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| CDIS Consultation process |
| Victorian Maternal and Child Health (MCH) Child Development Information System (CDIS) |

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# Recording universal consultations in CDIS

All clients whether a child or adult have a file which looks the same type of client file – always **ensure you are in the correct client file by checking the top blue ribbon for client details before entering any data**.

All universal consultations are counted for reporting purposes against the **child** record

All consultations are to be recorded from the **child** record – **only** in extenuating circumstances should a ‘consultation’ be recorded from the mother’s record.

**Exceptions:**

**Antenatal women** who are not yet mothers. Create client record and **open** for antenatal woman who is receiving MCH service and document activities or services given in that record.

**“Sleep and settling - Outreach” and “Enhanced MCH”** follow a different process that results in consultations being recorded for multiple family members. For more information see guidance documents for those programs.

The following should be recorded in the **child r**ecord:

* **all** KAS, additional, outreach and telephone consultations (including EMCH)
* **all** assessments (including EPDS, family violence, maternal wellbeing)
* **all** referrals
* pregnancy and delivery details pertaining to the birth of that child

Any information in these consultations pertaining to the child are to be written in the consultation notes. However, any information pertaining specifically to the mother (for example) should be written in the mother’s record (as a progress note.

For example, a mother telephones to discuss breastfeeding and how she is feeling:

1. Record ‘Telephone Consultation’ in child record – write notes about child and include ‘See M’s notes’
2. Add note in mother’s record – ‘Phone call received from M today (see child’s notes) – discussed…’

Another example, consultation with a mother to enhance parenting capacity for reunification with children:

1. Record ‘Additional Consultation’ with reason: ‘Parenting Support’ in youngest child record, ‘Did the client attend this appointment?’ – select ‘Yes’
2. Write in consultation notes – ‘Child not present - see M’s notes’
3. Add note in mother’s record – ‘Consultation with M today (children not present), discussed…’

**Note:** For **all consultations**, it is the MCH Nurse’s responsibility to review and follow-up.

# Recording Integrated Program consultations in CDIS

CDIS has been enabled with a range of additional capabilities to support specific “Integrated” programs that are delivered in accordance with a Model of Care. There are two Integrated Programs in CDIS, and both have associated consultations:

* Sleep and Settling – Outreach
* Enhanced MCH

CDIS will not allow you to save a new “Sleep and settling - Outreach” or “Enhanced MCH” consultation unless it is in the client health record of a parent/carer who is usually a Primary Carer Giver known as the Lead Client in an active Integrated Program.

For more information see guidance documents for those programs.

# Initial contact following birth notification

1. From the Home (search) screen, open the ‘General’ menu and select ‘Birth Notifications List’.
2. Select site from look-up list
3. Select ‘Single’ radio button
4. Select ‘Search’ button
5. Select ‘Client to h/v’ checkbox to tick
6. In the ‘Offer of a home visit’ screen, go to ‘Contact Attempt Details
7. Date of attempt: Enter using digits or down arrow (including AM or PM)
8. Appointment offered from this contact: Select ‘Yes’ if appointment offered and go to step . If appointment **not** offered, select ‘No’ and continue
9. Record your attempt to offer contact and the method: Type in free text field
10. Duration: Select from look-up list
11. Outcome: Pick by selecting radio button

* Recontact to offer home visit: Enter date using digits or calendar box
* Move to **active list**, no appointment: **only** **use in extenuating circumstances and document in notes**
* Transfer this client to the **BN list** at…: Select site from look-up list. This is only within your own Council.
* Unable to contact, close file: **do not use this reason unless you have exhausted all means of contacting the family including contacting the hospital and Midwifery Domiciliary Service.** **Follow your local Council policies for further actions.**
* Client deceased, close file: Enter deceased date using digits or calendar box, enter deceased notes in free text field if relevant
* Other, close file: Document in free text field above ‘Other reason’ (see note) **Follow your local Council policies for further actions.**

1. In ‘Home visit risks’, select ‘Show Pre Home Visit Safety Assessment’ button
2. In the ‘Pre Home Visit Safety Assessment’ pop-up box:

