Clinical Database Guidance

Welcome to Smilenotes!

Smilenotes is our online clinical database that we use to document our clinical notes from sessions. This is completely online so it is important that you are logged onto the venue's WIFI.

Please follow the below guide to learn how to operate our system. Any questions, please don't hesitate to call your Line Manager and they can video call you and give you a walk through on any issues that you are facing.

Thank you!

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1. Logging On

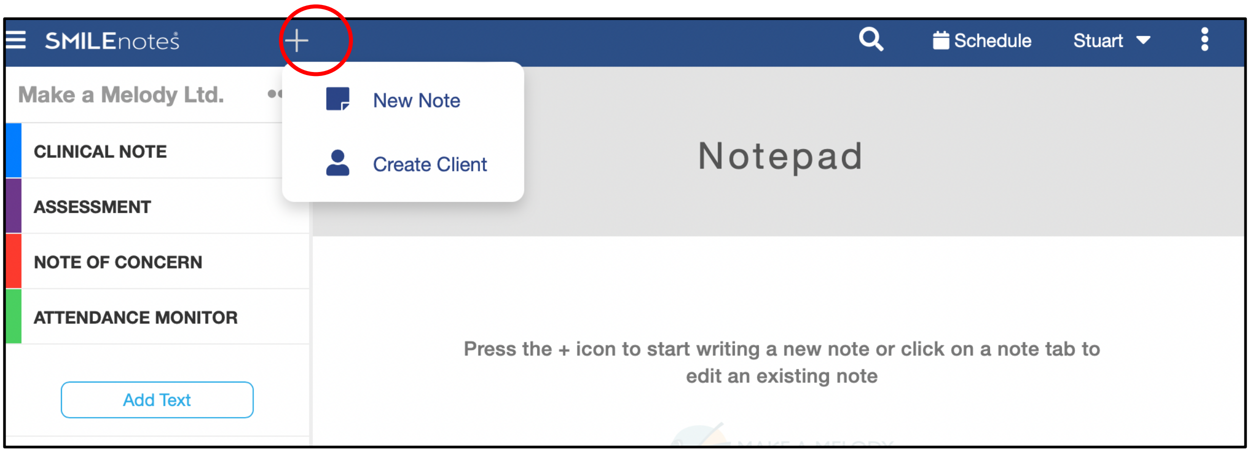
Website: www.smilenotes.co.uk

When you open Google Chrome, this should be a saved tab which you only need to click on.

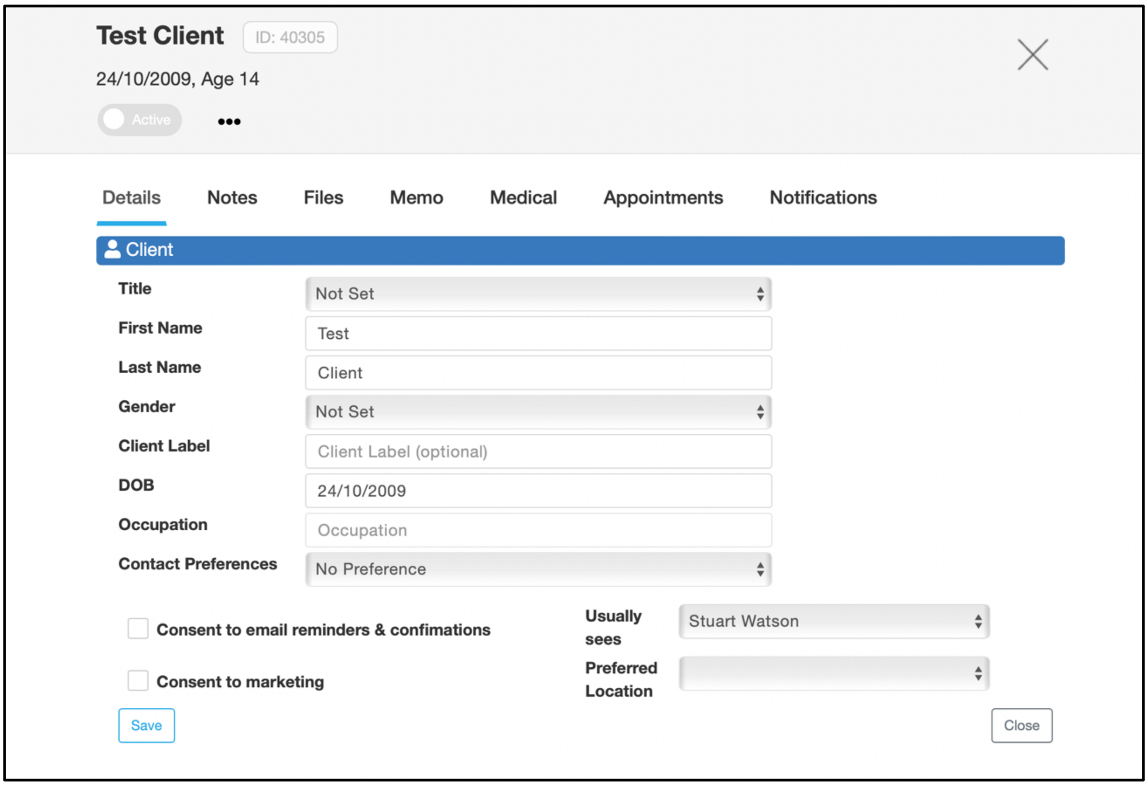
Login: Your email
Password: Summer24@

2. Creating a Client

A. Select the plus sign ‘+’ in the top left-hand corner, and select ‘Create Client’



B. Fill in their personal details from the Referral Form. No need to fill in all of these, just whatever is appropriate. Then select ‘Usually Sees’ and select your own name.



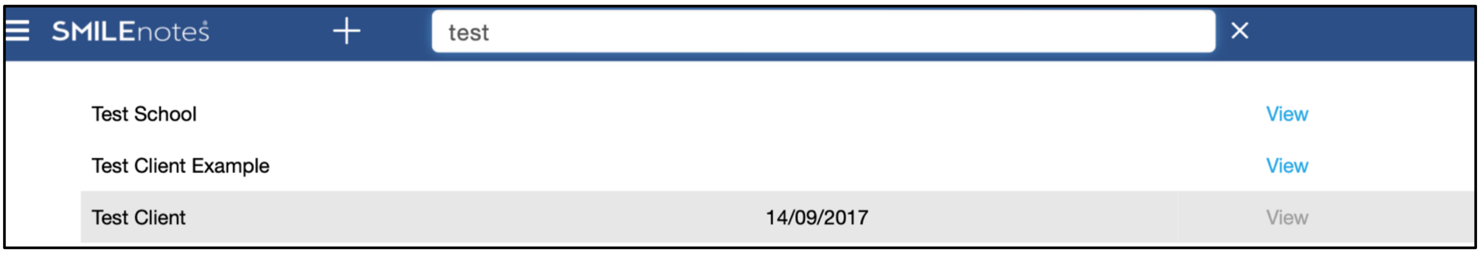
Then select ‘Save’. When you select ‘save’, a client ID will be automatically generated. This will appear beside their name.

C. Select on the two other blue ribbons ‘Contact’ and ‘Other’ to finish documenting the information. Please do not worry about entering a GP Name or Practice. It is difficult to get this type of information from a school referral. It is however essential to have an Emergency Contact: this can be a parent or guardian.

