

Ward Screen companion



How to login **3-7**

What the screen shows **8**

Where the data comes from **9-17**

Contact **18**

How to login

Power up the PC

Power up the screen

Check input and output connections

Select correct HDMI source on screen

You will need:

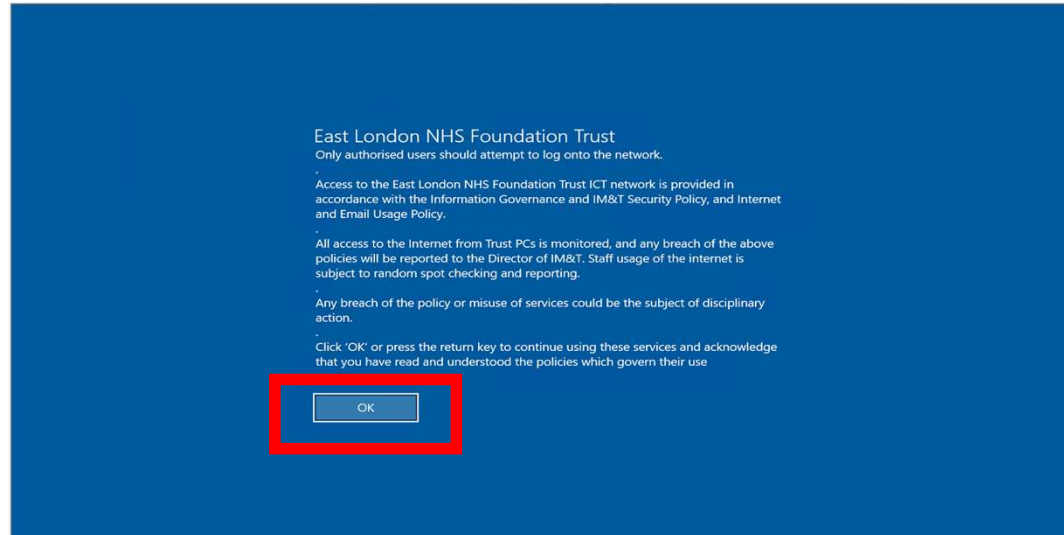
Ward email

Password

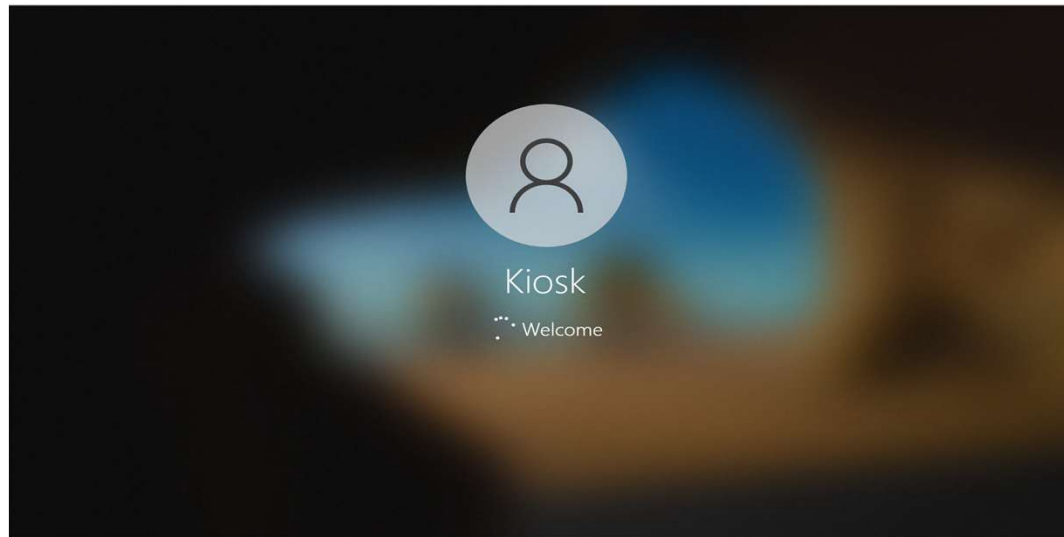
Keyboard & Mouse

Then complete the following 8 stages

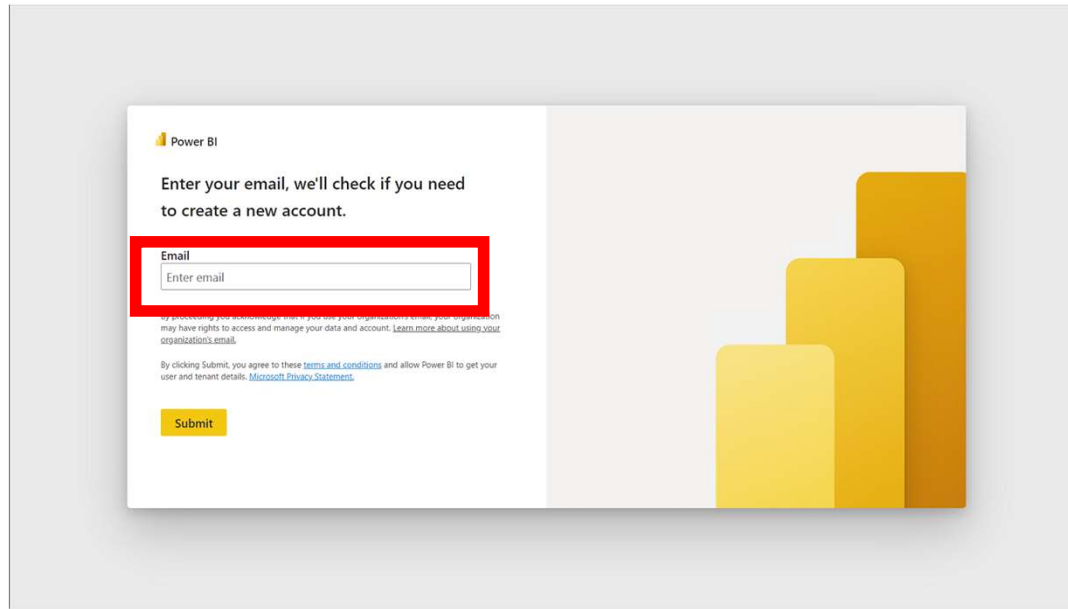
1. Welcome Page



2. Kiosk Login screen (automatic, so nothing to do)



3. Enter email address



Power BI

Enter your email, we'll check if you need to create a new account.

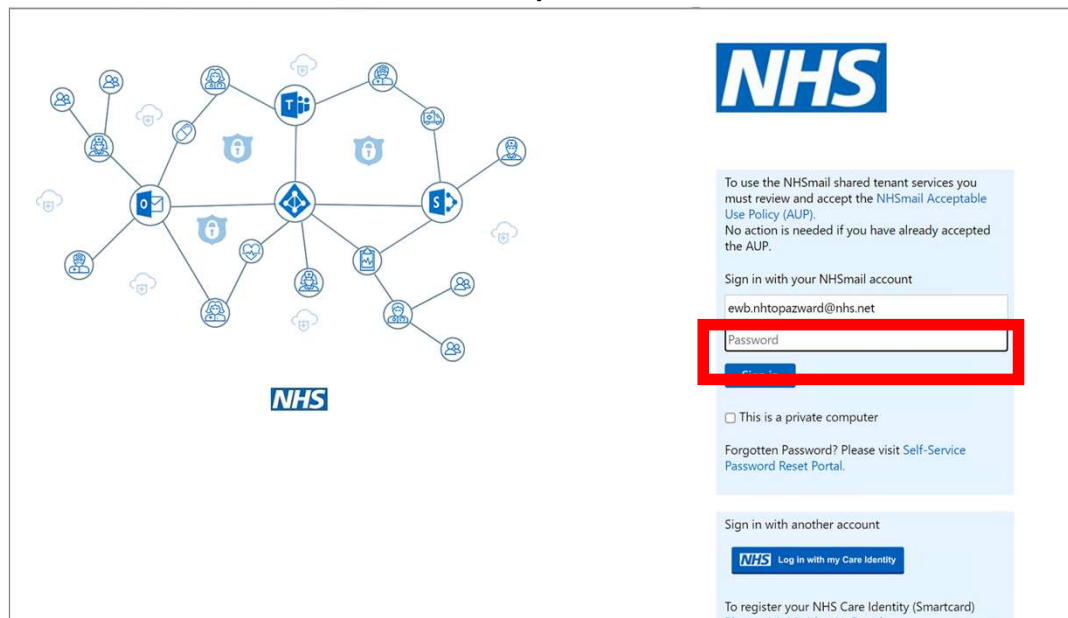
Email

Enter email

By clicking Submit, you agree to these [terms and conditions](#) and allow Power BI to get your user and tenant details. [Microsoft Privacy Statement](#)

Submit

4. Enter password



NHS

To use the NHSmail shared tenant services you must review and accept the NHSmail Acceptable Use Policy (AUP). No action is needed if you have already accepted the AUP.

Sign in with your NHSmail account

ewb.nhtopazward@nhs.net

Password

☐ This is a private computer

Forgotten Password? Please visit [Self-Service Password Reset Portal](#).