* Date: Enter using digits or Calendar Box
* Complete assessment: Select radio buttons - pre-populated, edit if required including confirmation of address
* Clinician: Ensure correct, defaults to User
* Comments: Enter notes if relevant
* Select ‘Save’
* Risk Assessment: This is a mandatory field. Select from look-up list
* Comments: Enter in free text field if relevant Issues discussed and outcomes for [Client]

1. In ‘Issues discussed and outcomes for [client], enter notes in free text field if relevant
2. In ‘Outcome for [client]’, select duration from look-up list
3. Outcome: Select by selecting radio button

* Make an appointment for selected client: Go to ‘[Make an appointment for selected client](#_Make_an_appointment)’
* Move client to **active list**, no appointment: **only** select if **not** using CDIS Calendar
* Services declined, close file: Document in free text field above ‘Service decline’ (see following). **Follow your local Council policies for further actions.**
* Selected client deceased, close file: Enter deceased date using digits or calendar box, enter deceased notes in free text field if relevant
* Other, close file: Document in free text field above ‘Other reason’ (see note)

**Note:** ‘Other’ reasons why a home visit may be declined or not offered:

* Client has moved interstate
* Client has moved overseas
* Client is receiving care from another service provider (such as private midwife care until six weeks of age).

**Current bug**: When closing a client via ‘Offer of a home visit’ (from ‘Birth Notification List’), a reason for being closed is not documented in the ‘Open/Change/Close Client’ screen.

# Make an appointment for selected client

1. In ‘Appointment Allocation’:

Council: Defaults to user Council

Site: Show sites only

Select appropriate site name in grey (on left-hand side)

1. In the ‘Schedule’ pop-up box:

* Select Date
* Ensure Site is correct
* Select desired start time – to highlight whole appointment with mouse, click (hold) and drag cursor down for the duration required
* Open context menu (right mouse click) on highlighted appointment slot and select New Client Appointment

1. In the ‘Schedule Appointment’ pop-up box:

* Client: Auto-filled from Client History
* Appointment type: Select ‘Home Visit’ from look-up list
* Start date and time: Ensure this is correct – use digits or to edit
* Site or centre: Site that client is assigned to
* Location: Select ‘Client’s Home’ from look-up list
* Mode: Select ‘Face to face’ from look-up list
* Interpreter required: Auto-filled tick if entered on Client Details screen – untick by selecting again
* Important note: Select checkbox if required – an icon is displayed on the appointment in calendar
* Notes: Type in free text field if relevant – displayed in calendar’s appointment summary
* Appointment confirmed: Auto-filled tick – appointment is confirmed when making with the client
* Immediate send (if appointment is within 3 business days) **or** Generate reminder (if appointment more than 3 business days away). Normally this is not ticked as you should have verbally confirmed the date and time of the home visit for the client. It is to be ticked for future appointments.
* Select checkbox to select who receives SMS or email reminder – only sent if primary contact or contact has this entered in Client Details. Always check that the correct caregiver is noted to receive the SMS as if the caregiver details are not present or are incorrect, you will need to open the child’s file and correct Relationship for the child. (See instructions below) \*\*\*
* If overriding default SMS or email text, change text as required – **do not change the fields in square brackets []**
* Select ‘Save’

1. ‘Schedule’ pop-up box, navigate to and select ‘Close’ button
2. In ‘Appointment Allocation’, select ‘Close’ button

# All consultations

**Note:** Always record a DNA via the calendar’s edit function and select ‘Record Did Not Attend’ checkbox.

1. From the ‘Home’ screen, select relevant client appointment
2. Select Client name which is a blue hyperlink in Appointment Summary (right-hand side of screen)
3. From the CDIS Details (child) screen, open the ‘Clinical Activity’ menu and select ‘Consultations’
4. Select relevant consultation type hyperlink (that is with matching date), such as ‘2 Week Consult’
5. In ‘Child Health Assessment’:

* Did the client attend this appointment?: Select ‘Yes’. **Do not select ‘No’** – if DNA, see ‘[Did Not Attend](#_Did_not_attend)’

1. In ‘Assessment Details’, ensure appointment details are correct and edit if required

* Present: Select appropriate checkbox of those present
* If other…: Enter name in free text field and select relationship from look-up list

1. In ‘Weight and Growth’, complete fields using digits or the arrows

Remember to click out of the weight and height input boxes as it is possible for the weight and height to be altered once you input the data and have not clicked out of the input boxes.