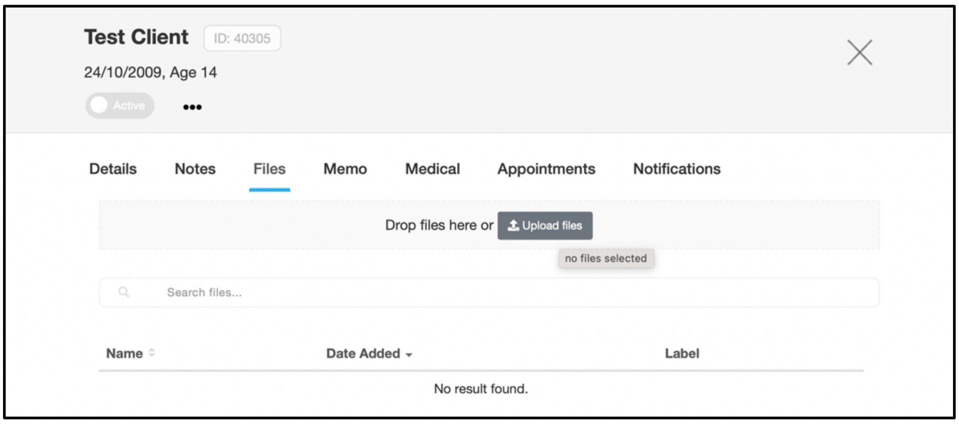
3. Uploading a File

There are several files that you will need to upload; the Referral Form, the Consent Form is required, and a Note of Concern to name the most common documents. The Referral should always be a digital copy sent to your email. However, for those hard copy documents, please take them to the office and request the administrator to can and send the document to you. Once it has been successfully sent to you, and you have confirmed opening it, please shred it at the school. **Do not take hard copies of documentation home with you.**

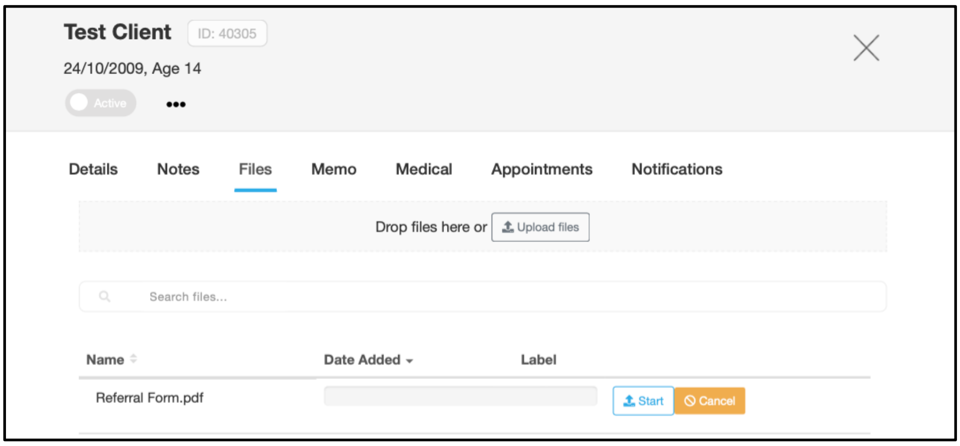
A. On the blue strip at the top of the screen, there will be a magnifying symbol. Click on this and then enter the client's name you wish to search for. When found, select 'view'. Do not just click on their name as nothing will happen, you must select 'View'.



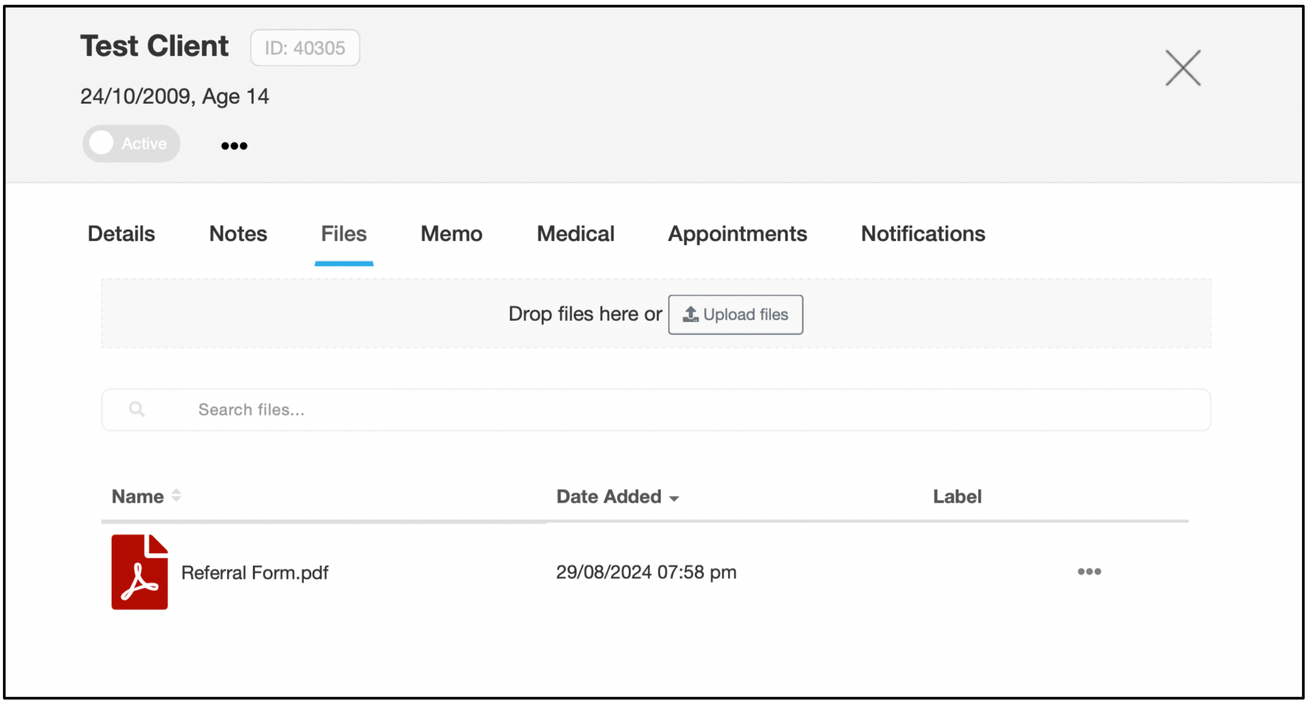
B. The Test Client case file will load. There are several tabs that will be shown. Please select the 'Files' tab. The screen below will appear. Please select 'Upload Files' and then upload the particular document that you wish.



C. Once selected, it will appear on the screen like below. Select 'Start'. This will upload it and save it to the case file, along with a time stamp on when it was added.