Sign in with another account

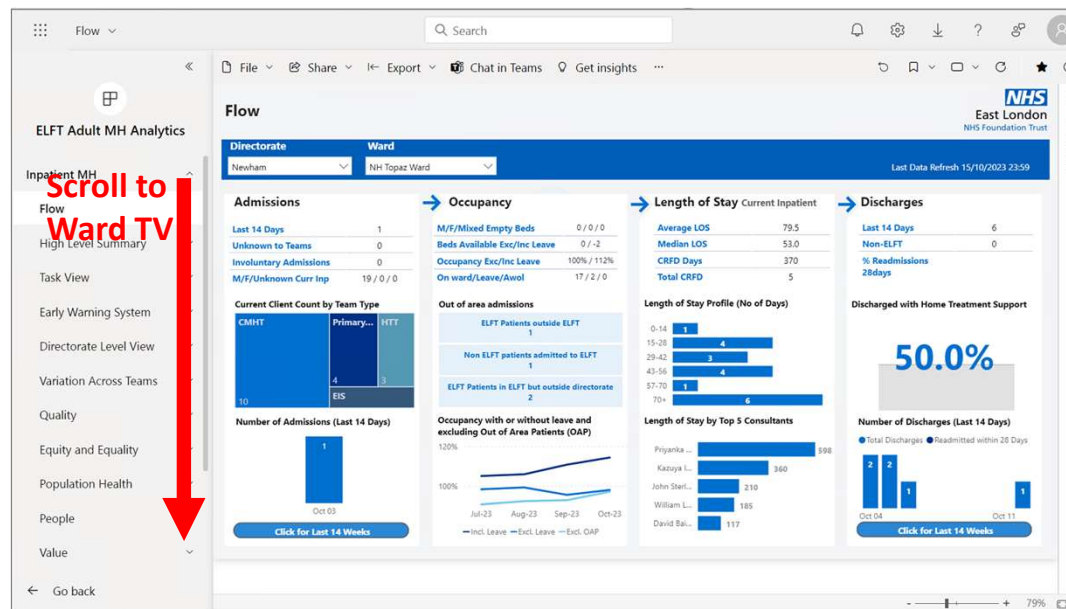
[NHS Log in with my Care Identity](#)

To register your NHS Care Identity (Smartcard) please visit [NHS Care Identity Portal](#)

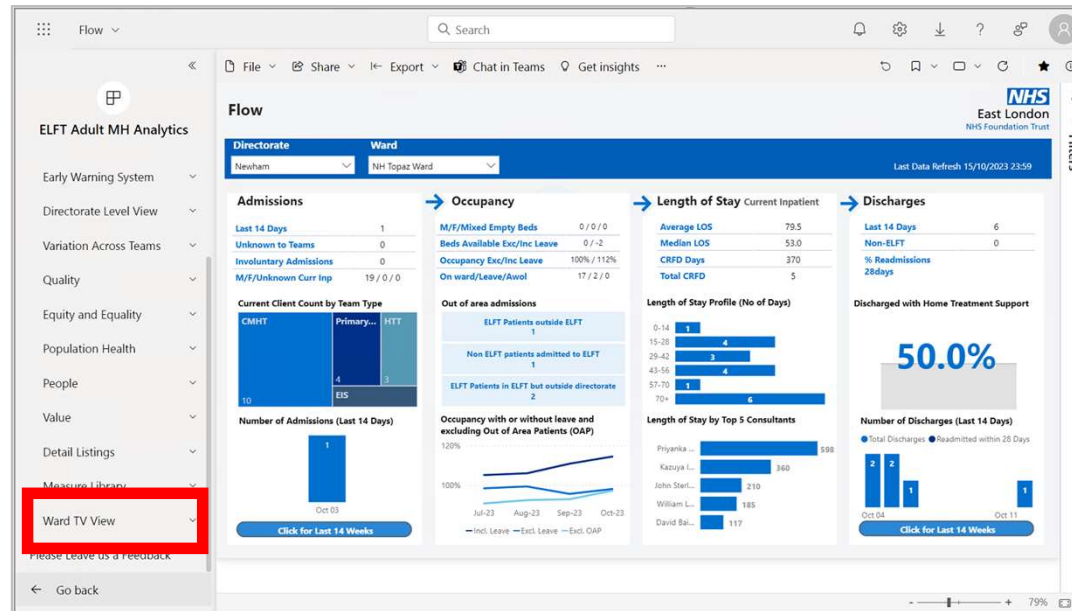
5. Stay Signed in? YES!



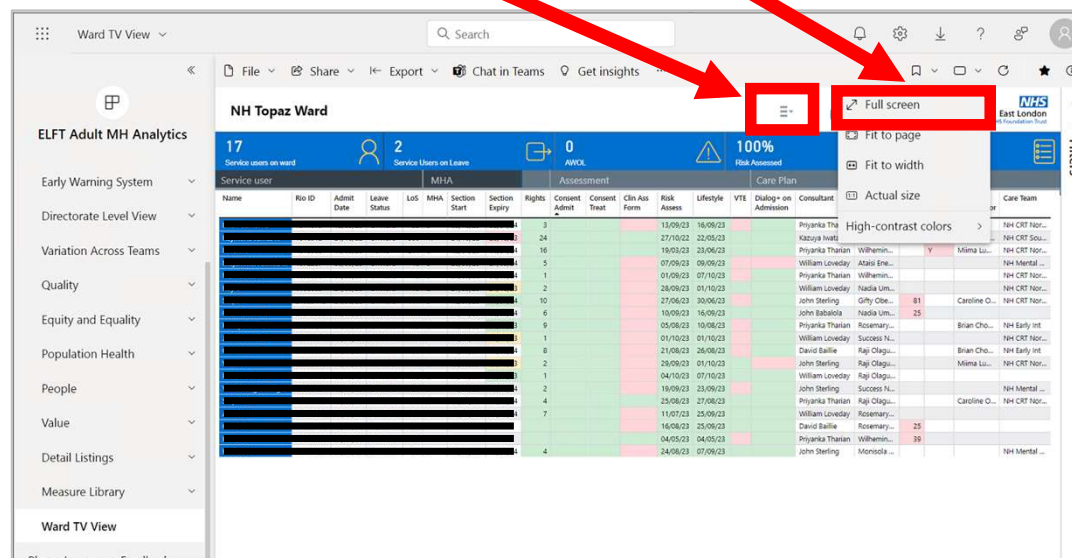
6. Inpatients landing page



7. Select Ward TV link



8. Select Ward and Fullscreen view



What the screen shows

NH Emerald Ward

18 Service users on ward | 3 Service Users on Leave | 0 AWOL | 100% Risk Assessed | 0 Beds Available

Last data refresh: LIVE 14/05/24 11:13 | 24hrs 13/05/24 23:59 | NHS East London NHS Foundation Trust

Service user				MHA		Assessment				Care Plan				Locality							
Name	Rio ID	Admit Date	Leave Status	LoS	MHA	Section Start	Section Expiry	Rights	Consent Admit	Consent Treat	Clin Ass Form	Risk Assess	Lifestyle	VTE	Dialog+ on Adm (Hrs)	Consultant	Named Nurse	CRFD Days	Out of Area	Care Coordinator	Care Team
[REDACTED]	[REDACTED]	[REDACTED]	OnWard	383	3	05/03/24	04/09/24	17	[REDACTED]	[REDACTED]	[REDACTED]	27/04/23 12:16	17/02/24	[REDACTED]	483	Priyanka Tharian	Nichole H...			Johnson	NH CRT Nor...

Annotations:

- Date of Admission on ward (points to Admit Date)
- Total number of days on ward (points to LoS)
- Patient's rights were read prior to admission and the number of rights read (points to Rights)
- Patient consent to treatment (points to Consent Treat)
- Risk Assessment for Venous Thromboembolism completed (points to Risk Assess)
- Number of days between the clinically ready for discharge date and the discharge end date or current date (points to CRFD Days)
- Patient is on ward or home (points to Leave Status)
- MHA section number (points to MHA)
- Patient consent to admission to ward (points to Consent Admit)
- Patient has a clinical assessment form completed and linked to admission (points to Clin Ass Form)
- Patient had lifestyle assessment completed (points to Lifestyle)
- Dialog+ completed (points to Dialog+ on Adm (Hrs))
- Patient admitted from outside ELFT (points to Out of Area)

Where does the data come from in RiO?

Service User

MHA

Assessment

Care Plan

Locality

Admit Date

In RiO's
Case Record Menu

From the **Inpatient Management** drop-down list
Select **Admission**

Case Record Menu

- East London Patient Record (HIE)
- BLMK Shared Care Record
- RiO Patient Record Summary
- Liaison Psychiatry Form
- Documents & Editable Letters
- Medical Documentation (Mental Health)
- Conditions (SNOMED)/Diagnosis (ICD10)
- Risk Information
- Physical Health
- Recovery Care Pathway Documentation
- Safeguarding
- Mental Health Act & Mental Capacity Act
- Clustering
- Client Referrals
- Client Related Data Views
- Inpatient Management**
 - Admission**
 - Discharge
 - Clinically Ready for Discharge
 - Pre Discharge Planning

Admit Date is
drawn from the
Admission Date Field

Admission

Ward: BD Cedar House

Patient Group: Adult MH Patients

Ward Gender: Any

Bay: Cedar Hse Overbooking (15 Free Beds)

Bed: 8

Referral Consultant: No valid referrals exist for this client

Named Nurse: [Redacted]

Type Of Stay: Rehabilitation

Referral Source: Accident And Emergency D

Referral Reason: Detention under the MHA

Referral Type: External Referral

Decided To Admit Date & Time: 23 October 2023 11:17

Admission Date: 23 October 2023 11:17

Admission Source: Care Home Without Nursing

Admission Method: Emergency - Other

Client Classification: Ordinary Admission

Intended Discharge Date: [Redacted]

First in a Regular Series: [Redacted]

Consultant Service: ADULT MENTAL ILLNESS

Other Consultant: [Redacted]

Intended Management: Client to stay in hospital for at least one night

Legal Status on Admission: Section 3

Psychiatric Patient Status: Not known

Administrative Category: NHS Patient, excluding Overseas Visitors

EWS System: NEWS

Transforming Care Indicator: No - Patient is not in scope of transforming care

Associated Documents

Date Type Time

No Documents Associated

Save **Clear**

All mandatory fields
need to be complete
and **Saved**

Leave Status

In RiO's
Demographics window

Select **Inpatient Status**

On bed select
Leave /
Leave Details

Leave Reason and
all mandatory fields
need to be complete
and **Saved**

Demographics

Full Name (ClientID): [Redacted]

Preferred Name: [Redacted]

Alerts

LATEST RISK INFORMATION

My safety is my advance directive

Access to child who has Protection Plan?

Client has a Child Protection Plan?

Next Of Kin

Address

Communication Preferences

Other Communication Info

Interpreter Required

Contact Number(s)

Email Address

Does the Client have a Carer?