* ‘View History’: Select to view in pop-up box
* ‘View Growth Chart’: Select to view and print in pop-up box (**Current bug**: No client identification on this page)

1. In ‘Nutrition’, complete fields by using look-up lists

* View History

1. In ‘Family Health And Wellbeing’, select ‘Yes’ or ‘No’ as appropriate
2. In ‘Assessments/Interventions’, select ‘Assessment’ from look-up list
3. Select ‘Assessment’ button
4. In ‘Assessment pop-up box, complete assessment by entering data fields
5. Select ‘Save’
6. Repeat for all required assessments

To remove assessments, select the red X button.

**Note**: Assessments cannot be edited once they are saved, they need to be deleted and re-completed

1. In ‘Topics discussed’, select checkboxes to pick relevant topics
2. For ‘Counselling’, see *Counselling and recommended contact processes*.
3. ‘Referrals from this assessment’ –see *Internal referral process* and *External referral process*
4. ‘Recommended Contact’ –see *Counselling and recommended contact processes*.
5. In ‘Notes’:

* Observations and discussions: What is observed and discussion from that observation
* Health education and recommendations: What is recommended, including referrals
* Management plan: Follow-up action

1. Enter time spent with client, time note-taking and travel time. Only one needs to be entered even though each is marked as a mandatory field.
2. Select ‘Save’ or if you need to add further notes or information on the day of consultation select Save as Draft.
3. This consultation must be completed and saved prior to the end of the working day.
4. Select ‘OK’ to successfully save

# KAS consultations

There are 10 key age and stage consultations:

* home visit
* two weeks
* four weeks
* eight weeks
* four months
* eight months
* 12 months
* 18 months
* two years
* 3.5 years

## Ensuring correct KAS consultation

As per MCH framework, each KAS can only be **scheduled** once. If a client has multiple visits, only enter **one** as the KAS and the others as ‘Additional Consultations’.

Before opening the Client hyperlink in the calendar appointment summary:

* ensure the correct KAS is selected for the correct age of the child (as any KAS can be input at any age)
* edit the appointment type via the calendar as it cannot be altered once the consultation is started.

Before selecting the relevant consultation type hyperlink to start the consultation, ensure it is displaying the correct date as consultations can be attended against a future date.

## Adjusting for prematurity

As per MCH framework, KAS are to be performed to the child’s corrected age – prematurity is less than 37 weeks’ gestation.

CDIS automatically corrects or adjusts age for premature children if recorded in client record. If not entered when client record created:

1. Open the ‘Client Details’ menu and select ‘Update Client Details’
2. Select ‘premature’ checkbox just under birth date
3. Enter how many weeks and days baby is premature – **not** the gestation at birth
4. Select ‘Save’.

For example:

* if child is 35+3 weeks’ gestation: Enter ‘4 weeks and 4 days premature’
* If child is 36+6 weeks’ gestation: Enter ‘3 weeks and 1 day premature’

Growth charts graph both actual or chronological and corrected or adjusted age:

: Actual or chronological age

: Corrected or adjusted age.

## Assessments

All assessments relevant to the KAS are populated in the consultation look-up list.

Any assessment can be attended at any KAS or additional consultation. If further assessments are required:

1. Complete and save current consultation first **or** open ‘Duplicate tab’
2. Open the ‘Assessments’ menu and select ‘Assessments/Interventions’
3. Select ‘Complete Assessment’ button for relevant assessment
4. Complete ‘Assessment pop-up box’ details
5. Select ‘Save’ and close ‘Duplicate tab’

See [Appendix 1: Assessments](#_Appendix_1:_Assessments).