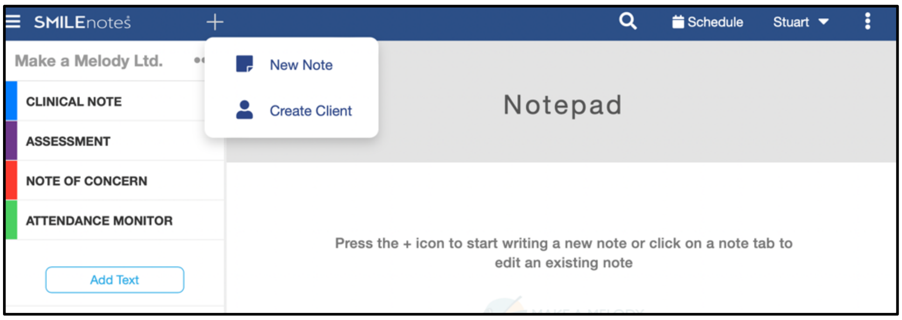
D. It should appear as below:



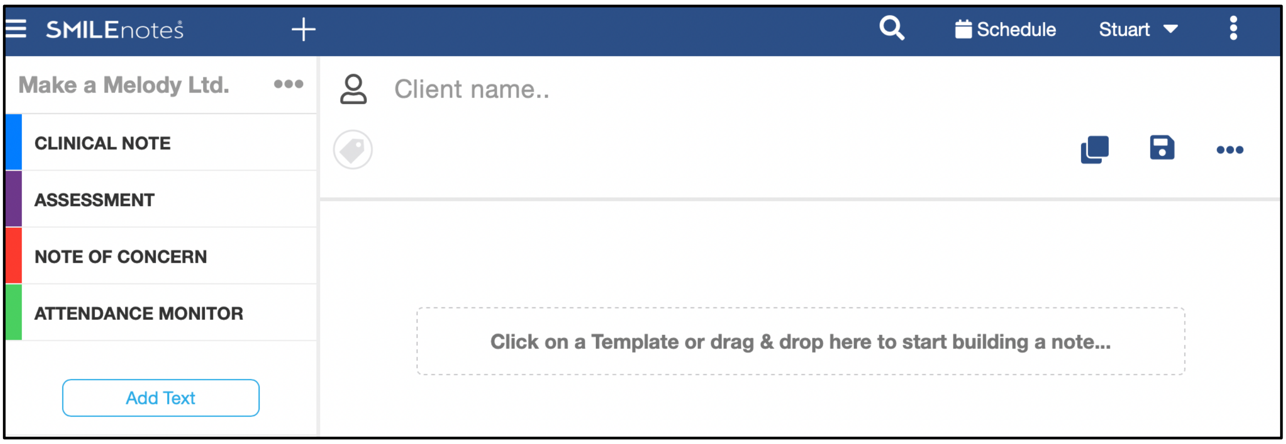
E. You can repeat this process for any documents, such as Consent Forms, Note of Concerns, or any art pieces that the client has created. The most important thing is that you **do not take home documents**. Please take all documents to the office/reception and ask them to scan to you. If you do not have time to upload, check that you have received them correctly, and that there are no errors in scanning, and then shred the documents, and upload to case files the next working day.

4. Input a New Clinical Note

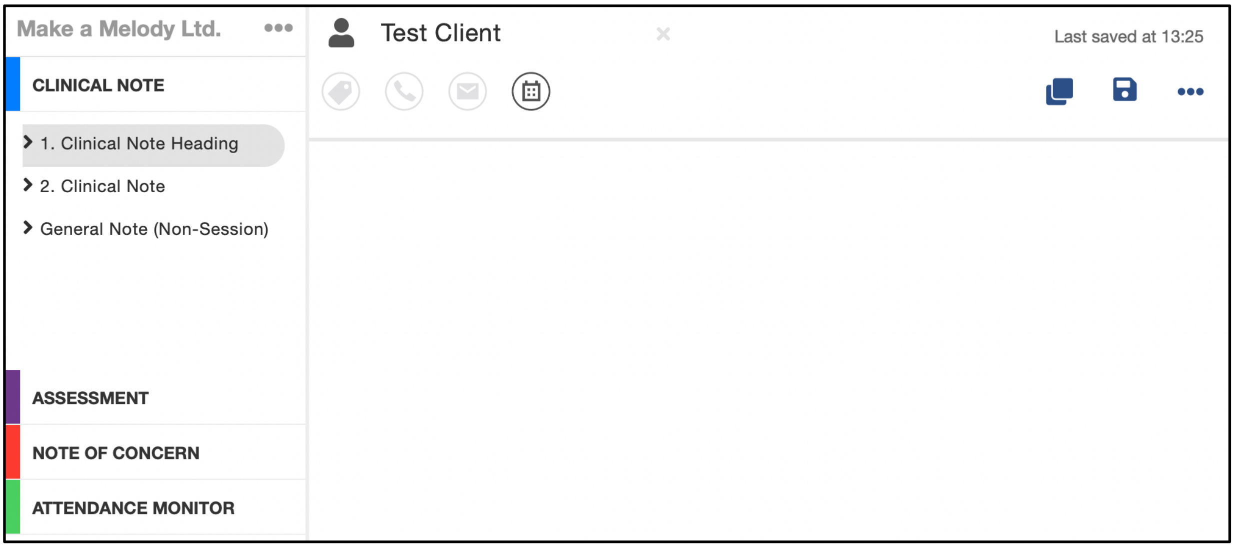
A. Select the plus sign '+' in the top left hand corner, and select 'New Note'



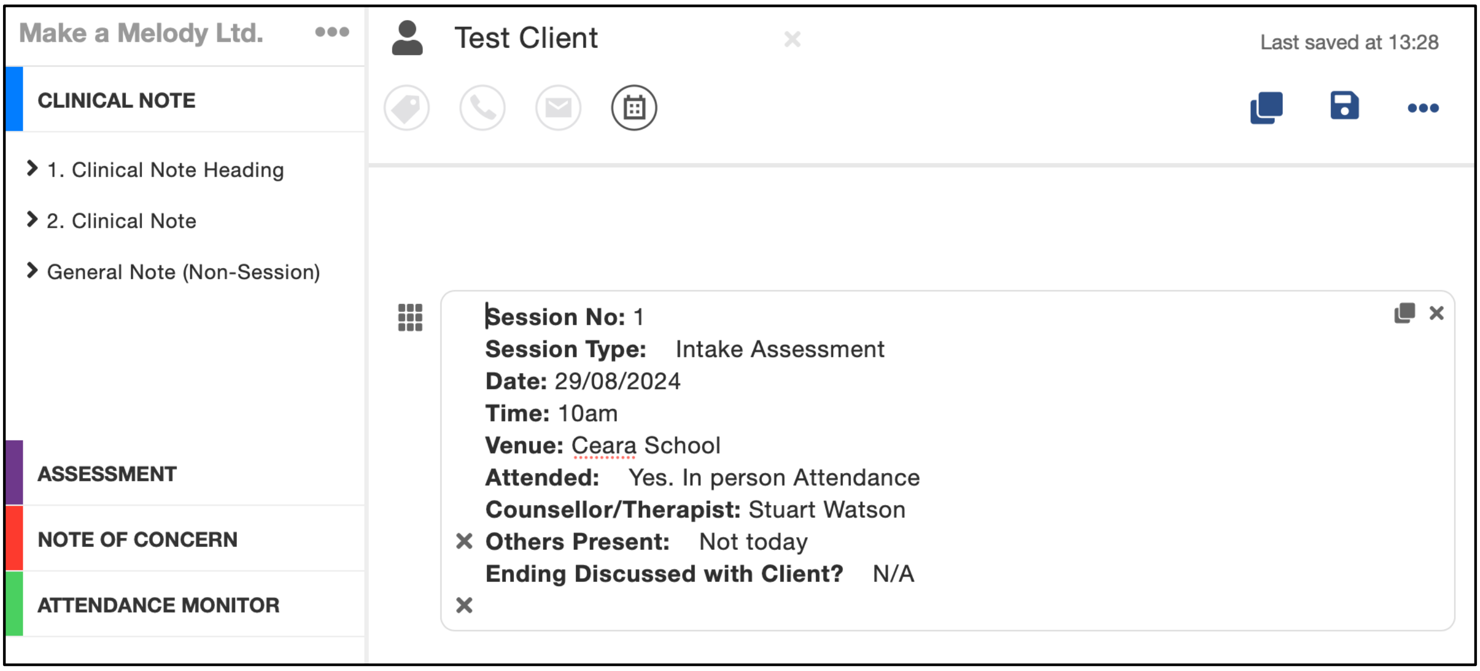
B. Where is says 'Client Name', start writing the first name of your client and a list of all client with that name will appear. For this example, I will select 'Test Client'.