Dependants

Registered GP

Teams

Care Co-ordinator

Current Care Level

Cluster Status

MHA Status

Inpatient Status

Subst

Role

Alternative Legacy CHN RiO ID

Bed 5

[Redacted]

Case Record

Admission Record

Discharge

Transfer

Leave **Leave Details**

Sleepover

AWOL

Inpatient Leave

Planned Date & Time: 20 October 2023 14:00

Planned Return Date & Time: [Redacted]

Current Legal Status: Section 3 - Admission for treatment (17 Jan 2024)

Leave Reason: Home Leave

Escorted

Actual Leave Date & Time

Actual Return Date & Time

End Reason

Other Information

Please Select:

- Absent
- Extended Leave
- Home Leave
- Section 17
- Short Leave
- Temporary transfer outside the trust
- Trial Leave

LoS

Length of Stay

Length of Stay in Days (LoS)
= Current Date – Admission date

MHA

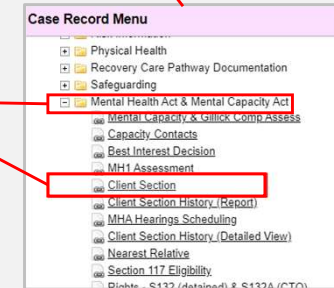
Section number

Section Start

Section Expiry

In RiO's
Case Record Menu

From the **Mental Health Act
& Mental Capacity Act**
drop-down list
Select **Client Section**



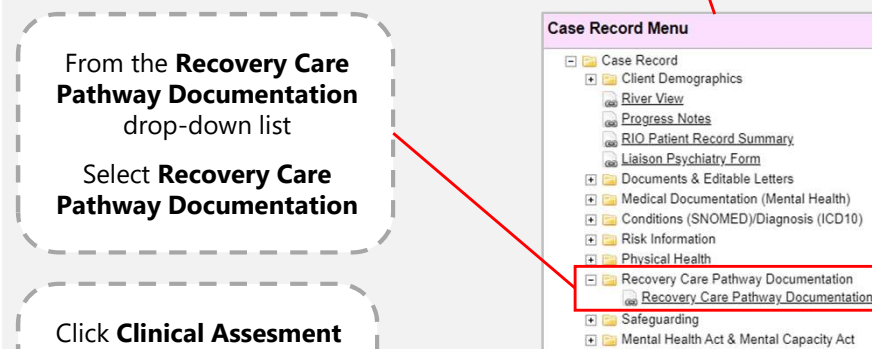
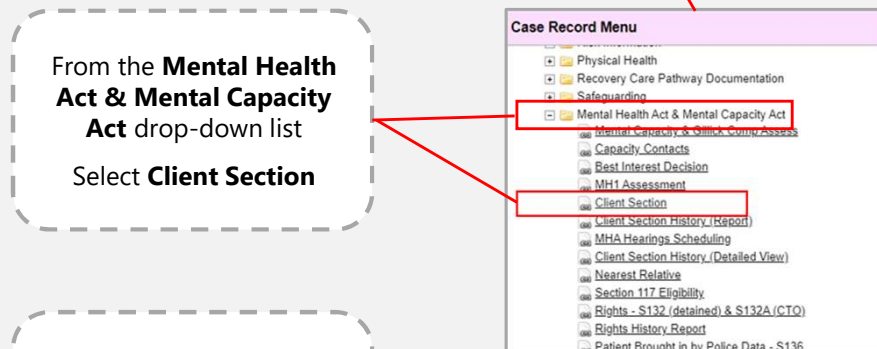
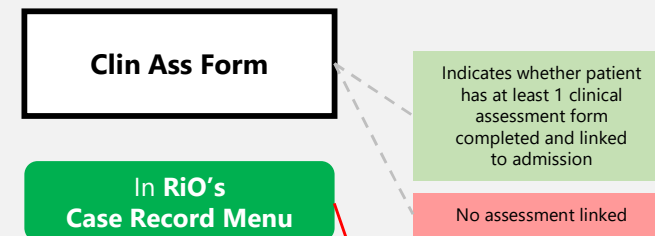
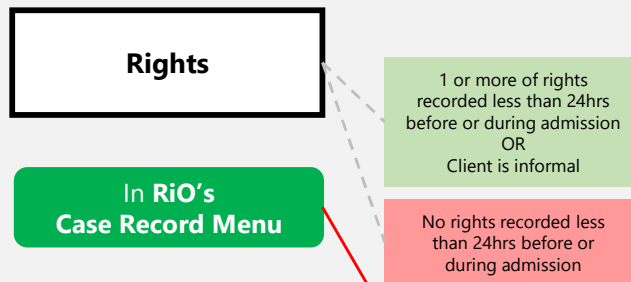
MHA
comes from the
Section Code field
in **Section Detail**

This form is
completed by
the MHA team

A screenshot of the 'Mental Health Act Section' form. The 'Section Detail' section shows 'Section Code' as 'Section 3 - Admission for treatment' (highlighted with a red box) and 'Start Date & Time' as '2 Oct 2023, 16:10' (highlighted with a red box). The 'Reviews' section shows 'Next Expiry Date & Time' as '1 Apr 2024, 23:59' (highlighted with a red box). A red line connects the 'Section Code' field to the text box above. Another red line connects the 'Next Expiry Date & Time' field to the text box below. The form also includes a 'Screen Sections' menu on the left with options like Section Detail, Reviews, Forms Entry, Understanding of Rights, Leaflets, and Associated Documents.

Section Expiry
comes from the
**Next Expiry Date &
Time** field in **Reviews**

Section Start
comes from the
Start Date and Time
field in **Section Detail**



Under **Screen Sections**
Click **Understanding of Rights** to view most recent record

Click **Clinical Assessment** to view complete records
Clin Ass Form comes from last completed form linked to admission

This form is completed by the MHA team

Screen Sections

- Section Data
- Review
- Form Entry
- Understanding of Rights**
- Leaflets
- Associated Documents
- Court Appearances
- Section 117
- Section Discharge

Form Received

Date Form Received

Understanding of Rights

Date and time Patient's rights explained

Level of Patient's understanding

Interpreter required

Comments

Has Patient been informed about IMHA?

Nearest Relative Involvement Attitude

Decision to Appeal

HCP who made assessment

First language

Leaflets

Leaflet Given

Date Given

Menu

- Return Screening & Triage
- DIALOG+
- History and Social
- Clinical Assessment**
- My Safety Plan
- Section 117 Aftercare
- Adult Risk Assessment
- CAMHS Risk Assessment

Clinical Assessment

Assessment	Date/Time	Referral / admission
Assessment	19 June 2023 14:49	Admission: (2)
Assessment	17 June 2022 16:59	Not appropriate
Assessment	9 March 2022 14:00	Not appropriate
Assessment	25 June 2021 08:00	Ref: (25 Jun 2)

Select **Form** to view, Edit current or Create new

CPA Documentation (MH)

Clinical Assessment

Client: ZZTEST, Dummy Patient - 1024059

Date/Time: 19 June 2023 14:49

Referral / admission: Admission (24 Apr 2023) TEST DUMMY

Select the appropriate option for this service user

Service user agreed assessment

Presenting situation / complaints

Admitted from Luton CRHT due to suicidal ideation. Referred to Luton CRHT by GP on 9/7/20 - 'Chaotic lifestyle stays at different addresses, with various people referred to as 'friends'. She was also mentioned been low in mood, tearful most days and

Edit current **Create new** **Index** **History** **Save validation details**

Consent Admit

Consent Treat

In RiO's
Case Record Menu

First assessment done 24hr
or more than 48hrs after
admission date

No assessment after
admission date

From the **Mental Health Act & Mental Capacity Act** drop-down list

Select **Mental Capacity & Gillick Comp Asses**

Consent to Admit and Consent to Treat are determined by the selection from dropdown menu

All mandatory fields
need to be complete
and **Saved**

Case Record Menu

- East London Patient Record (HIE)
- BLMK Shared Care Record
- RiO Patient Record Summary
- Liaison Psychiatry Form
- Documents & Editable Letters
- Medical Documentation (Mental Health)
- Conditions (SNOMED)Diagnosis (ICD10)
- Risk Information
- Physical Health
- Recovery Care Pathway Documentation
- Safeguarding
- Mental Health Act & Mental Capacity Act**
- Mental Capacity & Gillick Comp Asses**
- Capacity - conscious
- Best Interest Decision
- MH1 Assessment
- Client Section
- Client Section History (Report)
- MHA Hearings Scheduling
- Client Section History (Detailed View)
- Nearest Relative
- Section 117 Eligibility
- Rights - S132 (detained) & S132A (CTO)
- Rights History Report
- Patient Brought in by Police Data - S136
- MHA Section Expiry Report - In Word

ClientID* ZZTEST, Dummy Patient - 1024059

Date of Assess. 23 October 2023 11:54

Name of Assessor

Area for which capacity is being assessed

Stage 1

Does the patient have a mental health condition that affects the way their mind works?

Additional information

ACW/RTK, Priya (L1)

Please Select

Please Select

Consent to inpatient admission

Consent to treatment

Consent to information sharing

Finances

Abode/residence

Other

Please Select

Save

Clear

Cancel

Risk Assess

First assessment on or
after admission date

No assessment after
admission date

In RiO's
Case Record Menu

From the **Risk Information** drop-down list

Select **Adult Risk Assessment Form**

Review Assessments Done

Create New form

All mandatory fields
need to be complete
and **Saved**

Case Record Menu

- Progress Notes
- RiO Patient Record Summary
- Liaison Psychiatry Form
- Documents & Editable Letters
- Medical Documentation (Mental Health)
- Conditions (SNOMED)Diagnosis (ICD10)
- Risk Information
- Risk Incidents
- Risk Screening
- Adult Risk Assessment Form**
- CAUHS Risk Assessment Form
- Valorate Risk Assessment Form
- HCR-20

Adult Risk Form

Auto-Saved	Date/time risk summary undertaken	Created by
	15 April 2022 12:35	
	15 March 2022 21:34	
	21 October 2020 14:12	
	9 May 2019 12:00	
	11 July 2018 11:13	
	2 November 2017 15:20	
	29 October 2017 01:39	
	14 September 2017 13:16	
	3 February 2017 14:34	
	20 January 2017 11:23	
	9 January 2017 09:31	
	4 December 2016 15:53	
	1 December 2016 02:51	
	4 July 2016 10:32	

[Create new](#)

Adult Risk Form

Client

Date/time risk summary undertaken

Ref

Open progress notes

With risk, please update the safety plan appropriately to reflect this

Previous and / or Current History

Please tick the boxes to identify the risks from the list below then give details in the free text box