## Time

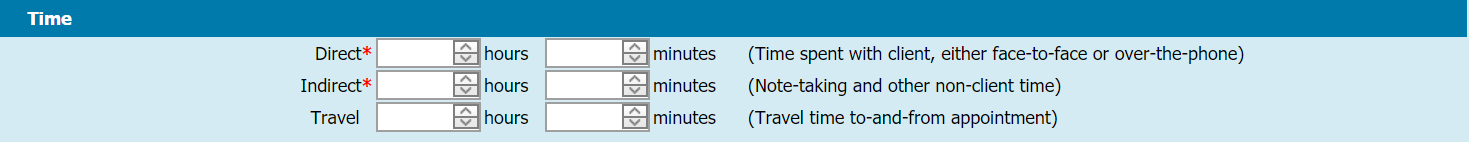
Direct, indirect and travel time to be completed at the conclusion of all consultations in minutes or hours

Consultation time is collected across three different categories:

* **Direct** – defined as time spent with client, either face-to-face or over-the-phone
* **Indirect** – defined as note-taking and other non-client time
* **Travel** – defined as travel time to-and-from an appointment

Users are obligated to complete these fields with as much accuracy as possible. Please **do not** enter the standard time allocation for the consultation you are delivering. Accurate data will improve service-wide understanding of the real time and cost of MCH service delivery.

In CDIS it is mandatory to complete at least one of the **Direct** or **Indirect** fields, with a value greater than zero. For example, you could enter 20 into the **Direct Minutes** field, and leave all other fields blank. Any field left blank will be recorded as a value of zero.



# Home visit consultation

**Note:** In addition to the KAS consultation, the following screens need to be completed following a home visit.

## 1. Child: Update client details

1. From the CDIS Details (child) screen, open the ‘Client Details’ menu and select ‘Update Client Details’
2. In ‘Demographics’, update details as required
3. **Other details**
   * + Main language at home: Once selected, language look-up list becomes available
     + Primary care-giver - Interpreter required: (Previously labelled “Interpreter required”): required.
       - Select Checkbox: Yes, No, or Unknown.
       - When selecting Yes: Select from Language look up list
     + Birth country: Required: Enter first 3 letters and select from look-up list.

Note If receiving a birth notification, this will be ‘Australia’.

Select State of Victoria if newborn was born in Victoria

* + - Year of arrival: Enter
    - Aboriginal/TSI: Select from look-up list -
    - Health Care Card: Type ‘Y’ for yes or ‘N’ for no or UnK for unknown

**Language exposure**

* + - Select language and ‘Exposed Environment’ from look-up list
    - Use digits for exposed time (defaults to percentage)
    - Select the green plus sign add button
    - Repeat process for additional languages

**Family Customs**

* + - Select language and ‘Family customs” from look-up list
    - Select the green plus sign add button
    - Repeat process for additional family customs

**Additional needs – if applicable**

* + - Select ‘Type of Additional Need’ and ‘Additional Need’ from look-up list (such as ‘Child – Prematurity’, ‘Parent – First time mother for this child’)
    - Type comments in text-free field, if required
    - Select ‘Add’ button

**Allergies – if applicable**

* + - Select allergy from look-up list
    - Type comments in free text field (such as type of reaction, symptoms or management)
    - Select green plus sign add button

**Child Protection – if applicable**

* + - In ‘Child Protection Status’, If applicable, complete all fields if known
    - Select ‘Save’
    - Select ‘OK’ to successfully save

## 2. Child: Consent for Victorian MCH service

**Note:** Additional consents for individual Councils and specific programs may also be required as per Council’s internal policy. Add here and attach documents as required.

1. From the CDIS Details (child) screen, open the ‘Client Details’ menu and select ‘Consent’
2. Select ‘Add’ button and enter the following:

* Date consent signed or updated: Enter using digits or calendar box
* Type: Select ‘Universal’ from look-up list
* Consent for service: Select appropriate from look-up list
* Privacy information: Select appropriate from look-up list
* ‘Victorian/Council’: Select ‘Victorian MCH Service’ from look-up list
* Consent form status: Select appropriate from look-up list – upload attachment as required
* Consent notes: Enter in free text field if relevant

1. Select ‘Save’

## 3. Child: flags and alerts (if relevant)

1. From the CDIS Details (child) screen, open the ‘Clinical Activity’ menu and select ‘Flags/Alerts’
2. Select ‘Add’ button and complete fields (see [Appendix 4](#_Appendix_4:_Flags))
3. Select ‘Confirm’ button

## 4. Child: Pregnancy and delivery

1. From the CDIS Details (child) screen, open the ‘History/Notes’ menu and select ‘Pregnancy and Delivery’
2. Complete fields

**Notes**:

* Select the green plus sign add button where present after making selection to add more than one selection
* First-time mother for this child – counted here for reporting purposes
* ‘Home Visit Details’ consent – refers to consent to attend home visit and **not** consent for MCH service
* See: ‘[Adjusting for prematurity](#_Adjusting_for_prematurity)’.