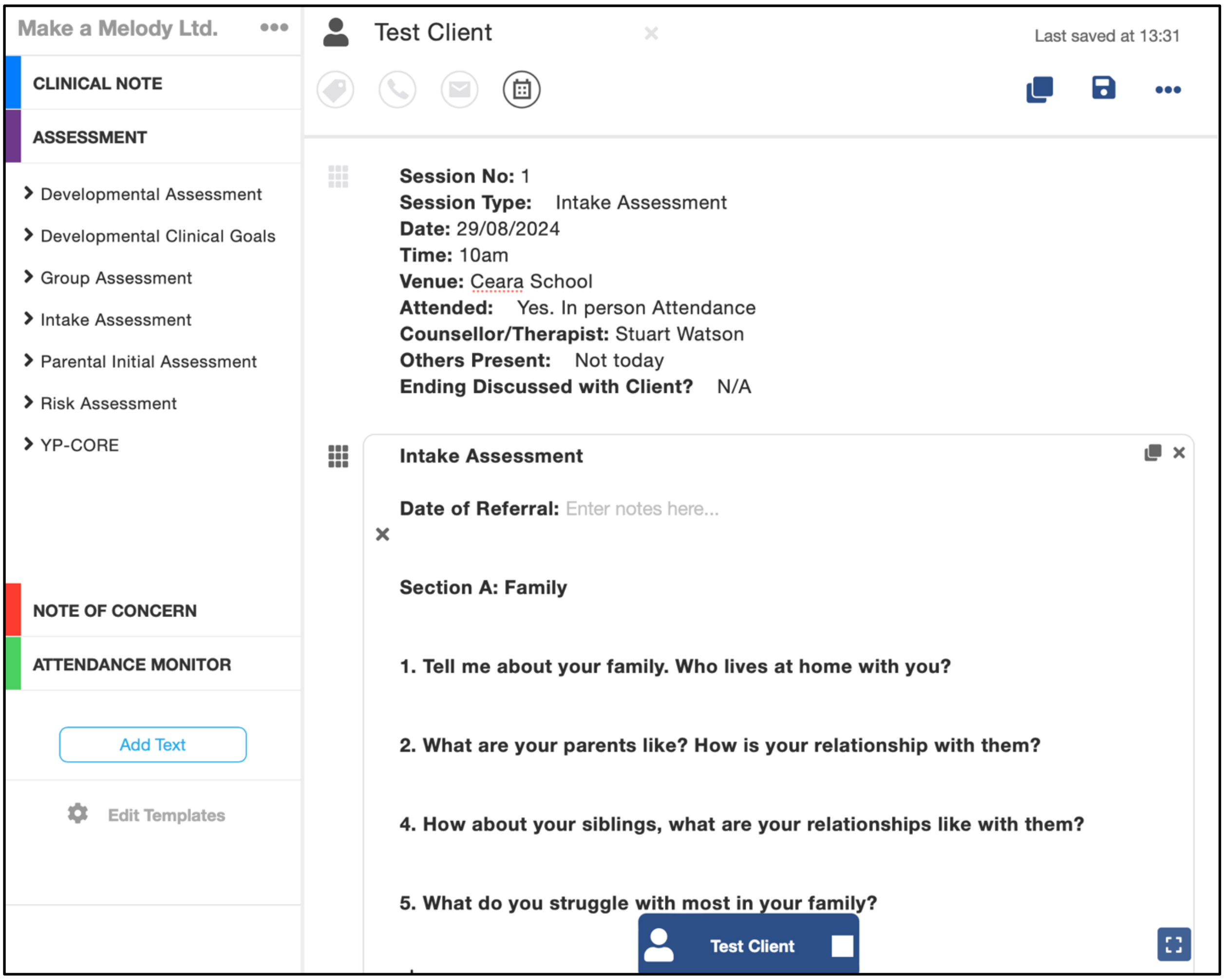
C. In the left column, you will observe Note Templates. For all of your notes, please select 'Clinical Note' and from the submenu, please select 'Clinical Note Heading'. This must be on all notes other than 'Note of Concern' or 'Risk Assessment'.



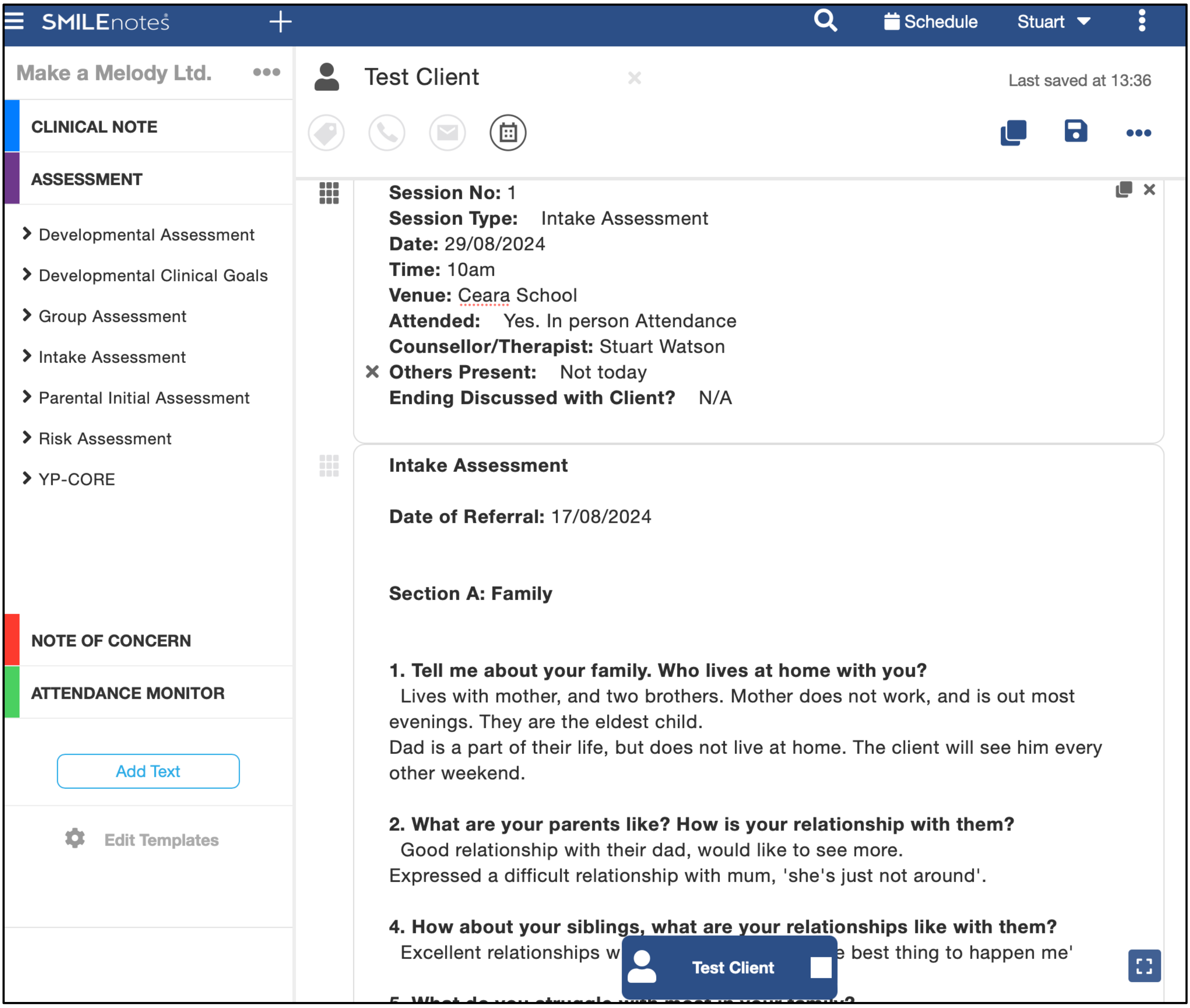
D. The Note Heading template will load and you will observe space to enter your data. Please enter all data into the template like below. For this example, our first session is an Intake Assessment with Test Client



