risk, information governance and staff development. |
| Target audience   | These guidelines apply to all provider services and temporary staff who will be contributing towards the creation and maintenance of electronic patient records during their time with NPCT |
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| Department        | Implementation Team                      |
| Directorate       | IM&T                                     |
| Approved by       | Information Governance Steering Group     |
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| External distribution |                                          |
| Availability      | All ratified policies, strategies, procedures and protocols are published on the Trust Intranet and Public Website. |
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1.0 INTRODUCTION

This document aims to provide guidance and direction for all community staff using SystmOne within Northamptonshire PCT.

The main purpose is to:
- Provide better information for patient care, wherever and whenever it is available.
- Improve communication between community teams.
- Improve flow and transition through patient pathways.
- Meet record-keeping standards at a local and national level.

This document supports the delivery of the Trusts underlying principles of continuous quality improvement, minimising risk, Information governance and staff development.

SystmOne revolutionises the way information flows around the health service making it possible to deliver faster, safer and more convenient patient care.

This policy document has been subject to discussion and review by lead clinicians throughout the PCT via the County Wide Steering Group.

The Information Governance Steering Group has ratified this document.

2.0 BACKGROUND

Since June 2005 Northamptonshire PCT IM&T Directorate has embarked on the implementation of Electronic Patient Record (EPR) for various clinical staff within the Northamptonshire community. Following a 10 year plan set by the Department of Health (DOH) (2000) a National Programme for Information Technology (NPfIT) has been formulated, and the delivery of this programme was handed over to the government agency Connecting for Health (CfH). The CfH agency is acting on behalf of the NHS while the implementation of NPfIT has been assigned to the Local Service Providers (LSP) and to the local implementation teams within each of the NHS trusts.

The current LSP for Northamptonshire PCT is Computer Science Corporation (CSC) while NHI CfH Project Team represents the local implementation team.

The total number of Northamptonshire PCT community staff is estimated ca. 1600 clinicians. The chosen clinical software for these clinicians is The Phoenix Partnership SystmOne community module, widely known as TPP or S1.

Over the last 15 months the following clinical groups have become active users of System One:
- Community Matron
- Diabetes (Kettering General Hospital)
- District Nurses
- Physiotherapy Admin
- Family Planning
- Falls Co-ordinators
- Evening Nurses
- CRT/ICT (Intermediate Care Teams)
- CAS (Clinical Assessment Team)
3.0 GETTING STARTED

Before using SystmOne, all staff are required to be issued with a smart card and have undertaken the Core Skills Training programme.

3.1 SMARTCARDS

Smart Cards 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 need to do their job. Smart Cards work in much the same way as Chip and PIN credit or debit card i.e. access is gained when inserted into a reader and a PIN is entered.

The process of registering for a Smart Card is as follows:

- RA01 form completed, line managers must sign this form.
- To be issued with a Smart card, an appointment needs to be booked with the Registration Authority (RA)
- RA sessions are held every week in Northampton and Kettering: Wednesday Afternoon’s 14:00 until 16:00 and Thursday Morning’s 09:30 until 11:30

Proof of identity must be provided at this session; this must be made up of the following:

1. Photo ID - Photo Card Driving License, Passport
2. Active in the community document with a name and address on - these can be utility bills, bank statement, etc.

To book an appointment please call: 01604 615300

3.2 CORE SKILLS TRAINING PROGRAMME

Every month there is a SystmOne Core skills course aimed at new members of staff from the community who work in teams that currently use SystmOne. This is a two-day course, starting at 9am and finishing at 5pm each day. The course is delivered by means of presentations and demonstrations by the trainer, as well as plenty of practical hands-on learning. There are opportunities for group discussions and questions and answers. Trainees have their own computer to work on, and demonstrations and step-by-step instructions are followed by lots of practice.

Trainees will receive an introduction to the National Programme for IT (NPfIT) and information governance relating to the use of SystmOne. Throughout the duration of the course, trainees will learn how to log on to SystmOne using their smartcard, how to register a patient for care, record referrals received, complete event details electronically, manage caseloads on screen and end patient care. In terms of clinical recording, trainees learn how to create, complete and review care plans, complete assessment tools electronically, record consultations and share patient records with other staff within the healthcare community.
4.0 Data Quality

Data analysis is the act of transforming data with the aim of extracting useful information and facilitating conclusions. The data contained on SystmOne is only as good as the information recorded by clinical staff. Therefore information should be relevant, clear, timely and accurate. To enable accurate reporting required by the PCT, all patients registered must be matched to the spine with their relevant NHS number. Unmatched patients only appear on local records and are missed on reports resulting in inaccuracies.