## 5. Primary caregiver: update client details

1. From the CDIS Details (child) screen, open the ‘Client Details’ menu and select ‘Client Relationships’
2. Open the relevant Client Identifier Number hyperlink
3. From the CDIS Details (primary caregiver) screen, open the ‘Client Details’ menu and select ‘Update Client Details’
4. Update details as required
   * + Ensure correct mobile number and email address
     + Ensure to select SMS or email reminders for the primary caregiver
     + Main language at home: Once selected, language look-up list becomes available
     + Level of English: select from look up list
     + Birth country: Required: Enter first 3 letters and select from look-up list.

Note If receiving a birth notification, this will be ‘Australia’.

* + - Year of arrival: Enter
    - Aboriginal/TSI: Select from look-up list –
    - Occupation type: select from look up list
    - Employment Status: select from look up list
    - Education Level: select from look up list
    - Health Care Card: Type ‘Y’ for yes or ‘N’ for no

**Language exposure**

* + - Select language and ‘Exposed Environment’ from look-up list
    - Use digits for exposed time (defaults to percentage)
    - Select the green plus sign add button
    - Repeat process for additional languages

**Family Customs**

* + - Select language and ‘Family customs” from look-up list
    - Select the green plus sign add button
    - Repeat process for additional family customs

**Additional needs – if applicable**

* + - Select ‘Type of Additional Need’ and ‘Additional Need’ from look-up list (such as ‘Child – Prematurity’, ‘Parent – First time mother for this child’)
    - Type comments in text-free field, if required
    - Select ‘Add’ button

**Allergies – if applicable**

* + - Select allergy from look-up list
    - Type comments in free text field (such as type of reaction, symptoms or management)
    - Select green plus sign add button

**Child Protection – if applicable**

* + - In ‘Child Protection Status’, If applicable, complete all fields if known
    - Select ‘Save’
    - Select ‘OK’ to successfully save

1. Select ‘Save’
2. (5a) Primary caregiver – Consent
3. (5b) Primary caregiver – Flags and alerts (if relevant)
4. (5c) Primary caregiver – Notes (if relevant)

## 6. Child: Add relationship contacts – search, transfer, merge, add, create

Relationship may be, for example, father, caregiver, sibling and so on.

1. From the CDIS Details (child) screen, open the ‘Client Details’ menu and select ‘Client Relationships’
2. Select ‘Add Relationship’ button
3. Perform ‘State’ search:

* No matching records found: ‘Create contact’
* Matching record is found: ‘Create relationship’, transfer and merge records if required.
* Refer to *Birth notifications process*.

1. (6a) Relationship Contacts – Update details
2. (6b) Relationship Contacts – Update address – this must be done in each individual client record as selecting update all will remove all previous address records for that person.
3. (6c) Relationship Contacts – Consent
4. (6d) Relationship Contacts – Flags and alerts (if relevant)
5. (6e) Relationship Contacts – Notes (if relevant)

## 7. Child: Add to first-time parent group (if mother is a primigravida)

From the CDIS Details (child) screen, open the ‘Clinical Activity’ menu and select ‘Book Group’

Refer to *Groups process*.

# Additional consultations

**Note:** Any consultations outside of the 10 KAS consultations or family consultation (where the client **is** present) are additional consultations – remember to enter a reason for the consultation.

When booking an additional consultation into the calendar, write the appointment reason and age of child in appointment ‘Notes’. This ensures the purpose of the appointment is easily identified in the calendar appointment summary.

An additional consultation may require ‘Counselling’ or ‘Referral’ (or both) to be recorded on the Consultation page.