E. After you have done the 'Heading' you will then enter whatever note it is you are writing. For this clinical note, I am doing an Intake Assessment. So I open the 'Assessment' menu on the left column and select 'Intake Assessment' from the submenu.

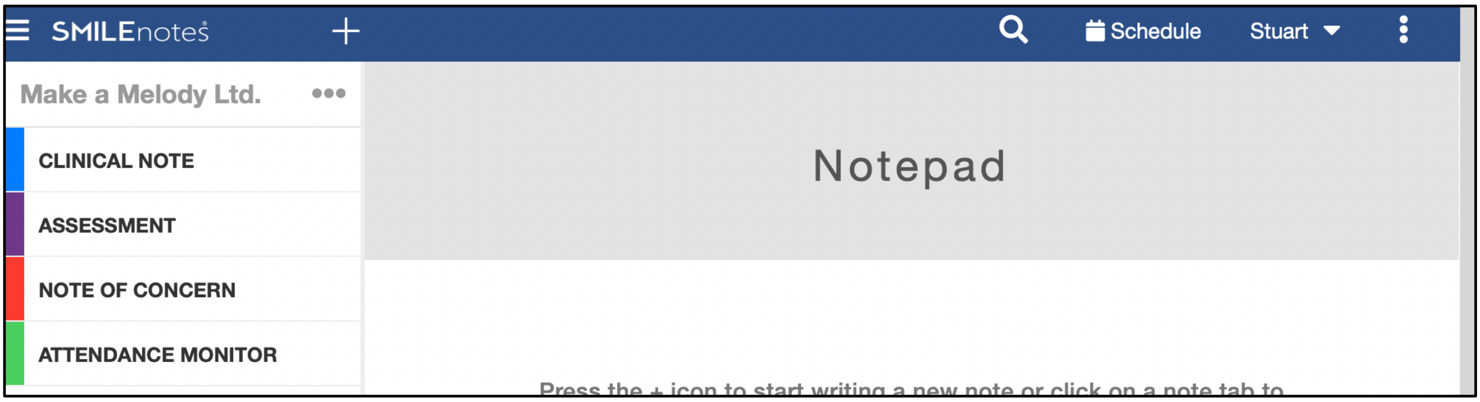


F. Fill out the template as you wish. When you are finished, you will see a 'floppy disc' symbol in the right corner. Please select it; this is now the note saved. To 'finish' the note and file it away, look towards the bottom of the screen and you will observe a blue box, with the name of the client and a white box to the right of their name. Select this white box, and the note will be filed away into the client's notes.

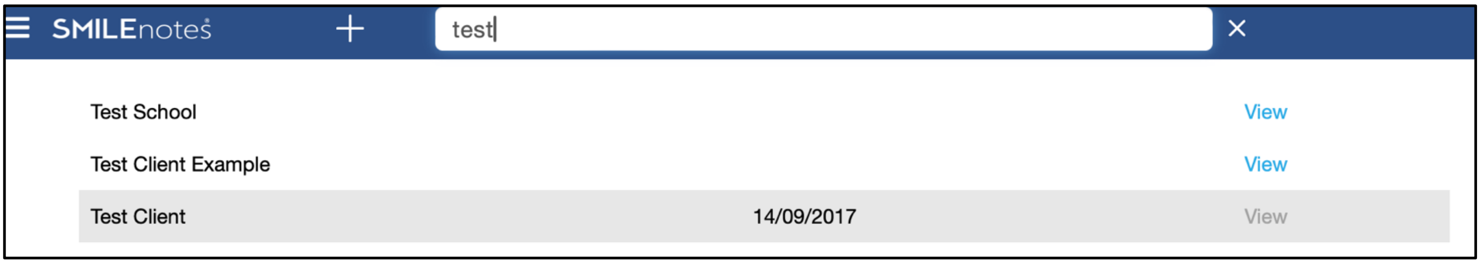


5. Viewing a Client’s Notes

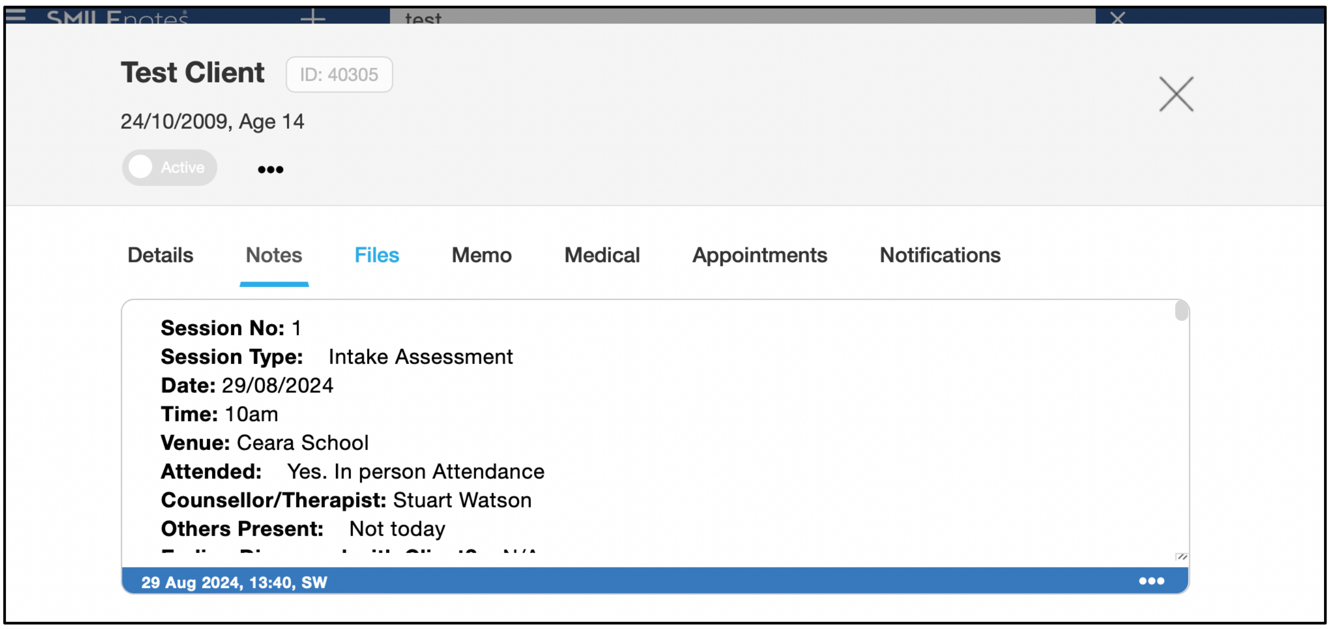
A. At the top of the screen, you will see a blue strip. In the centre, just off to the right, you will see a magnifying glass. Select it to open the ‘search’ function.