Aggression / Violence to others, including sexual/domestic/other abuse

Preconception with unknown

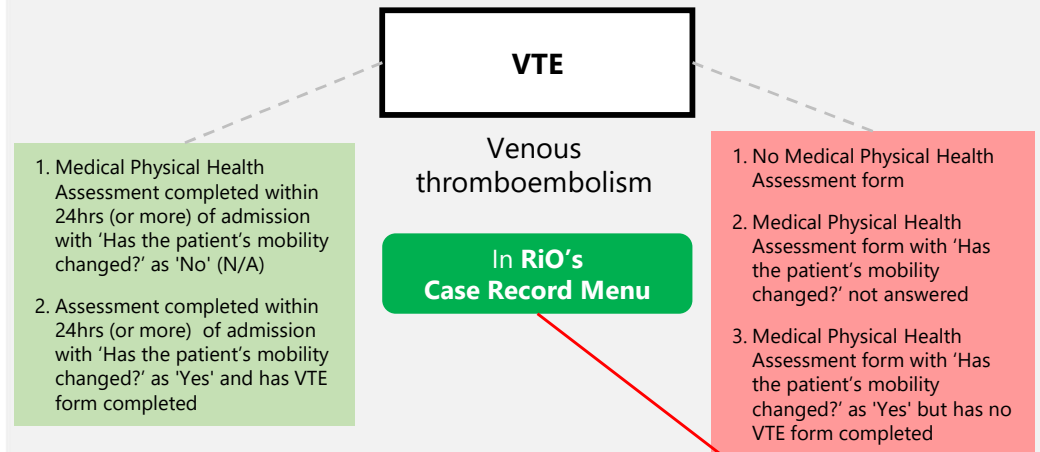
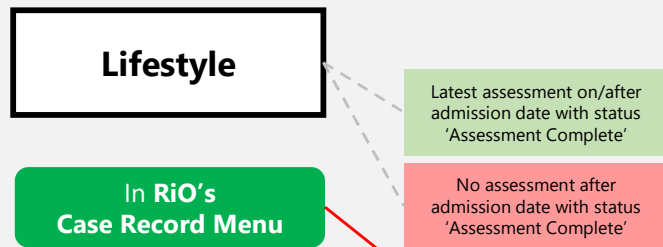
Conviction for violent or sexual c

Arson / Fire setting

Save

Clear

Cancel



From the **Physical Health** drop-down list
Select **Physical Health Assessment Form**

Click **Lifestyle Assessment Form**

All mandatory fields need to be complete and **Saved**

From the **Risk Information** drop-down list
Select **Risk Assessment For VTE**

Create New Form

All mandatory fields need to be complete and **Saved**

VTE can also be set using the Medical Physical Health Assessment form where 'Risk of VTE' field has been entered

**Dialog+
on Adm (Hrs)**

**In RiO's
Case Record Menu**

Number of hours since
assessment done within
48hrs (or more)
of admission.
Minimum 1 question must
be answered by patient for
Dialog + to be counted

No assessment after
admission

From the **Recovery Care
Pathway Documentation**
drop-down list

Select **Recovery Care
Pathway Documentation**

Case Record Menu

- Documents & Editable Letters
- Medical Documentation (Mental Health)
- Conditions (SNOMED)/Diagnosis (ICD10)
- Risk Information
- Physical Health
- Recovery Care Pathway Documentation
- Safeguarding
- Mental Health Act & Mental Capacity Act
- Clustering
- Client Referrals
- Client Related Data-Views
- Inpatient Management
- CAMHS
- Intellectual Disability

Select **Dialog+** then
select **Create New** form

MENU

- Referral Screening & Triage
- DIALOG+**
- History and Context
- Clinical Assessment
- My Safety Plan
- Adult Risk Assessment
- CAMHS Risk Assessment
- Safeguarding forms
- Recovery CPA documentation on the Intranet
- Personal contacts hyperlink

All mandatory fields
need to be complete
and **Saved**

Save Clear Cancel

Consultant

Named Nurse

**In RiO's
Demographics window**

Case Record Menu

- Case Record
- Client Demographics
- Physical Health
- Physical Health Assessment Forms (MH)
- Physical Health Assessments (CommHealth)

Demographics

Full Name (ClientID)
Preferred Name or Surname
Alerts
LATEST RISK INFORMATION
My safety is my advance directive
Access to child who has Protection Plan?
Client has a Child Protection Plan?
Next Of Kin
Address
Communication Preferences
Other Communication Info
Interpreter Required
Contact Number(s)
Email Address
Does the Client have a Carer?
Dependants
Registered GP
Team
Care Coordinator
Current Care Level
Cluster Status
MHA Status
Inpatient Status
School

Select radio button to set
Consultant and **Named Nurse**

All **mandatory fields** need to
be complete and **Saved**

Transfer Out Feb 202

Transfer Client from

Ward	TEST OPEN RIO
Bay	TEST OPEN RIO
Bed	4
Consultant	BALDWIN, Toby (CH)
Service	City and Hackney Adult
Other Consultant	
Named Nurse	

Transfer Date

CRFD

Clinically Ready
for Discharge

In RiO's
Case Record Menu

Case Record Menu

- Physical Health
- Recovery Care Pathway Documentation
- Safeguarding
- Mental Health Act & Mental Capacity Act
- Clustering
- Client Referrals
- Client Related Data-Views
- Inpatient Management
- Admission
 - Clinically Ready for Discharge**
 - Pre Discharge Planning
 - Admission History

From the **Inpatient Management** drop-down list
Select **Clinically Ready for Discharge**

Update Admission Details

View **Update Admission Dates**

CRFD is set when
Ready for Discharge Date
and **all mandatory fields**
are complete and **Saved**

Update Admission Details

Decided To Admit Date & Time

Admission Date: 21 September 2023 12:38

Consultant: [Name]

Named Nurse: [Name]

Consultant Service: Newham Adult

Other Consultant: No Selection Made

Referral: No valid referrals exist for this person

Admission Source: NHS other hospital provider - ward for

Admission Method: Planned

Client Classification: Ordinary Admission

Intended Discharge Date: [Date]

First in a Regular Series: []

Intended Management: Discharge Selected

Ready for Discharge Date: [Date]

Reason for Discharge Delay: Please Select

Legal Status on Admission: Informal

Psychiatric Status: No previous Hospital Provider Spell

Administrative Category: [Category]

Save **Clear** **Cancel**

Out of Area

In RiO's
Demographics window

Case Record Menu

- Case Record
- Client Demographics

Click Demographics

Demographics

Full Name (ClientID)	[Name]
Preferred Name	Unknown
Alerts	
LATEST RISK INFORMATION	None Re
My safety is my advance directive	No
Access to child who has Protection Plan?	(None re
Client has a Child Protection Plan?	(None re
Next Of Kin	

Scroll down next screen
Out of Area is based
on **CCG of GP Practice**

Date Registered	7 Feb 2023
GP Opt Out	
GP	[GP Name]
Practice Name	THE DE PARYS GROUP
Practice Address	DE PARYS GROUP, 23 DE PARYS AVENUE, BEDFORD, MK40 2TX
Practice Phone Number	01234 351341
CCG of GP Practice	NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES ICB - M1J4Y(M1J4Y)
Date Registered With GP Practice	28 Sep 2023
Main Carer	

Care Coordinator

In RiO's
Demographics window

Case Record Menu

Click **Demographics**

Demographics

Full Name (ClientID)
Preferred Name
Alerts
LATEST RISK INFORMATION
My safety is my advance directive
Access to child who has Protection Plan?
Client has a Child Protection Plan?
Next Of Kin
Address
Communication Preferences
Other Communication Info
Interpreter Required
Contact Number(s)
Email Address
Does the Client have a Carer?
Dependants
Registered GP
Teams
Care Co-ordinator
Current Care Level
Cluster Status
Inpatient Status
School
Role
Alternative Legacy CHN RIO ID

Dummy ZZTEST (1024059)
Dale GREENWOOD
Diabetes, Learning Disability, may require reasonable not send text messages. Do not contact Family, Inter aggression, Domestic abuse in household, Learning Attender, Lone worker, Epilepsy, Harassment / Stalk communication support needs, Child in Need, EHCP Accessible information and/or communication support Gender confidentiality issues (see alert text for detail Accessible information and/or communication support 03 Aug 2022 11:10 - Risk Progress Note
Yes
(None recorded) (There may be more data in the Risk Test FAMILY TEST
3 Rush Court, Bedford, Bedfordshire
MK40 3JT
Does not want letters sent to home address
Does not want to receive text messages
Carer's contact details: 0000000000
Interpreter required in Bengali & Dhaka
1254445557 (Home), 0745 486 6377 (Mobile), 0787 test@gmail.com
Not Assessed
Boo Test (Son, 49 week(s) old), Child Test Dummy (Davidson Davidson (Daughter, 6 years old), Test Chi (Unborn, 4 year(s), 5 month(s) old), Ztest Child (So UNKNOWN/Unknown or no GP Practice.)
BD CAMHS Perinatal Infant Psychotherapy, BD Rec CAMHS SPE, Dummy Team, Dummy Team 2, DUMI Born Blood Spot Screening, NH ABT, NH CAMHS EI CRT South, NH Early Intervention Service, NH SPE TH Autism Assessment, TH Bethnal Green Team 1, Respon

Select **Current Care Level**

All mandatory fields need to be complete and **Saved**

CPA/Standard Care Management Edit

CPA Episode Start Date/Time
23 October 2023 10:00

Care Co-ordinator/Lead HCP
ABBAS, Zarina (CA) (CH)

Current Care Level
CPA

Save Clear Cancel

Care Team

In RiO's
Case Record Menu

Case Record Menu

Click **Actions** (top right)

Demographics

Full Name (ClientID)
Preferred Name
Alerts
LATEST RISK INFORMATION
My safety is my advance directive
Access to child who has Protection Plan?
Client has a Child Protection Plan?
Next Of Kin

Mrs Joa
Unknown
None Re
No
(None re

Actions

Select **Referrals/Exit/Entry**
Care Team is drawn from the Referral data

Service	Care Setting	Team	HCP Referred To	Date & time referral received	Contact	To Discharge
Bedford MHCOP	Community Team	BD Mid Beds CMHT OP Sec 117 Reviews (31 Aug 2023)	BAJPAI, Prashant (BD) MITCHELL, Esther (BD)	30 May 2023, 13:25	Y	Transfer
Discharged Referrals						
Bedford Adult	Community Team	BL Street Triage Team	COOMBER, Colleen (BD)	2 May 2023, 16:00	Y	2 May 2023
Bedford Adult	Community Team	BD Crisis Team		27 May 2023, 02:00	Y	27 May 2023
Bedford Adult	Community Team	BD Crisis Team		16 Oct 2023, 13:53	Y	16 Oct 2023



East London
NHS Foundation Trust

For Ward Screen Support Contact

elft.analytics@nhs.net

Ward Screen companion



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Where the data comes from **9-17**

