RiO

The mental health solution

The RiO mental health electronic records system is already being used by thousands of people across the NHS, providing an electronic version of each client's care record. In many trusts this means that, for the first time, up to date client information is available when it is needed, rather than remaining filed as a paper record where the treatment was given. This enables healthcare professionals to provide more joined up, safer care.

What are the benefits?

RiO mental health system is very versatile and has a broad range of clinical and administrative functions. You can set up clinics, check availability and book or change appointments. It is easy to manage large caseloads as you can assign or change cases allocated to members of the care team. Planning is more straightforward as you can schedule regular activities such as developmental reviews. Having appointments in an electronic calendar also means that it is easier to manage clients if a member of staff has an unplanned absence.

> "The new systems are all about making life simpler – simpler for NHS staff to access patient data which is in the right place at the right time, and simpler for patients to deal with a more efficient NHS."
> **Martin Baggaley, medical director and consultant psychiatrist**

Here is a brief overview of the benefits to patients and staff:

Key benefits of RiO	Client	Clinical staff	Admin staff
Better care for clients as assessments can be shared across teams, speeding up decision-making.	✓	✓	✓
Greater client safety and risk management with online access to complete and accurate risk assessments, leading to earlier identification of risks and issues.	✓	✓	✓
Improved client crisis management from real-time access to crisis plans.	✓	✓	✓
Better planning and coordination of care with the ability to manage caseloads more effectively across multi-disciplinary teams.	✓	✓	✓
Greater client security with a reduction in multiple records and fewer one-off and repeated assessments.	✓	✓	✓
Client confidentiality safeguarded through nationally agreed role-based access controls.	✓	✓	✓
Better legal compliance with tools available to manage sections, appeals, reviews and tribunals.		✓	✓
More proactive planning of services with management information and mandatory reporting, including mental health minimum data set, sourced from more accurate and timely data.		✓	✓

Reaping the rewards: the benefits of RiO

Clinicians are embracing the switch from paper to electronic records that RiO enables. Client care is being improved by ensuring clinicians have accurate, up to date and secure information available round the clock – something that is often vital in an emergency.

Oxleas NHS Foundation Trust was one of the first of London's mental health trusts to have completed a trust-wide switch to electronic records. The trust serves three South East London boroughs with a combined population of about a million people. Dr Hashim Reza, consultant psychiatrist and clinical director at Oxleas NHS Foundation Trust, said: "The London mental healthcare community now has a computerised client record system that is as good as any in the world. It is helping clinicians to provide the best care to our clients by giving them the information they need at their fingertips, when and where they need it".

Case study

North East London NHS Foundation Trust – improving client care

Since it started using RiO in 2007, North East London NHS Foundation Trust has reaped the benefits of being able to provide better client care, as well as staff working more effectively and efficiently. The Trust provides mental health services in the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest, serving a community of almost one million people.

Prior to RiO, the Trust used a variety of computer and paper based systems in each individual service. Information was difficult to track and share, electronic systems could not communicate and there was just one paper record available to view at a time. RiO has driven significant service improvements and led to better care for clients.

The Trust's chief executive, Judy Wilson, commented: "We are looking at really big benefits. RiO means it is so much easier to transfer data and drive forward quality and unified standards based on NICE guidelines. The deployment of RiO allowed the Trust to drive forward a standard approach to service delivery across all four boroughs, which made the transformation to working together straightforward and quick."

Thanks to RiO, the Trust's staff are experiencing benefits in all these areas:

- **Quick access to care records**

  Staff can now access a client's care record at the click of a button, even if someone else is reading it at the same time. Before RiO it could take up to 24 hours to track a paper record.

- **Better bed management**

  RiO helps staff manage bed lists more effectively. Real time access to ward availability has meant that the time it takes to find beds has fallen from half an hour to one minute.

- **Saves time form filling**

  RiO reduces the amount of time clinical and administration staff spend filling in assessment and referral forms because previous assessments can be called up in a matter of seconds. One staff member agrees: "RiO makes everything we do quicker – referrals, discharges and communication between teams."

- **Clinical processes standardised across sites**

  RiO is designed so that all the clinical processes are standardised across the trust. This has reduced client risk and delay as well as the problems associated with illegible handwriting and missing dates.

- **Routine clinical risk assessment**

  RiO makes clinical risk assessment a routine procedure at the trust. Since RiO went live, the number of risk assessments carried out each month has risen from 50 to 500, leading to higher standards.