B. Start writing in the name of your client and a list of clients who share the same first name will appear. Select the client you wish to view. It’s important that you scroll your cursor to the right and select the ‘view’ option, otherwise nothing will happen.

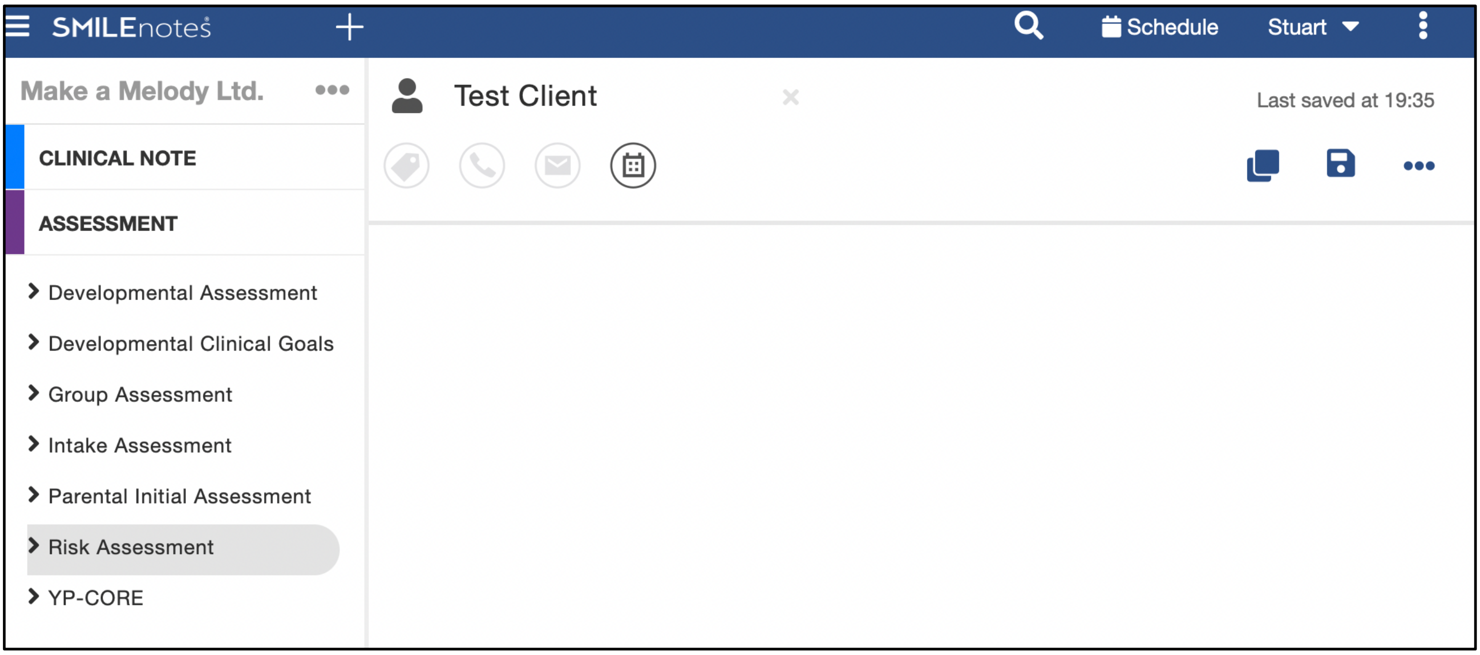


C. There will be a variety of tabs. You will already be familiar with the ‘Details’ tab. To view their notes, select the ‘Notes’ tab and all their clinical notes will be uploaded. You will be able to see the first note as the one we have just input. Please note that at the bottom of each note, there is a date, and time stamp along with your initials. This acts as an electronic signature and cannot be edited after 24 hours.

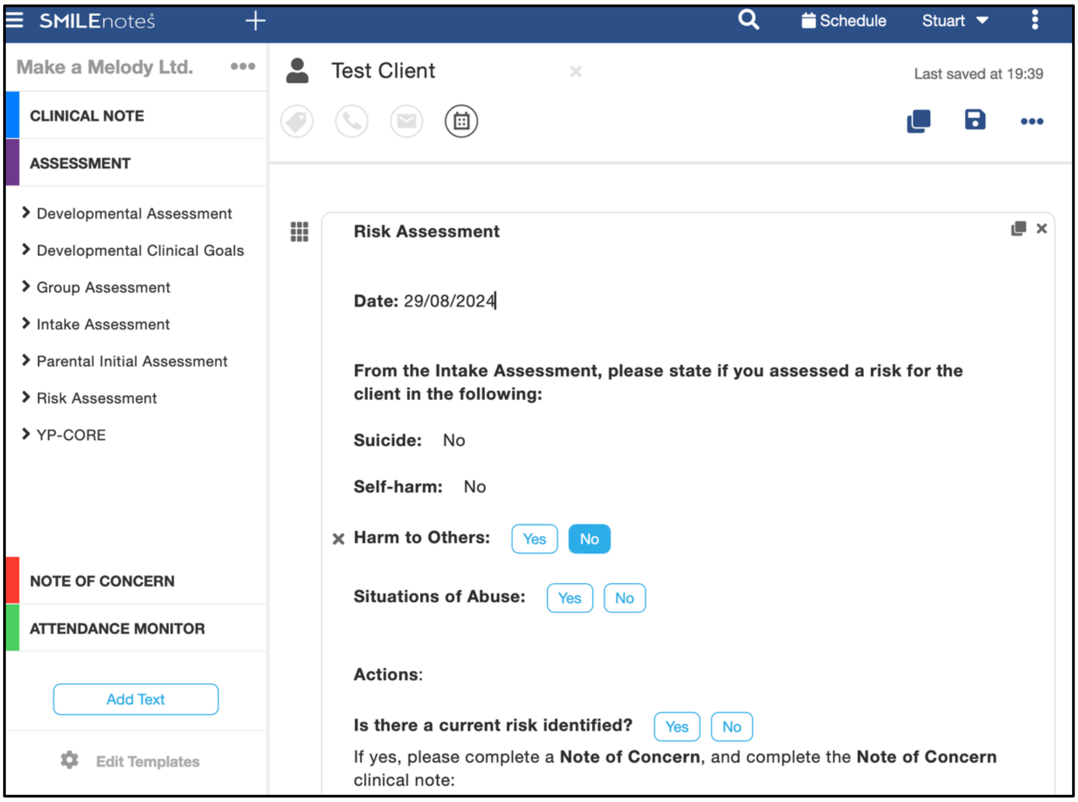


6. Completing a Risk Assessment

A. This must be completed after **every assessment** and at the **start of every client's** file. Create a New Note. Input the client's name under 'Client' Name'. For this example, we will continue to use Test Client. Then, on the left column, select the 'Assessments' and load up the 'Risk Assessment' Template.