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Power up the PC

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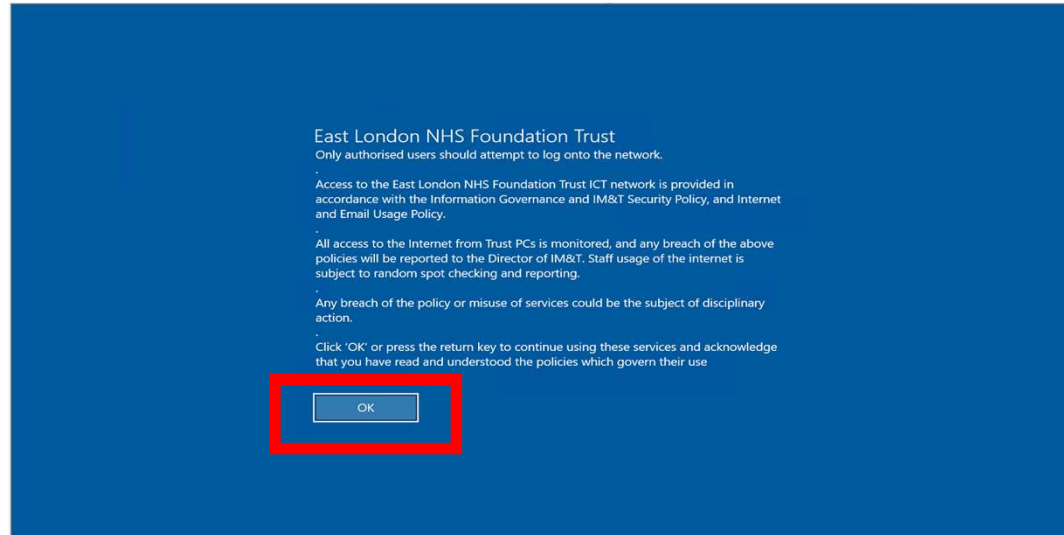
Ward email

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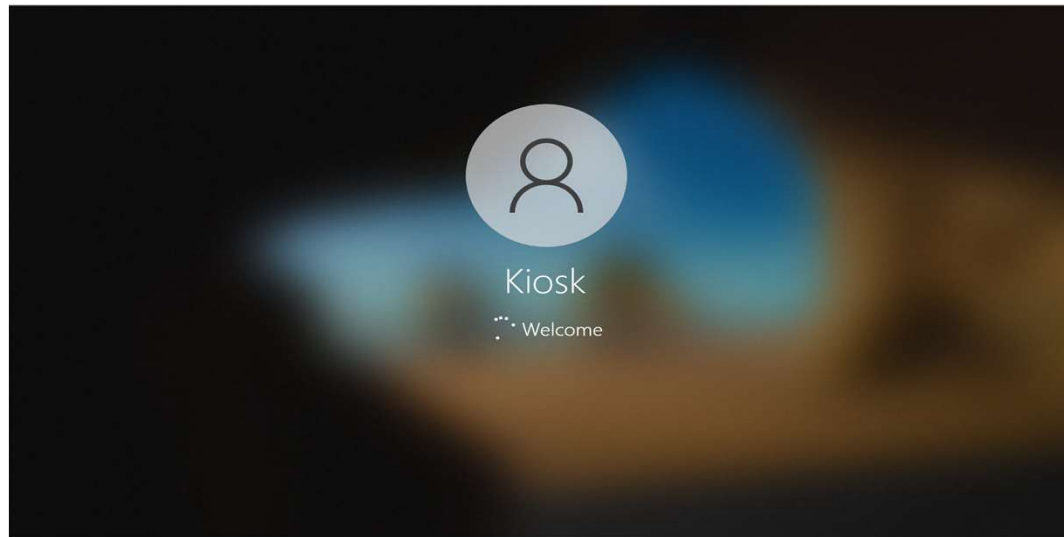
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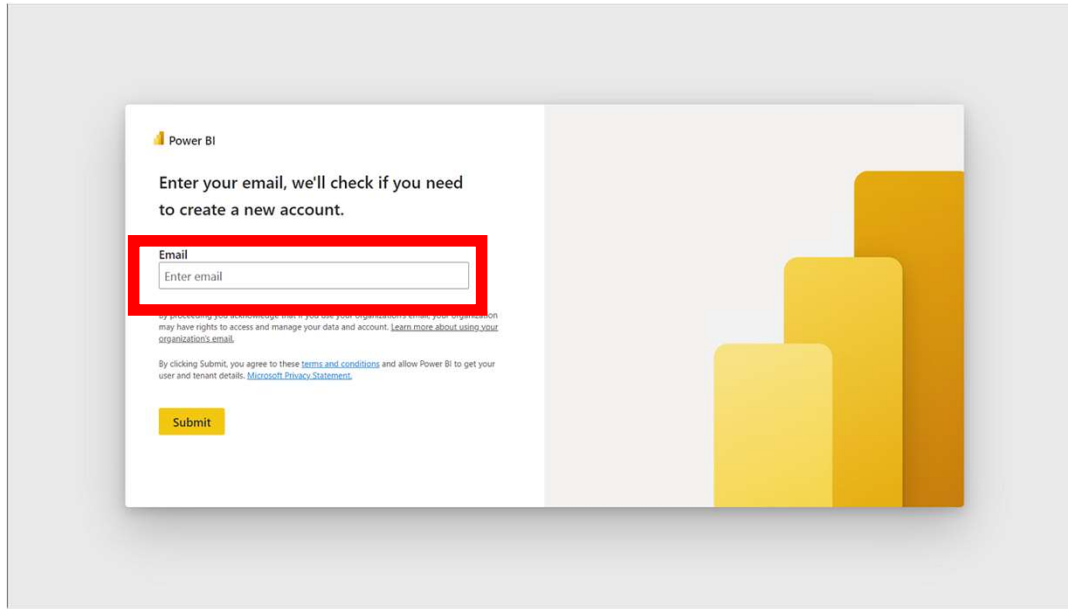
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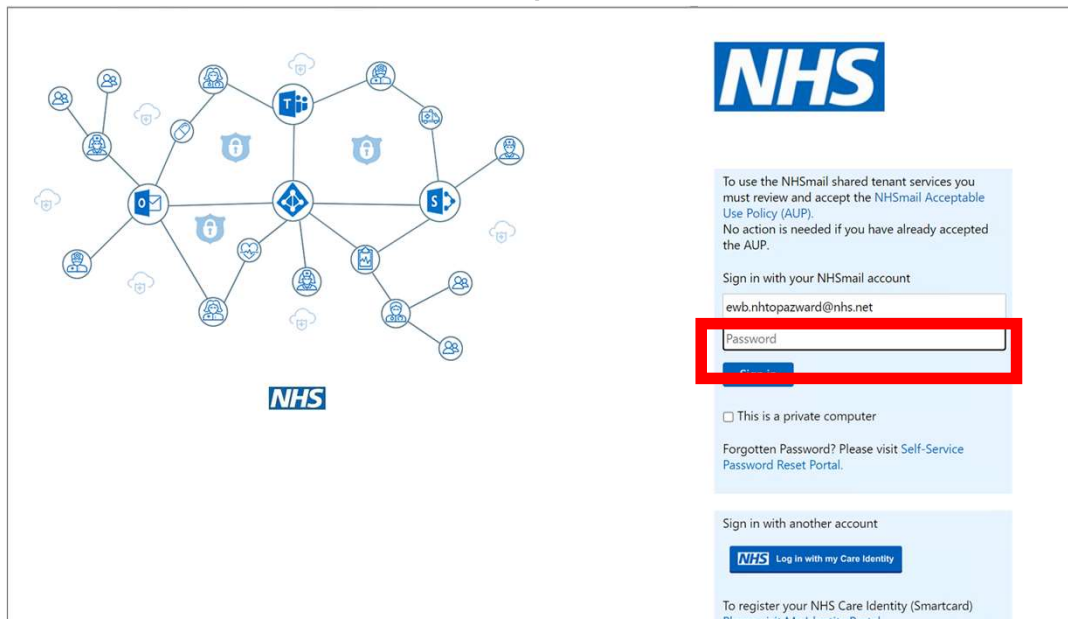
Email

Enter email

By clicking Submit, you agree to these [terms and conditions](#) and allow Power BI to get your user and tenant details. [Microsoft Privacy Statement](#)

Submit

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NHS

To use the NHSmail shared tenant services you must review and accept the NHSmail Acceptable Use Policy (AUP). No action is needed if you have already accepted the AUP.

Sign in with your NHSmail account

ewb.nhtopazward@nhs.net

Password

☐ This is a private computer

Forgotten Password? Please visit [Self-Service Password Reset Portal](#).

Sign in with another account

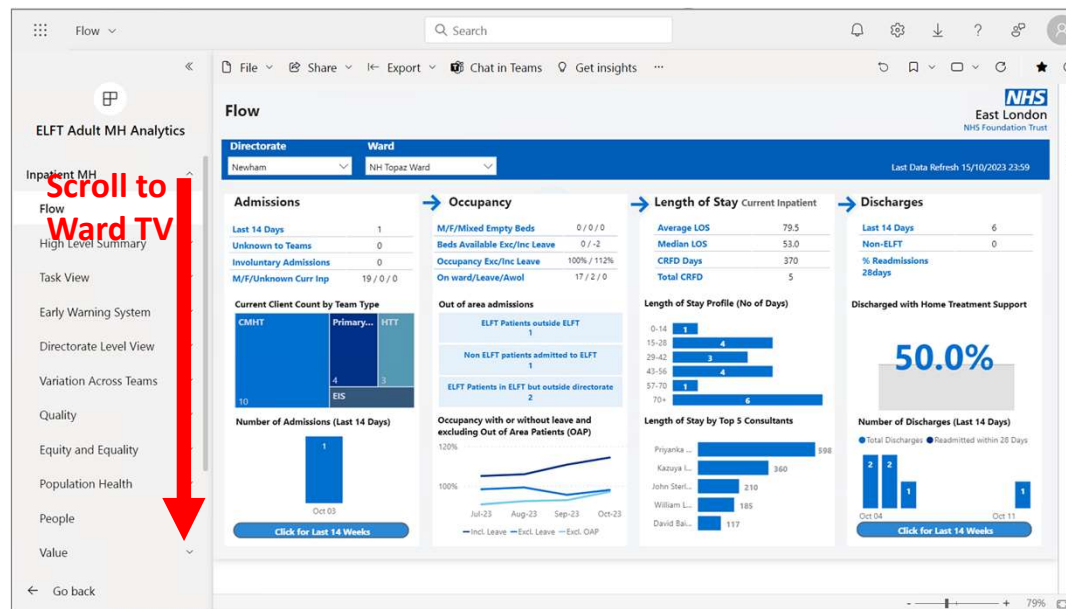
[NHS Log in with my Care Identity](#)