4.1 Minimum Data Entry

The PCT expects all clinical staff working within the community that have had SystmOne implemented, to record the following details:

FOR CLINICAL ACTIVITY:

- All patients must be registered and discharged
- Programme budgeting categories (PBC) templates must be completed for all patients
- Admission avoidance template must be completed for all patients (if relevant)
- Care plans completed
- Medication history completed (using current medication details template)
- Allergies recorded

FOR REPORTING PURPOSES:

- All patients must be registered and discharged in a timely manner
- Programme budgeting categories (PBC) template completed for all patients per financial year
- Admission avoidance template completed for all patients (if relevant)
- Read Code template to be completed for all activities

4.2 Record Keeping Standards

All data entered onto SystmOne should adhere to the PCT Records Management Policy, and Professional Regulations

Best practice principles of recording information are:
- The need to protect confidentiality
- To ensure consent
- To assist patient, clients and carers to make informed decisions.
- To demonstrate clinical effectiveness
- To communicate information timely, accurately and in completeness.
- To support standard setting and provide an audit trail

All data regarding patient care/ intervention should be recorded as soon as possible following the event.
Abbreviations should be avoided where possible (as per Professional Regulatory Body guidance), however, if they are used, they should conform to the approved Trust Wide list.

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.

4.3 Patient Registration

It is expected that all patients should be registered using the spine. This will help to ensure patients’ personal demographic details are accurate and up to date.

To complete a full registration the following patient details are required:

- Full given name
- Date of birth
- NHS number (if known)
- Contact telephone number
- Next of kin details & other significant relationships
- Referral details (see below)

Telephone and Key safe details can be recorded using the Quick Action toolbar.

If key safe details are recorded, an alert for other staff members should be made using the Reminders functionality.

4.4 Referral

Referrals should be recorded at the point of registration.

Within the referral process the following fields must be completed:

- Service offered
- Referral source
- Referral date
- Reason for referral (as many as appropriate)
- Date of action
- Outcome
- Referral status
- Default contact location
- Caseload

In order to enable accurate 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.
4.5 Assessment templates

Each team will have an agreed suite of assessment templates available to them on their default clinical tree within their unit.

There are three types of templates within SystmOne ACC templates, TPP templates and NPCT templates;

- ACC templates have been created and agreed nationally
- TPP templates have been created and agreed by TPP
- NPCT templates have been created locally and agreed across Northamptonshire PCT

The PCT recommends that for the main, only the unit agreed templates on the default clinical tree should be utilised. However, if individuals need to add additional templates to their clinical trees, they should only add either ACC templates or NPCT templates.

If clinical teams require new templates to be created, they should follow the agreed trust wide process (detailed in section 10).

Please note: due to potential clinical risk issues, individuals must not create assessment templates outside of the agreed Trust Wide process

4.6 Care Plans

Each team will have an agreed suite of core care plans available to them. Within SystmOne, treatment plans or goal plans are referred to as ‘care plans’. These core care plans have been agreed and signed off on a countywide Trust basis. There is an agreed escalation process for requesting new core care plans to be added to the system (please see section 13 below).

There is functionality within the system to create one off individualised care plans as required. These care plans will not be clinically audited/ risk assessed and responsibility for the accuracy of them lies with the individual clinician creating them.

If a care plan has been assigned to a patient, it should be completed after each visit, evaluation should be recorded using the template functionality within the care plan.

Review of a care plan should be given a due date and recorded in the review functionality within the care plan. The system now prevents continuation of care recording once the date is reached unless review is undertaken

4.7 Patient Consent to Assessment and Treatment

It is a requirement of all Professional regulatory bodies that patients consent is obtained and recorded prior to any assessment, treatment or intervention. Consent needs to be re-affirmed and documented if there are changes to the treatment plan, or if the patients’ condition affects the balance of significant risks, benefits or likely outcomes of treatment. This can be achieved by ensuring that clear written instructions are added to the beginning of each care plan within the system. If care plans are not utilised by a
Professional group, then the issue of consent should be addressed within the consultation notes.

4.8 Read Codes
Each team will have an agreed read code template situated on their default clinical tree and should be completed for all interventions following each visit. It is imperative that all members of staff complete this template to enable the Trust to accurately report on Community activities and treatments.

4.9 Medication History
A record of medication history must be recorded within SystmOne. This is recorded using the current medication details template option on the default clinical tree.

4.10 Nurse Prescribing
Nurse prescribing is available on the system using Issues on the clinical tree. NB Only five GP practices are currently using SystmOne, therefore prescribing will also need to be entered on the appropriate GP system.

4.11 Allergies
The PCT expects all clinical staff to record sensitivities/allergies relating to each individual patient using the Sensitivities & Allergies option on the default clinical tree.