B. Follow the template according to the Intake Assessment, or from information gained through the Parental Initial Assessment. If there is no risk identified at the current time, please finish the note, save it, and close it. If there is a Risk Identified, you must fill in a Note of Concern. The Note of Concern will be available from the Office/Reception at each school. A preview can be viewed here.



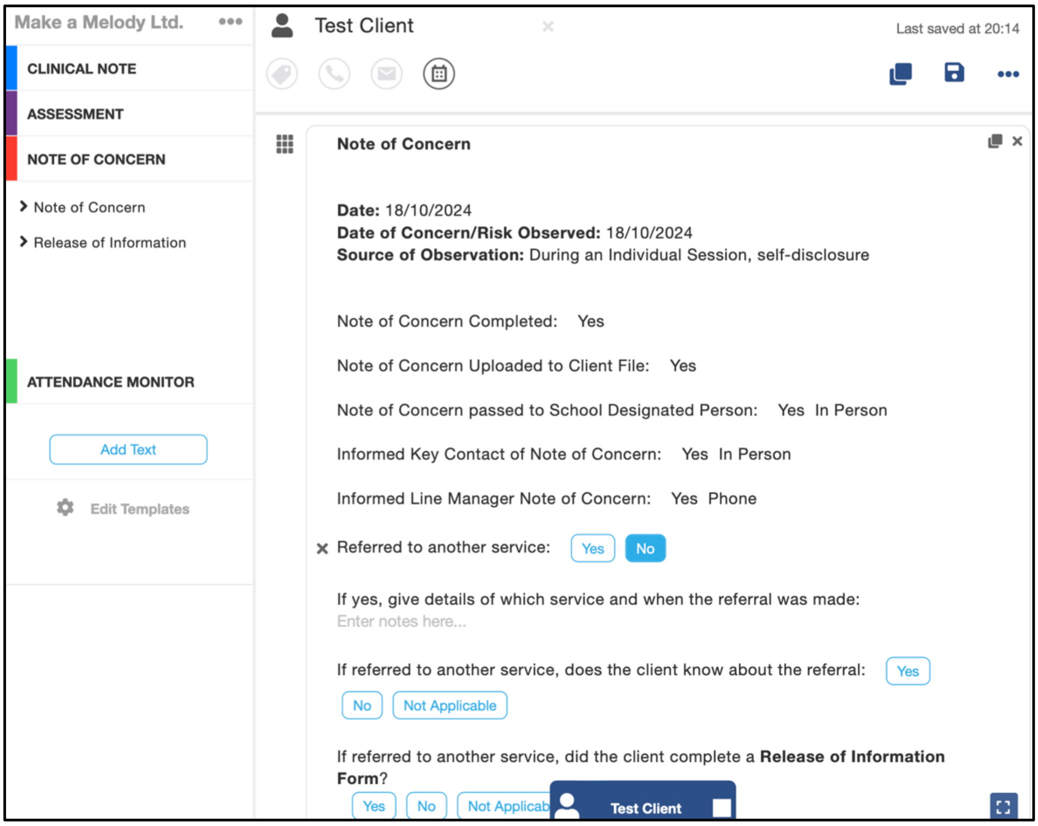
7. Completing a Note of Concern and Documenting in Case File

If, at any time, a risk becomes observed for a client, a Note of Concern should be immediately completed. This may be a disclosure that was made within the session or assessment, or you may have observed markings on the client's body. Regardless of the source of perceived risk, a Note of Concern must always be completed. A copy of the Note of Concern can be found here.

A. Go to the office to obtain a Note of Concern. Otherwise, go to the Designated Person for Safeguarding and obtain a copy from them. Once completed, go to the office/reception and request that it is scanned and emailed to you. Then pass it on to the Designated Person or Key Contact, and discuss a plan with them. Then please telephone your Line Manager to inform them. Safeguarding pathway is found here: EA Safeguarding Pathway.

B. When you have received the scanned copy, follow Section 3 of this document to Upload Document to Case File.

C. After you have uploaded the Note of Concern to the client's file, you must complete the clinical note 'Note of Concern'. To do this, please create a New Note and link it to the client. When ready, on the left column there will be a section specifically called 'Note of Concern' which contains a template called 'Note of Concern'. Select this template and load it to the note.



Please follow through the check-list. Not only are you documenting your actions, it also serves as a check-point for you. On this template it seeks to know if you have passed the Note of Concern to Designated Person and if you have informed your line manager and Key Contact. As well as the Yes or No option, it will request you to select whether this was by 'Email, Phone, In-person'. Please don't forget to state this.

At the end of the Note of Concern, it will ask you was a **Safety Plan** required. Please see next section.

8. Completing a Safety Plan

Going forward, when a referral is made for social services or CAMHS, it is the requirement of the counsellor/therapist to remain with the client and continue to meet with them during individual sessions, even as they walk through feelings and behaviours of self-harm and suicide.

If a client is at risk with suicidal ideations, you must complete a **Safety Plan** with them. This can be found here. Please make a note of when this was started in a session in your clinical note.

A copy of the Safety Plan needs to be uploaded onto the client's file. Please follow step 3: uploading a document.

9. Inputting a General Note

Often times we may want to record a phone call, or a discussion with a teacher/parent, or the client themselves outside of a counselling/therapy session. To do this, we will not load a 'Clinical Note Heading' but just a 'General Note'. To do this:

A. Create New Note

B. Search and select intended client

C. To input a General Note, on the left column, under the section 'Clinical Note', there will be a template called 'General Note (Non-Session). Select it and then write your general note.