To register your NHS Care Identity (Smartcard) please visit [NHS Care Identity Portal](#)

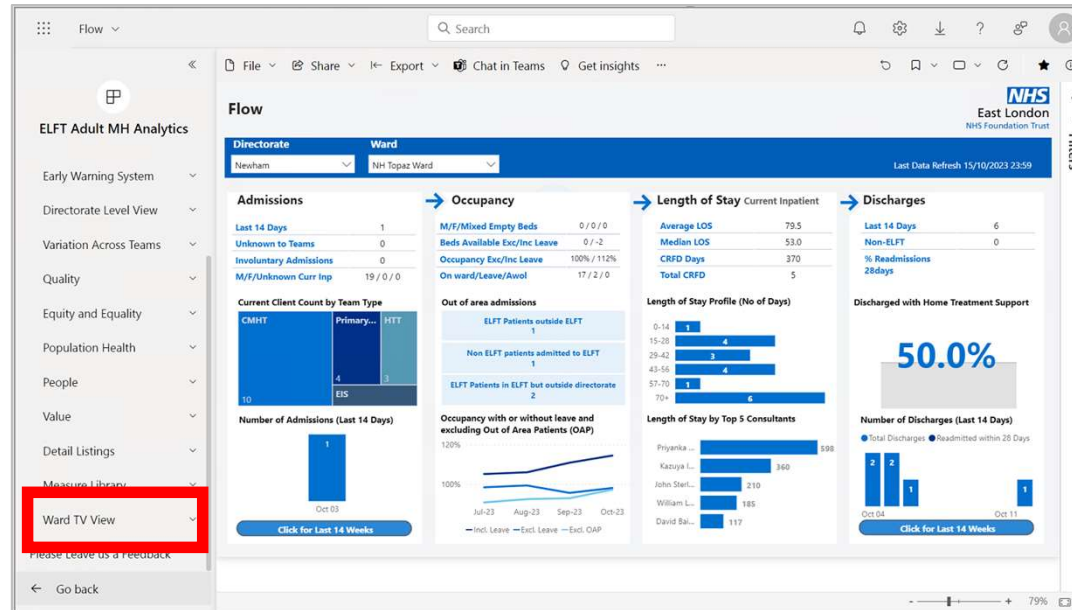
5. Stay Signed in? YES!



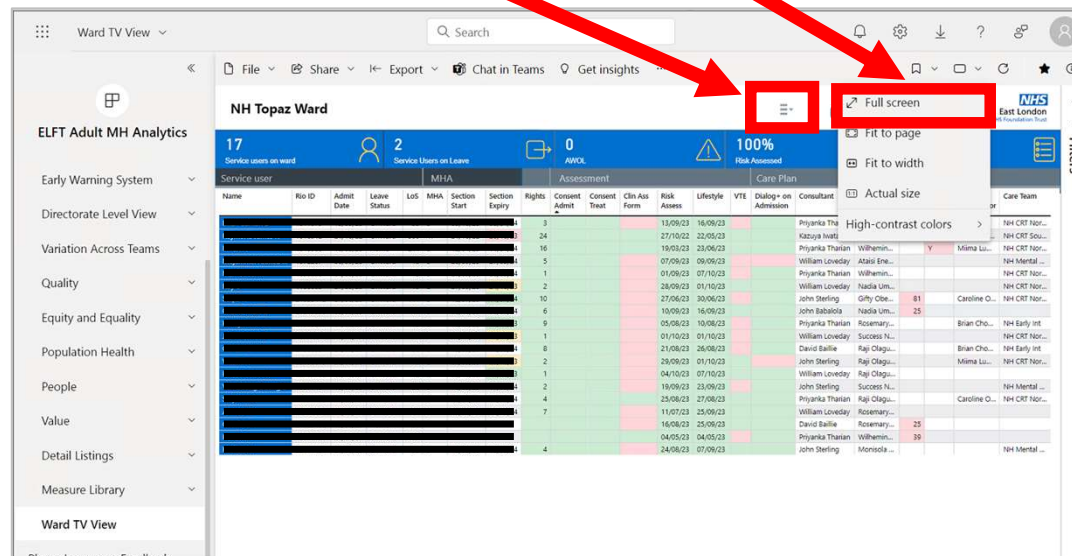
6. Inpatients landing page



7. Select Ward TV link



8. Select Ward and Fullscreen view



What the screen shows

NH Emerald Ward

18 Service users on ward | 3 Service Users on Leave | 0 AWOL | 100% Risk Assessed | 0 Beds Available

Last data refresh: LIVE 14/05/24 11:13 | 24hrs 13/05/24 23:59 | NHS East London NHS Foundation Trust

Service user				MHA		Assessment				Care Plan				Locality							
Name	Rio ID	Admit Date	Leave Status	LoS	MHA	Section Start	Section Expiry	Rights	Consent Admit	Consent Treat	Clin Ass Form	Risk Assess	Lifestyle	VTE	Dialog+ on Adm (Hrs)	Consultant	Named Nurse	CRFD Days	Out of Area	Care Coordinator	Care Team
[REDACTED]	[REDACTED]	[REDACTED]	OnWard	383	3	05/03/24	04/09/24	17	[REDACTED]	[REDACTED]	[REDACTED]	27/04/23 12:16	17/02/24	[REDACTED]	483	Priyanka Tharian	Nichole H...			Johnson	NH CRT Nor...

Annotations:

- Total number of days on ward (points to 18)
- Date of Admission on ward (points to Admit Date)
- Patient's rights were read prior to admission and the number of rights read (points to Rights)
- Patient consent to treatment (points to Consent Treat)
- Risk Assessment for Venous Thromboembolism completed (points to Risk Assess)
- Number of days between the clinically ready for discharge date and the discharge end date or current date (points to CRFD Days)
- Patient is on ward or home (points to Leave Status)
- MHA section number (points to MHA)
- Patient consent to admission to ward (points to Consent Admit)
- Patient has a clinical assessment form completed and linked to admission (points to Clin Ass Form)
- Patient had lifestyle assessment completed (points to Lifestyle)
- Dialog+ completed (points to Dialog+ on Adm (Hrs))
- Patient admitted from outside ELFT (points to Out of Area)

Where does the data come from in RiO?

Service User

MHA

Assessment

Care Plan

Locality

Admit Date

In RiO's
Case Record Menu

From the **Inpatient Management** drop-down list
Select **Admission**

Case Record Menu

- East London Patient Record (HIE)
- BLMK Shared Care Record
- RiO Patient Record Summary
- Liaison Psychiatry Form
- Documents & Editable Letters
- Medical Documentation (Mental Health)
- Conditions (SNOMED)/Diagnosis (ICD10)
- Risk Information
- Physical Health
- Recovery Care Pathway Documentation
- Safeguarding
- Mental Health Act & Mental Capacity Act
- Clustering
- Client Referrals
- Client Related Data-Views
- Inpatient Management**
 - Admission**
 - Discharge
 - Clinically Ready for Discharge
 - Pre-Discharge Planning

Admit Date is
drawn from the
Admission Date Field

Admission

Ward: BD Cedar House

Patient Group: Adult MH Patients

Ward Gender: Any

Bay: Cedar Hse Overbooking (15 Free Beds)

Bed: 8

Referral Consultant: No valid referrals exist for this client

Named Nurse: [Redacted]

Type Of Stay: Rehabilitation

Referral Source: Accident And Emergency D

Referral Reason: Detention under the MHA

Referral Type: External Referral

Decided To Admit Date & Time: 23 October 2023 11:17

Admission Date: 23 October 2023 11:17

Admission Source: Care Home Without Nursing

Admission Method: Emergency - Other

Client Classification: Ordinary Admission

Intended Discharge Date: [Redacted]

First in a Regular Series: [Redacted]

Consultant Service: ADULT MENTAL ILLNESS

Other Consultant: [Redacted]

Intended Management: Client to stay in hospital for at least one night

Legal Status on Admission: Section 3

Psychiatric Patient Status: Not known

Administrative Category: NHS Patient, excluding Overseas Visitors

EWS System: NEWS

Transforming Care Indicator: No - Patient is not in scope of transforming care

Associated Documents

Date Type Time

No Documents Associated

Save **Clear**

All mandatory fields
need to be complete
and **Saved**

Leave Status

In RiO's
Demographics window

Select **Inpatient Status**

On bed select
Leave /
Leave Details

Leave Reason and
all mandatory fields
need to be complete
and **Saved**

Case Record Menu

- Case Record
- Client Demographics
- River View

Physical Health

- Physical Health Assessment Forms (MHA)
- Physical Health Assessments (CommHealth)
- Height, Weight and BMI Record
- Physical Health COQIN Overview
- Physical Health COQIN missing data
- Recovery Care Pathway Documentation

Demographics

Full Name (ClientID)

Preferred Name or Surname

Alerts

LATEST RISK INFORMATION

My safety is my advance directive

Access to child who has Protection Plan?

Client has a Child Protection Plan?

Next Of Kin

Address

Communication Preferences

Other Communication Info

Interpreter Required

Contact Number(s)

Email Address

Does the Client have a Carer?