4.12 Patient Discharge
In order to enable accurate reporting and effective caseload management within SystmOne, the PCT expects that all patients are discharged from the system as soon as possible. If a patient is only seen periodically throughout the year, it is recommended that they are made inactive (for further information on changing active status please refer to SystmOne training manual).

4.13 Countersigning Entries
If data entry requires countersigning, the PCT recommends clinicians to record a statement of agreement using the consultation functionality within the system (the frequency should reflect usual working practices already in place).

4.14 Clinical Trees
Each unit will have an agreed default clinical tree set up within their unit. The PCT requires all staff to adopt the default clinical tree, in order that any Trust Wide changes can only be viewed on the default clinical tree.

5.0 Sharing Records
SystmOne enables accurate and timely patient information to be shared, as needed, across NHS care environments. This will assist communication so as to improve the patient’s journey/experience. For further guidance regarding this, please refer to the Confidentiality and Disclosure Policy (DRAFT August 2007).
5.1 Patient informed prior to sharing

SystmOne works on the basis of implied consent. However, it is recommended that Clinicians have a responsibility to discuss and inform their patients that some of their personal information is being recorded onto a local clinical computer system. Furthermore, that this information if required, may be shared with another community service.

It is the responsibility of the clinician to record that their patient has been informed of this on the patient informed template (held on the clinical tree - within the system). It is also the responsibility of the clinician to provide their patient with appropriate information leaflets (available on the intranet).

For further information see ‘Information Governance Data Protection Act’ on the intranet

5.2 Within the organisation

It is the responsibility of the person referring a patient to another service to ensure a share has been set up within SystmOne

5.3 Outside of the organisation

Including GP’s on SystmOne; it is the responsibility of the person making a referral to set up the share and also inform the patient that information regarding them has been shared. If a referral is received from a SystmOne GP, It is the responsibility of the person receiving the referral to request a share of the patients record.

6.0 Safety and Security of Information

The smartcard regulates the level of access to health care information. The duty of the smartcard holder is to keep patient information secure and confidential.

A smartcard holder is responsible for:

- Carrying the card when access is required to the NHS (CRS)
- Keeping the smartcard safe and secure
- Never sharing the PIN number
- Never allowing the smartcard to be used by someone else (check on access will be made and the card holder will be held responsible for all patient data recorded and accessed using that card)
- Never leaving the smartcard unattended

A number of commitments have been made that govern how information is held in the NHS Care Records Service (CRS). These are published in the NHS Care Record Guarantee

For further information regarding the Care Record Guarantee go to:
www.connectingforhealth.nhs.uk/crdb
7.0 Entering clinical data onto GP systems

Community staff will enter information onto GP records where this is required to minimise clinical risk.
Examples include:

- Immunisations given
- Vaccinations given
- Child protection issues
- Protection of Vulnerable Adults (POVA) issues
- Medication changes
- Significant events (terminal care/ sudden change in condition)
- Abnormal observations
- Allergies

It is recognised that this is not a definitive list and clinicians are expected to use their professional judgement to inform their decisions about what to enter and what not to enter. However, as a general rule of thumb it is recommended that any information the clinician deems important enough to verbally share with a GP, should also be entered into the patients clinical record on the GP’s IT system.

8.0 Reporting

SystmOne enables provider services to extract vital activity data for their commissioners. Much of SystmOne reporting is achieved by recording Read Codes against clinical information and activities. It is therefore important that only the agreed read codes are used.

There are also specific templates, which must be filled in according to PCT guidance

- Programme Budget Categories- all patients
- Admission Avoidance template- if relevant

9.0 New starters / leavers

It is the responsibility of the line manager to ensure that the following occurs:

1. Issued with a smart card
2. Booked onto the ‘core’ SystmOne training programme
3. Ongoing training occurs as required

It is imperative that when someone leaves the Organisation, their line manager ensures SMART cards are returned
10.0 The creation of new clinical tools

In order to help monitor consistency throughout the PCT, the following process for development of new clinical tools has been agreed:

10.1 Clinical templates

The IM&T implementation team will work with clinicians to either identify existing or create a range of discipline/service specific clinical templates that will be used within SystmOne.

These county wide agreed discipline/service specific templates will be added to the default clinical tree of the relevant clinical teams by the health informatics team.

For this reason, clinicians should utilise the default clinical tree option within their unit.

The PCT will then have an agreed portfolio of discipline/service specific clinical templates that can be viewed and accessed via the intranet.

The process for building new clinical templates is:

- Due to potential clinical risk - individual clinicians do not write clinical templates in isolation.

- All new clinical templates should be initially written in conjunction with the IM&T implementation team (either the clinical system team or the clinical change team). Request for this should be made using the appropriate form (CT01) -held on the intranet.