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Features and functionality of RiO mental health

The RiO mental health solution supports the Care Programme Approach (CPA) and the Mental Health Act (MHA), and offers a range of functions. These include prescribing, referral and caseload management, inpatient bed planning, scheduling of admissions, transfers and discharges, care planning and recording of clinical information in structured multi-disciplinary assessments and progress notes. CPA review management and MHA information can be recorded including section, hearings and consent to treatment details.

With RiO version 5 there is also the benefit of:

- **Spine compliance** allowing the system to query and update the Personal Demographics Service (PDS) with demographic information such as address and client contact details.

- **Single sign-on** providing secure smart card access and connection to the Spine – the secure national database of key information about clients' healthcare. This means users can only access the parts of the system they need to do their jobs, known as role based access control (RBAC).

- **Choose and book slots** can be published for external bookings using the NHS Choose and Book system.

What can RiO do for me?

Key features include:

Annotated clinical diagrams allow users to associate annotations to points on the body maps in certain forms.

Assessments enable users to record new assessments and view existing ones. A range of evidence based assessment tools support the Care Programme Approach, as well as outcome measures such as HoNOS. Assessment forms can be pre-populated with data from earlier assessment and selection lists make completion faster.

Bed planning and scheduling provides a diary-based graphical view of current and anticipated activity. System users will be able to schedule admissions, transfers, leave and discharges as appropriate. A list of planned events will also be available, grouped by date.

Care planning - client's care needs and problems can be recorded, updated and prioritised within their care plan. Previous problems, needs and interventions or actions can be recorded and associated information (such as review dates) can be viewed. Standard care plans can be quickly added into an individual's record from the Trust Care Plan Library and tailored to their needs. Crisis plans can be recorded on a single care plan, including information on previous problems and actions taken.

CPA review scheduling allows users to plan for CPA review meetings including automatic invites to attendees, with both the clients' and the trust staff diaries, updated to reflect the scheduled review. Users can capture the outcomes and minutes from the meetings. Review packs can also be produced with details of the new agreed care plan which can be stored against the review record.

Case record forms the 'front sheet' to the client's clinical record and provides the link to other parts of the system such as assessments and care planning depending upon the user's level of access.

Caseload management advises users of their current caseloads and helps team leaders allocate or transfer clients within their team.

Clinic management enables staff to set up clinics and create, manage and book appointments. Clinicians' availability can be viewed and checked. Follow-up appointments can be booked and missed appointments noted.

Diary facilities and planning tools are available, with daily, weekly or monthly views for both regular and ad hoc appointments. There is the facility to make individual and repeat bookings, cancel and validate appointments. Client appointments can be viewed for the day, and the client diary shows a list of all appointments, both in the past and in the future.

Document upload enables scanned paper assessments, referral letters and other electronic documents to be attached to the client's record.

Editable letters can be generated and exported into MS Word templates. These letters use data selected from the client's record. Standard templates are provided.

Family links allow clients records to be linked, highlighting relationships where appropriate. Family members living at the same address can be identified.

Help function allows the trust to provide end users with information, and 'organisational help' to offer guidance on specific services or screens.

Mental Health Act (MHA) enables section details to be recorded in line with MHA legislation. Appeals, renewals, changes in legal status (regrades), tribunals and their outcomes can be recorded as well as details of consent to treatment.

Operational reports include progress notes by clinical discipline, bed summary reports and caseload views. The system also produces statutory reports including the Mental Health Minimum Dataset (MHMDS). Audit reports are also available to track access and actions within the system.

Organisations and professional contacts list links professional and organisational contacts with multiple clients, so that when a contact's details change all the relevant individuals records are automatically updated.

Progress notes record a client's progress, and can be added to and updated by different team members. Significant notes such as client risks can be flagged, as can those that contain third party information. Notes that have not been validated can be identified.

Referral management provides a chronological list of current and discharged (closed) referrals, including details of the speciality or service and other care professionals that the client is being referred to.

Risk functionality provides a chronological list of risk related notes which can then be categorised by risk-type. Risk related progress notes can be highlighted and information can be added retrospectively. Risk assessments, risk history and progress notes details are identified on the case record.

Security mechanisms are available to ensure that, through single sign-on care professionals are granted access to the client records, or parts of records, which they are entitled to view. All authorised users can access records for any client in an emergency situation, but are required to give a reason. All access to records is auditable.

'To do' list can be added to notify healthcare professionals allocated to a particular client of any developments in their care. The 'to do' list allows health care professionals to exchange messages.

Validation of clinical notes within assessments enables system users to see the current status of each field on a form, such as who edited it last, whether that end user is qualified to enter their own clinical notes, or whether validation is required.

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