Dependants

Registered GP

Teams

Care Co-ordinator

Current Care Level

Cluster Status

MHA Status

Inpatient Status

Subst

Role

Alternative Legacy CHN RiO ID

Bed 5

Case Record

Admission Record

Discharge

Transfer

Leave **Leave Details**

Sleepover

AWOL

Inpatient Leave

Planned Date & Time: 20 October 2023 14:00

Planned Return Date & Time: [Redacted]

Current Legal Status: Section 3 - Admission for treatment (17 Jan 2024)

Leave Reason: Home Leave

Escorted: [Redacted]

Actual Leave Date & Time: [Redacted]

Actual Return Date & Time: [Redacted]

End Reason: [Redacted]

Other Information: [Redacted]

Please Select:

- Absent
- Extended Leave
- Home Leave
- Section 17
- Short Leave
- Temporary transfer outside the trust
- Trial Leave

LoS

Length of Stay

Length of Stay in Days (LoS)
= Current Date – Admission date

MHA

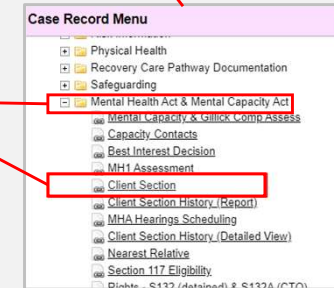
Section number

Section Start

Section Expiry

In RiO's
Case Record Menu

From the **Mental Health Act
& Mental Capacity Act**
drop-down list
Select **Client Section**



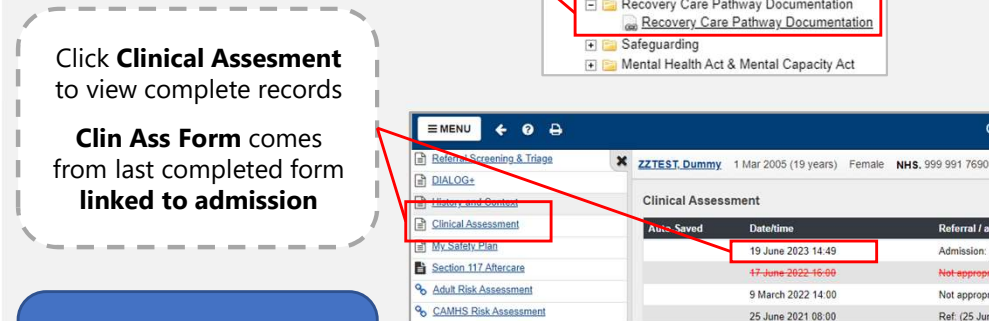
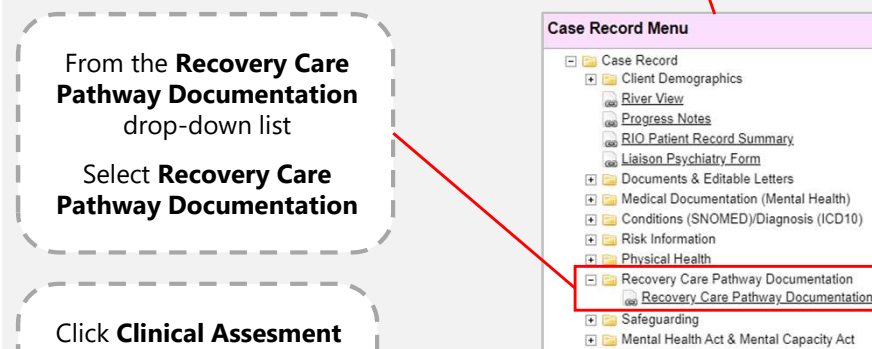
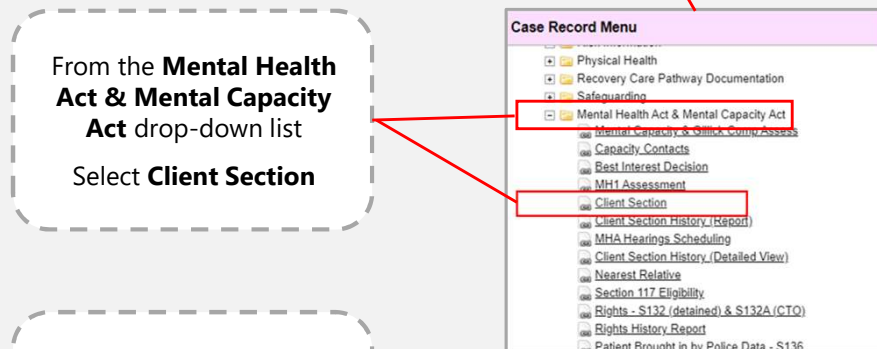
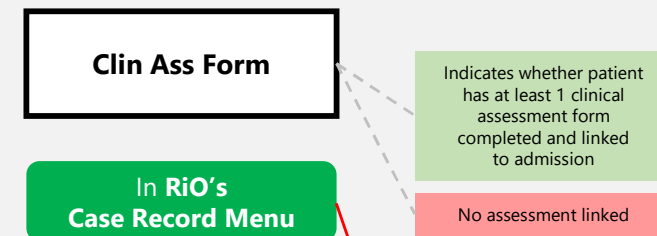
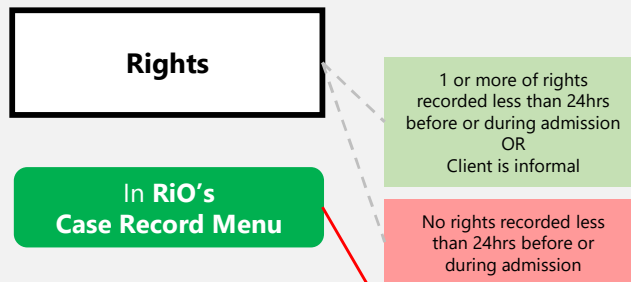
MHA
comes from the
Section Code field
in **Section Detail**

This form is
completed by
the MHA team

The screenshot shows the 'Mental Health Act Section' form. The 'Section Detail' section includes fields for 'Section Code', 'Start Date & Time', 'Admission Legal Status', 'Responsible Clinician', 'First Medical Recommendation', 'Section Made By', 'Client Category', 'First Relative Notified Date', and 'Admission Date'. The 'Reviews' section includes fields for 'Next Expiry Date & Time', 'Next Review Date & Time', and 'Review Held Date & Time'. Red boxes highlight the 'Section Code' field in 'Section Detail' and the 'Next Expiry Date & Time' field in 'Reviews'.

Section Expiry
comes from the
**Next Expiry Date &
Time** field in **Reviews**

Section Start
comes from the
Start Date and Time
field in **Section Detail**



Screen Sections

- Section Data
- Review
- Form Entry
- Understanding of Rights**
- Leaflets
- Associated Documents
- Court Appearances
- Section 117
- Section Discharge

Form Received

Date Form Received

Understanding of Rights

Date and time Patient's rights explained

Level of Patient's understanding

Interpreter required

Comments

Has Patient been informed about IMHA?

Nearest Relative involvement Attitude

Decision to Appeal

HCP who made assessment

First language

Leaflets

Leaflet Given

Date Given

CPA Documentation (MH)

Clinical Assessment

Client: ZZTEST, Dummy Patient - 1024059

Date/Time: 19 June 2023 14:49

Referral / admission: Admission (24 Apr 2023) TEST DUMMY

Select the appropriate option for this service user

Service user agreed assessment

Presenting situation / complaints

Admitted from Luton CRHT due to suicidal ideation. Referred to Luton CRHT by GP on 9/7/20 - 'Chaotic lifestyle stays at different addresses, with various people referred to as 'friends'. She was also mentioned been low in mood, tearful most days and

Edit current **Create new** **Index** **History** **Save validation details**

Consent Admit

Consent Treat

In RiO's Case Record Menu

First assessment done 24hr or more than 48hrs after admission date

No assessment after admission date

From the **Mental Health Act & Mental Capacity Act** drop-down list

Select **Mental Capacity & Gillick Comp Asses**

Consent to Admit and Consent to Treat are determined by the selection from dropdown menu

All mandatory fields need to be complete and Saved

Case Record Menu

- East London Patient Record (HIE)
- BLMK Shared Care Record
- RiO Patient Record Summary
- Liaison Psychiatry Form
- Documents & Editable Letters
- Medical Documentation (Mental Health)
- Conditions (SNOMED)Diagnosis (ICD10)
- Risk Information
- Physical Health
- Recovery Care Pathway Documentation
- Safeguarding
- Mental Health Act & Mental Capacity Act**
- Mental Capacity & Gillick Comp Asses**
- Capacity - conscious
- Best Interest Decision
- MH1 Assessment
- Client Section
- Client Section History (Report)
- MHA Hearings Scheduling
- Client Section History (Detailed View)
- Nearest Relative
- Section 117 Eligibility
- Rights - S132 (detained) & S132A (CTO)
- Rights History Report
- Patient Brought in by Police Data - S136
- MHA Section Expiry Report - In Word

Mental Capa

ClientID* ZZTEST, Dummy Patient - 1024059

Date of Assess. 23 October 2023 11:54

Name of Assessor

Area for which capacity is being assessed

Please Select

Please Select

Consent to inpatient admission

Consent to information sharing

Finances

Abode/residence

Other

Please Select

Save

Clear

Cancel

Risk Assess

First assessment on or after admission date

No assessment after admission date

In RiO's Case Record Menu

From the **Risk Information** drop-down list

Select **Adult Risk Assessment Form**

Review Assessments Done

Create New form

Case Record Menu

- Progress Notes
- RiO Patient Record Summary
- Liaison Psychiatry Form
- Documents & Editable Letters
- Medical Documentation (Mental Health)
- Conditions (SNOMED)Diagnosis (ICD10)
- Risk Information
- Risk Incidents
- Risk Screening
- Adult Risk Assessment Form**
- CAUHS Risk Assessment Form
- Valorate Risk Assessment Form
- HCR-20

Adult Risk Form

Auto-Saved	Date/time risk summary undertaken	Created by
	15 April 2022 12:35	
	15 March 2022 21:34	
	21 October 2020 14:12	
	9 May 2019 12:00	
	11 July 2018 11:13	
	2 November 2017 15:20	
	29 October 2017 01:39	
	14 September 2017 13:16	
	3 February 2017 14:34	
	20 January 2017 11:23	
	9 January 2017 09:31	
	4 December 2016 15:53	
	1 December 2016 02:51	
	4 July 2016 10:32	