- Upon completion, the new clinical template will be submitted to the CSG for review and analysis of associated risk.

- If the template is signed off by the CSG it will be published locally into the relevant community modules (via the default clinical tree) by the health informatics team.

- A list of county wide agreed discipline/service specific templates will be held on the intranet (as source of reference for other professional groups).

This process flowchart is presented in APPENDIX 1
10.2 Core care plans

Similarly the IM&T implementation team will work with clinicians to either identify existing or create a range of core care plans that will be used within SystmOne.

The process for building new core care plans is:

- Initially Core care plans should be written and agreed locally by individual Professional groups/ or clinical teams.
- They will then be submitted to the county wide clinical steering group (CSG) using agreed form (CT01) - held on the intranet.
- The CSG will review the content, discuss/ highlight any potential areas for clinical risk and then sign off.
- Once the CSG have signed the core care plan off, it will then be published locally into the relevant community module within SystmOne.
- A list of county wide agreed core care plans will be held on the intranet (as a source of reference for other professional groups).

This process flowchart is presented in APPENDIX 2

This process does not apply to bespoke care plans created by individual clinicians for individual patients. In this instance the responsibility for creating this care plan lies with the individual clinician.

11.0 Development requests

In order to help monitor consistency throughout the PCT, the following process for development requests is recommended:

1. All development requests will initially be made via line managers utilising the development request form (CT02) held centrally on the intranet
2. This form will be submitted to the CSG for review
3. The CSG will collate, assess and prioritise the urgency of development requests, then forward them onto the Clinical System Team at Highfield
4. The clinical systems team will escalate development requests onto our Local Service Provider (CSC) - who will prioritise requests and escalate them to TPP as required
5. All escalated development requests will be posted on the PCT intranet site whereby all clinical staff will be able to track progress.
12.0 Where to go for help

Any ongoing help/ advice/ support should initially be requested through the IM&T Help Desk you can contact them by calling 01604 615300.

13.0 References

Department Of Health The NHS Plan 2000

Northamptonshire PCT IM&T 01 Records Management policy Nov 2007

Northamptonshire PCT IM&T 05 Information Governance Strategy 2007/8 July 2007

Northamptonshire PCT GOV 11 Consent to examination and treatment policy March 2007

Northamptonshire PCT IM&T Draft Confidentiality and disclosure policy August 2007

NMC Guidelines on Records and Record Keeping NMC 2004

CSP Core Standards of Physiotherapy, Chartered Society of Physiotherapy 2005.

College of Occupational Therapists Professional Standards for Occupational Therapists 2003

Society of Chiropodists and Podiatrists SCP Guidelines Dec2004

Joint British Dietetics Association and Dieticians Board Guidance on Standards for Records and Record Keeping 2001

Royal college of speech and language therapy Signed up to Quality Feb 2004
APPENDIX 1

Process for requesting new Clinical Templates

1. New templates written and agreed locally
2. Submitted to CSG using Form CT01
3. Templates hazard assessed by CSG
4. Templates verified by CSG
5. Templates and safety report submitted to Clinical Governance Group for approval
   - Reviewed on an annual basis
   - Areas of concern are raised with local team, modifications made and re-submitted
6. Published locally into relevant unit within SystmOne
7. Held on intranet as a source of reference for other groups
APPENDIX 2

Process for requesting new Core Care Plans

1. Core Care Plan written and agreed locally

2. Submitted to CSG using Form CT01

3. Areas of concern are raised with local team, modifications made and re-submitted

4. Core Care Plan hazard assessed by CSG

5. Core Care Plan verified by CSG

6. Reviewed on an annual basis

7. Published locally into relevant unit within SystmOne

8. Held on intranet as a source of reference for other groups
Form CT01

APPENDIX 3

Request for Development of new:  Clinical template  ☐ Core Care plan  ☐

Request made by  (full name) _____________________________________________
Base: ______________________________ Contact Number: ____________________

Title of proposed template _______________________________________________

Reason for development request:

- Amendment to existing template  ☐
- Template does not already exist  ☐
- Change to current practice*  ☐
  *References to relevant best practice guidance must be given

Impact assessment:

- Which team/ professional group will use the template?

- Have they been involved in the development request so far?

- What is the evidence to support this development request?

- Are there any likely adverse effects of this development request?

Further supporting information:

Signed _____________________________  Date ___________________

Please send this form to Wendy Pears, Highfield, Northampton.
**Policy Impact Assessment – Screening Tool**

**Name of Directorate:** IM&T  
**Date of Assessment:** 30th August 2007  
**Policy being assessed:** SystmOne Community Operational Guidelines  
**Assessment Carried out by:** Wendy Pears

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No- these guidelines are for internal purposes only.