Reason for additional consultation is recorded on the Consultation page.

Possible reasons available from the look-up list include:

* acute illness
* asylum seeker
* baby sleep issues
* breastfeeding difficulties
* Brigance
* Case conference
* child behaviour
* child disability (physical/cognitive/emotional)
* child protection
* chronic illness
* council funded
* cultural confinement
* developmental concern
* developmental delay
* old enhanced maternal and child health
* failure to thrive/faltering growth
* family crisis
* family violence – this should be completed as a Family Consultation
* feeding review
* immunisation
* KAS completion
* Material/financial aid
* MIST vision test
* multiple birth
* multiple risk factors
* newborn sleep issues
* other
* paediatric follow up
* parent – mental health issues
* parental disability (physical, cognitive or emotional)
* parenting support
* post-natal depression
* prematurity
* pre-schooler sleep issues
* refugee
* SACS assessment
* Old sleep and settling outreach
* Toddler sleep issue

# Family consultations

The additional family consultation aims to increase capacity within the MCH Service to provide greater family violence support to families. **Family consultations are** an additional one hour of service for reasons related to family violence including:

* where family violence has been disclosed
* where family violence is suspected
* where there has been no prior opportunity to ask about family violence.

The MARAM Family Violence Assessment tool is to be used as part of the Family Consultation and if there is disclosure of Family Violence, the Safety Plan must be completed.

It is important that accurate data is collected for the number of and time required to conduct the family consultation. Although the nurse may be conducting a KAS which is an appointment in the calendar, if the need to undertake a Family Consultation becomes evident, the nurse **must ensure that a separate consultation** is used to document the Family Consultation.

* This can be done by completing and saving the current consultation first **or** opening a ‘Duplicate tab’ and undertaking the Family Consultation. The Family Consultation should be added to the calendar to ensure that the calendar reflects the work undertaken by the nurse for that day.
* The time for conducting each consultation must be accurately documented. This may require you to book the family for an additional consultation to complete the KAS which could not be completed due to the disclosure.
* A Family Consultation may also be booked into the calendar as a stand-alone appointment if the nurse considers that one of the indicators for the consultation listed above have been met.

**Note:** **Do not document family violence information as part of the KAS unless 4-week KAS.**

Documentation regarding the detailed family violence is recorded in the child/ren’s and parent/carers record – unless in the judgement of the nurse there are extenuating circumstances why this would not be appropriate. In these circumstances documentation in child’s notes is required stating “Family violence disclosed see (name, relationship and CDIS number) notes as well as any direct impacts on the child observed or disclosed.

Safety plans are documented in the child/ren’s and parent/carers notes.

# Outreach consultations

**Note:** Any consultation (KAS or additional) that occurs somewhere other than at a ‘Site’ is simply recorded as a KAS or ‘Additional Consultation’ (as appropriate), with the location selected from look-up list.

Location is to be selected when making Client appointment in the Calendar

A purple bar displays in the client appointment slot (down the left-hand side) to identify ‘out of office’ consults.

Refer to [KAS consultations](#_KAS_Consultations) or [Additional consultations](#_Additional_consultations) as appropriate.

# Telephone consultations

**Note:** ‘Telephone Consultation’ appointments in the calendar are **not** displayed in client ‘Consultations’. Telephone consultations can **only** be recorded in ‘Client Not Present’.

All telephone consultations to be recorded in the child record. For example, a mother phones up to discuss breastfeeding and how she is feeling

1. Record telephone consultation in child record ‘Client Not Present’ – write notes about child and include ‘See M’s notes’
2. Add note in mother’s record: ‘Phone call received from M today (see child’s notes) – discussed…’

Another example, initial phone call to family to offer home visit – mother starts to discuss breastfeeding and her feelings:

1. Record ‘Offer Home Visit’ in child record from ‘Birth Notifications List’
2. Save ‘Offer Home Visits’ screen first **or** open ‘duplicate tab’
3. Record telephone consultation around breastfeeding in child record’s ‘Client Not Present’ – write notes about child and include ‘See M’s notes’
4. Add note in mother’s record: ‘Phone call to offer home visit (see Child’s notes) – M discussed…etc’