Create new

Adult Risk Form

Client

Date/time risk summary undertaken

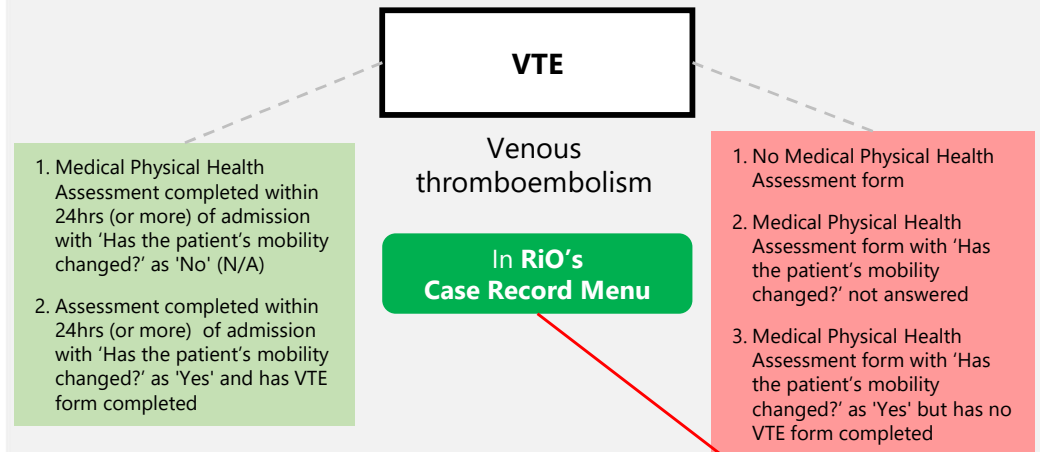
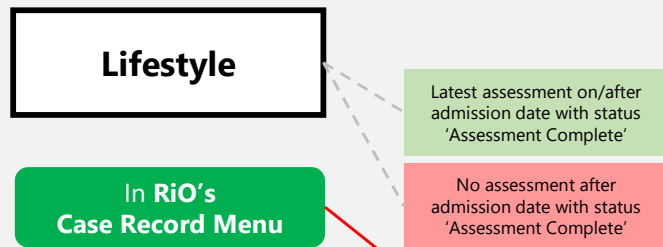
Ref

Clear

Save

Clear

Cancel



From the **Physical Health** drop-down list
Select **Physical Health Assessment Form**

Click **Lifestyle Assessment Form**

All mandatory fields need to be complete and **Saved**

From the **Risk Information** drop-down list
Select **Risk Assessment For VTE**

Create New Form

All mandatory fields need to be complete and **Saved**

VTE can also be set using the Medical Physical Health Assessment form where 'Risk of VTE' field has been entered

**Dialog+
on Adm (Hrs)**

Number of hours since
assessment done within
48hrs (or more)
of admission.
Minimum 1 question must
be answered by patient for
Dialog + to be counted

No assessment after
admission

**In RiO's
Case Record Menu**

From the **Recovery Care
Pathway Documentation**
drop-down list
Select **Recovery Care
Pathway Documentation**

Case Record Menu

- Documents & Editable Letters
- Medical Documentation (Mental Health)
- Conditions (SNOMED)/Diagnosis (ICD10)
- Risk Information
- Physical Health
- Recovery Care Pathway Documentation
- Safeguarding
- Mental Health Act & Mental Capacity Act
- Clustering
- Client Referrals
- Client Related Data-Views
- Inpatient Management
- CAMHS
- Intellectual Disability

Select **Dialog+** then
select **Create New** form

MENU

- Referral Screening & Triage
- DIALOG+**
- History and Context
- Clinical Assessment
- My Safety Plan
- Adult Risk Assessment
- CAMHS Risk Assessment
- Safeguarding forms
- Recovery CPA documentation on the Intranet
- Personal contacts hyperlink

All mandatory fields
need to be complete
and **Saved**

Save Clear Cancel

Consultant

Named Nurse

**In RiO's
Demographics window**

Case Record Menu

- Case Record
- Client Demographics
- Physical Health
- Physical Health Assessment Forms (MH)
- Physical Health Assessments (CommHealth)

Click **Inpatient Status**

On **Transfer**
select **Out**

Demographics

Full Name (ClientID)
Preferred Name or Surname
Alerts
LATEST RISK INFORMATION
My safety is my advance directive
Access to child who has Protection Plan?
Client has a Child Protection Plan?
Next Of Kin
Address
Communication Preferences
Other Communication Info
Interpreter Required
Contact Number(s)
Email Address
Does the Client have a Carer?
Dependents
Registered GP
Team
Care Coordinator
Current Care Level
Cluster Status
MHA Status
Inpatient Status
School
Job

Select radio button to set
Consultant and **Named Nurse**

All **mandatory fields** need to
be complete and **Saved**

Bed 4
ZZTEST, Dummy Three - 21601517 (Delayed Discharge)
Age: 37 years DOB: 13 Nov 1985 Sex: M

Transfer Client from

Discharge
MHA Sect
Section
Leave
Cluster
Observ
Seclusion
Access To
Delayed Di
Current Me
Sleepover
Observation Charts

Transfer Out Feb 202

Transfer Client from

Ward	TEST OPEN RIO
Bay	TEST OPEN RIO
Bed	4
Consultant	BALDWIN, Toby (CH)
Service	City and Hackney Adult
Other Consultant	
Named Nurse	

Transfer Date

CRFD

Clinically Ready
for Discharge

In RiO's
Case Record Menu

From the **Inpatient
Management**
drop-down list

Select **Clinically Ready for
Discharge**

Case Record Menu

- Physical Health
- Recovery Care Pathway Documentation
- Safeguarding
- Mental Health Act & Mental Capacity Act
- Clustering
- Client Referrals
- Client Related Data-Views
- Inpatient Management
 - Admission
 - Clinically Ready for Discharge**
 - Pre Discharge Planning
 - Admission History

Update Admission Details

View **Update
Admission Dates**

Decided To Admit Date & Time

Admission Date: 21 September 2023 12:38

Consultant: [Name]

Named Nurse: [Name]

Consultant Service: Newham Adult

Other Consultant: No Selection Made

Referral: No valid referrals exist for this person

Admission Source: NHS other hospital provider - ward for

Admission Method: Planned

Client Classification: Ordinary Admission

Intended Discharge Date: [Date]

First in a Regular Series: []

Intended Management: Discharge

Ready for Discharge Date: [Date]

Reason for Discharge Delay: Please Select

Legal Status on Admission: Informal

Psychiatric Status: No previous Hospital Provider Spell

Administrative Category: [Category]

CRFD is set when
Ready for Discharge Date
and **all mandatory fields**
are complete and **Saved**

Save

Clear

Cancel

Out of Area

In RiO's
Demographics window

Click **Demographics**

Case Record Menu

- Case Record
- Client Demographics**
- Physical Health

Demographics

Full Name (ClientID): [Name]

Preferred Name: Unknown

Alerts: [Status]

LATEST RISK INFORMATION: None Re

My safety is my advance directive: No

Access to child who has Protection Plan?: (None re

Client has a Child Protection Plan?: (None re

Next Of Kin: [Name]

Scroll down next screen
Out of Area is based
on **CCG of GP Practice**

Date Registered: 7 Feb 2023

GP Opt Out: [Status]

GP: [GP Name]

Practice Name: THE DE PARYS GROUP

Practice Address: DE PARYS GROUP, 23 DE PARYS AVENUE, BEDFORD, MK40 2TX

Practice Phone Number: 01234 351341

CCG of GP Practice: NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES ICB - M1J4Y(M1J4Y)

Date Registered With GP Practice: 28 Sep 2023

Main Carer: [Name]

Care Coordinator

In RiO's
Demographics window

Case Record Menu

Click **Demographics**

Demographics

Full Name (ClientID)
Preferred Name
Alerts
LATEST RISK INFORMATION
My safety is my advance directive
Access to child who has Protection Plan?
Client has a Child Protection Plan?
Next Of Kin
Address
Communication Preferences
Other Communication Info
Interpreter Required
Contact Number(s)
Email Address
Does the Client have a Carer?
Dependants
Registered GP
Teams
Care Co-ordinator
Current Care Level
Cluster Status
Inpatient Status
School
Role
Alternative Legacy CHN RIO ID

Dummy ZZTEST (1024059)
Dale GREENWOOD
Diabetes, Learning Disability, may require reasonable adjustments. Do not contact Family, Inter aggression, Domestic abuse in household, Learning Attender, Lone worker, Epilepsy, Harassment / Stalk communication support needs, Child in Need, EHCP Accessible information and/or communication support Gender confidentiality issues (see alert text for detail) Accessible information and/or communication support 03 Aug 2022 11:10 - Risk Progress Note
Yes
(None recorded) (There may be more data in the Risk Test FAMILY TEST
3 Rush Court, Bedford, Bedfordshire
MK40 3JT
Does not want letters sent to home address
Does not want to receive text messages
Carer's contact details: 0000000000
Interpreter required in Bengali & Dhaka
1254445557 (Home), 0745 486 6377 (Mobile), 0787 test@gmail.com
Not Assessed
Boo Test (Son, 49 week(s) old), Child Test Dummy (Davidson Davidson (Daughter, 6 years old), Test Chi (Unborn, 4 year(s), 5 month(s) old), Ztest Child (So UNKNOWN/Unknown or no GP Practice.)
BD CAMHS Perinatal Infant Psychotherapy, BD Rec CAMHS SPE, Dummy Team, Dummy Team 2, DUMI Born Blood Spot Screening, NH ABT, NH CAMHS EI CRT South, NH Early Intervention Service, NH SPE TH Autism Assessment, TH Bethnal Green Team 1, Responses
Nazeema (CH) Ramjaun
CPA
Cluster 7, WARNING: No start date recorded!
None
Alban Academy
Client and Carer: caring for No Clients
1136407

Select **Current Care Level**

All mandatory fields need to be complete and **Saved**

CPA/Standard Care Management Edit

CPA Episode Start Date/Time 23 October 2023 10:00

Care Co-ordinator/Lead HCP ABBAS, Zarina (CA) (CH)

Current Care Level CPA

Save

Clear

Cancel

Care Team

In RiO's
Case Record Menu

Case Record Menu

Click **Actions** (top right)

Demographics

Full Name (ClientID)
Preferred Name
Alerts
LATEST RISK INFORMATION
My safety is my advance directive
Access to child who has Protection Plan?
Client has a Child Protection Plan?
Next Of Kin

Mrs Joa
Unknown
None Re
No
(None re

Actions

Select **Referrals/Exit/Entry**
Care Team is drawn from the Referral data

Service	Care Setting	Team	HCP Referred To	Date & time referral received	Contact	To Discharge
Bedford MHCOP	Community Team	BD Mid Beds CMHT OP Sec 117 Reviews (31 Aug 2023)	BAJPAI, Prashant (BD) MITCHELL, Esther (BD)	30 May 2023, 13:25	Y	Transfer
Discharged Referrals						
Bedford Adult	Community Team	BL Street Triage Team	COOMBER, Colleen (BD)	2 May 2023, 16:00	Y	2 May 2023
Bedford Adult	Community Team	BD Crisis Team		27 May 2023, 02:00	Y	27 May 2023
Bedford Adult	Community Team	BD Crisis Team		16 Oct 2023, 13:53	Y	16 Oct 2023



East London
NHS Foundation Trust

For Ward Screen Support Contact

elft.analytics@nhs.net