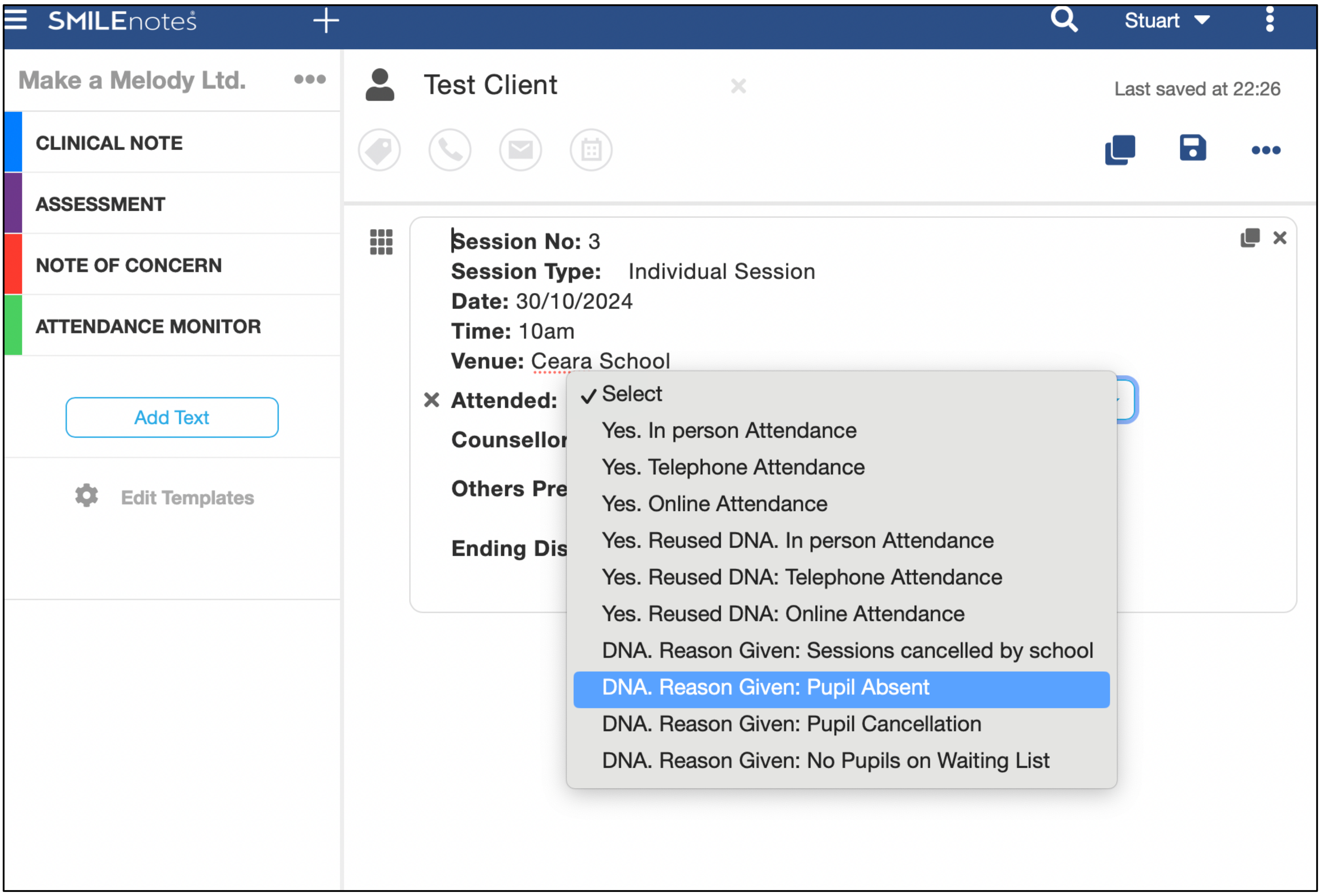
D. Click the save symbol at the top right, and then finish the note by selecting the white box beside the client's name in the blue box at the bottom centre-part of the screen.

10. Recording a DNA

Our aim is to keep this process very simple. To record a DNA:

A) Open New Note
B) Link with Client
C) Open 'Clinical Note' and select the 'Clinical Note Heading' as per a normal note entry

D) When completing this template, there will be an 'Attended' row with a dropdown, see below:



E) Select DNA and reason.
F) Save Note, and Finish Note.

11. Reusing a DNA

Create a new note as per normal, and beside 'Attendance' drop-down, select
- Yes. Reused DNA and whichever method of attendance

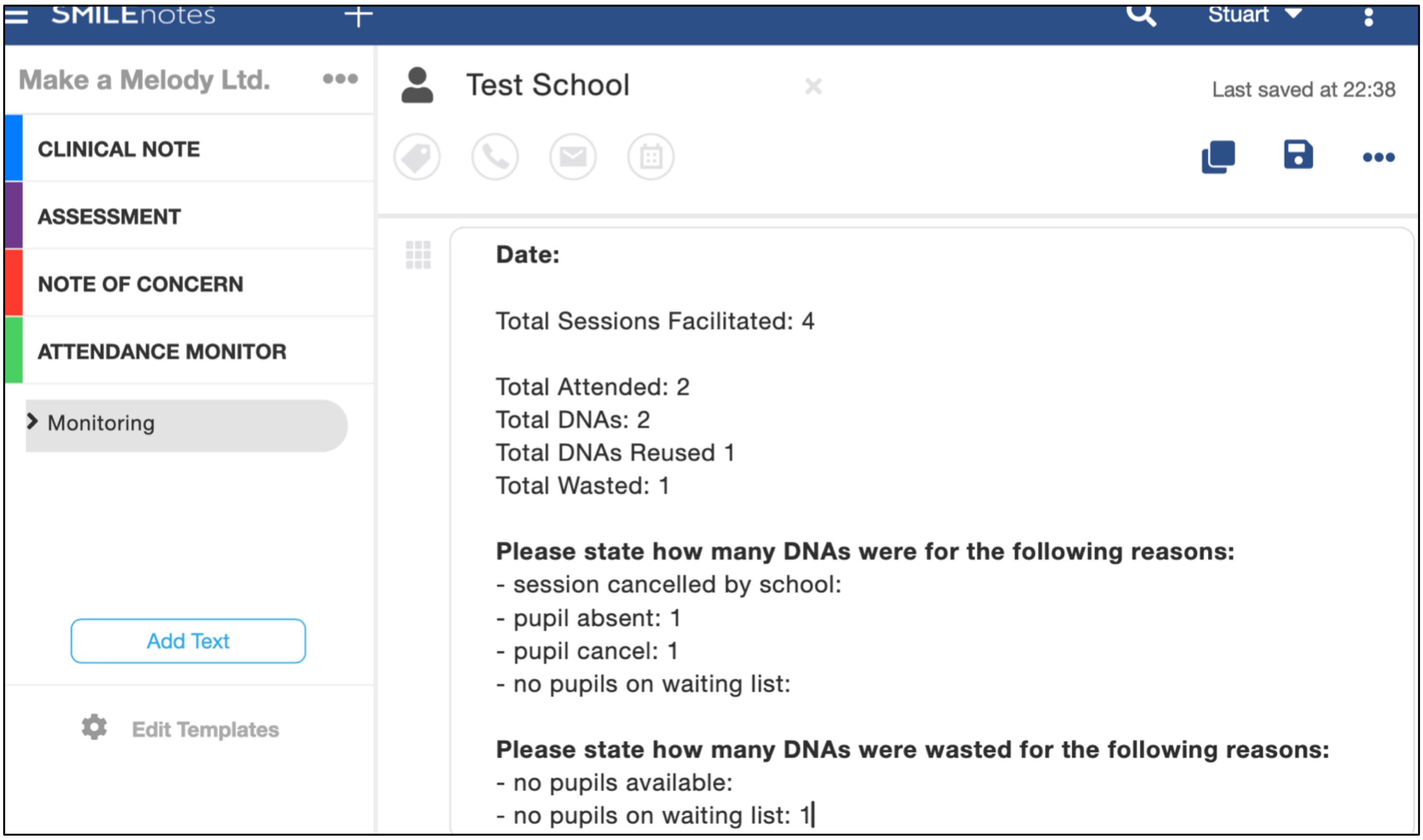
12. Weekly School Monitoring Entry

This is essential to staying on top of your DNAs and session types. This is a requirement of the company that you complete this every time you finish sessions in a school. It will allow easy access to recorded attendances.

A) Create a New Note

B) Instead of inputting a client's name, input your school's name. For this example, we will use 'Test School' client

C) On the left column, open 'Attendance Monitor' and select 'Monitoring'



Total Attended and *Total DNAs* **must equal.**

Total DNAs Reused and *Total Wasted* **must equal.**

When adding up the total recorded in the *DNA Reasons*, they **must equal** *Total DNAS*

When adding up the total recorded in the *DNA Wasted* Reasons, they **must** equal *Total Wasted*

Please contact your Line Manager for a walk-through if you would like more support in orienting the Clinical Database: Smilenotes.