## Process

1. From the CDIS Details (child) screen, open the ‘Clinical Activity’ menu and select ‘Client Not Present’
2. In ‘Client Not Present’:

* Service date: Auto-filled with today’s date, edit using digits or calendar box
* Start time: Auto-filled with current time, edit using digits
* Program: if this Client Not Present is related to an active program (eg. Enhanced MCH, Breastfeeding Support Service), select the program from the dropdown
* Agency: Mother – Leave blank **or** select from look-up list
* Service type: Select ‘Telephone Consultation’ from look-up list
* Location: Leave blank
* Others involved: Type in free text field if relevant
* Professionals involved: Select from look-up list (linked to client), Select Add if relevant
* Notes: Enter notes from telephone call in free text field
* Time: Enter time on phone with client as “Direct time”, and other clinical tasks associated with the Client Not Present as “Indirect time”.
* Select ‘Save’

If required, add note in other relevant client records (such as, mother)

1. In the CDIS Details (mother) screen, open the ‘History/Notes’ menu and select ‘Notes’
2. Select the ‘Add Note’ button and record information from telephone consultation about the mother

* Example: ‘Phone call received from M today (see child’s notes), discussed…’

# Case conference, consult and admin

**Note:** Record any case conference, consult or admin via child record – open the ‘Clinical Activity’ menu and select ‘Client Not Present’.

Complete ‘Client Not Present’ screen as per ‘[Telephone consultations’](#_Telephone_consultations):

* select the agency the consultation is with and the service type from the look-up lists
* Time: if the client is not on the call, record all time as Indirect time.

In the calendar, client appointments for case consult and clinical admin can be made (like telephone consultation); however, these are not hyperlinked to a ‘Consultation’ – ‘Client Not Present’ must be completed instead.

# Consultations without a booking

Consultations without a booking are applicable (and not limited) to:

* open sessions
* drop-in clients
* opportunistic consultations
* kinder or childcare outreach
* if not using CDIS Calendar

## Process

1. In the Search screen:

* Council: Leave – defaults to Council in user settings’
* Identifier (enter if known) **or** Last name (enter first 3 letters)
* First name: Enter first 3 letters

1. Select ‘Search’ button
2. Open Client Identifier Number hyperlink of selected client
3. From the CDIS Details (child) screen, open the ‘Clinical Activity’ menu and select ‘Consultations’
4. ‘New consultation for client with no booking’ – select ‘Consultation’ button
5. ‘Child Health Assessment’ – Did the client attend this appointment? Select ‘Yes’

* Do not select ‘No’ – if DNA, see ‘[**Did not attend**](#_Did_not_attend)’

1. ‘Assessment Details’, complete the following:

* Service date: Defaults to today’s date – edit by using digits of calendar box
* Start time: Defaults to current time – edit by using digits or selecting appropriate from look-up list
* End time: Defaults to current time plus 30 minutes – edit by using digits or selecting appropriate from look-up list
* Consultation type: Select appropriate from look-up list
* Location: Select appropriate from look-up list
* ‘Site/Centre’: Select appropriate from look-up list
* Present: Select appropriate tick-box of those present
* ‘If other…’: Enter name in free text field and select relationship from look-up list

1. Continue with ‘Child Health Assessment’ screen as per ‘[KAS consultations](#_KAS_Consultations)’ or ‘[Additional consultations](#_Additional_consultations)’.

**Note**: Assessments look-up list will populate with options relevant to selected consultation type.

**Note:** See **‘**[**Did not attend**](#_Did_not_attend)**’** for process of recording did not attend (DNA). when using CDIS Calendar or if not using CDIS Calendar.

# Did not attend or not home at home visit or outreach

**Note:** Did not attend (DNA) **must** be entered using the following process to be automatically recorded in ‘History/Notes’ and ‘DNA History’.

**Do not** go into the consultation and select ‘No’ for ‘Did the client attend this appointment?’

DNA is displayed in client record:

* ‘Service History’: ‘Cancelled/Re-Scheduled (Client declined appointment)’ – **Note: current bug**
* Notes (in ‘History/Notes’): ‘Cancelled on [date] – Reason: Client DNA (no contact)’
* DNA History (in ‘History/Notes’): ‘Client – Did Not Attend (No contact) and indicates SMS/Follow-up contact’
* Calendar appointment summary: Status is ‘Cancelled on [date] (Client declined appointment)’ (**Note: current bug**), ‘Notes’ is ‘Cancelled DNA’.

## Process

1. From the ‘Home’ screen: in the calendar, select the client appointment or home visit that was not attended, open the context menu (right mouse click) and select ‘Edit’
2. In the ‘Edit Appointment’ pop-up box:

* Select the ‘Cancel’ radio button
* Reason: Select ‘Client DNA (no contact)’ or relevant from look-up list
* Select the ‘Record Did Not Attend’ checkbox to tick
* DNA type: Select ‘Client – Did Not Attend (No contact)’ from look-up list
* Was a SMS sent? Select ‘Yes’ or ‘No’ as appropriate (yes means staff member has sent an SMS)
* Follow-up contact made? Select ‘Yes’ or ‘No’ as appropriate (yes means staff member has contacted family)
* Comments: Enter free-text comments (such as ‘message left for family to reschedule’)

1. If you wish to send an SMS or email to family to notify of DNA and request to reschedule:

* Select the ‘Immediate send’ checkbox to tick
* Select who to SMS or email by selecting checkbox
* Override default SMS or email text: **Do not change the fields in square brackets []**
* Example: ‘We missed seeing [ClientFirstName] for Maternal and Child Health appointment on [AppointmentStartDate], [AppointmentStartTime] at [SiteName]. Please call [SitePhoneNumber] to reschedule. AUTOMATED MSG NO SMS REPLY’

1. Select ‘Save’

## Process if not using CDIS Calendar

1. In ‘Child Health Assessment’:

* Did the client attend this appointment? Select ‘No’ if did not attend appointment
* DNA type: Select relevant reason from look-up list
* Was a SMS sent? Select ‘Yes’ or ‘No’ as appropriate (yes means staff member has sent an SMS)
* Was a letter sent? Select ‘Yes’ or ‘No’ as appropriate (yes means staff member has sent a letter)
* Follow-up contact made? Select ‘Yes’ or ‘No’ as appropriate (yes means staff member has contacted family)
* Comments: Enter free-text comments, such as appointment type. Example: ‘DNA 8mth KAS appointment, message left for family to reschedule’

1. Select ‘Confirm’ button
2. Select ‘OK’ to successfully save.

**Note:** This will record the DNA in the ‘DNA History’ **only** – where an appointment type will be blank. The DNA will **not** be recorded in the ‘Service History’ or in the ‘Notes’.

It is recommended you go to ‘History/Notes’, select ‘Notes’ and ‘Add note’.

# Saving consultations

**Note:** A consultation itself cannot be edited once it has been finalised – ensure it is correct and complete before selecting ‘Save’.

It is best practice to ‘Save’ consultation assessments or notes at the time of consultation or as soon as possibly practical afterward.

Draft consultations are **not counted** for reporting purposes. Currently consultations saved as draft are considered ‘pending’ and therefore **not** counted.

## Save as draft

‘Pending’ consultations’ are those saved as draft.

1. From the Home’ screen, open the ‘Letters/Reports’ menu and select ‘Draft Consultation Notes Report’
2. Open the hyperlink of the relevant client’s name
3. Open the ‘Clinical Activity’ menu and select ‘Consultations’
4. In ‘Incomplete consultations’:

* Select the ‘Continue’ button next to the relevant consultation to be completed
* Enter any further relevant details or notes for that consultation

Select ‘Save’

## Edit

Consultations and assessments **cannot** be edited, only the progress note can be edited.

If weight or growth measurements are edited here, they will not be altered in ‘Growth History’, ‘Charts’ and so on.

To edit a progress note, select ‘Edit’ button.

To ensure clear visibility of a change to a progress note, add the change at top.

Place the cursor at the start of the note, press ‘enter’ to make space at top, then place cursor at top and type ‘\*\*EDIT: [detail]\*\*’.

Figure 1: Add or edit progress note

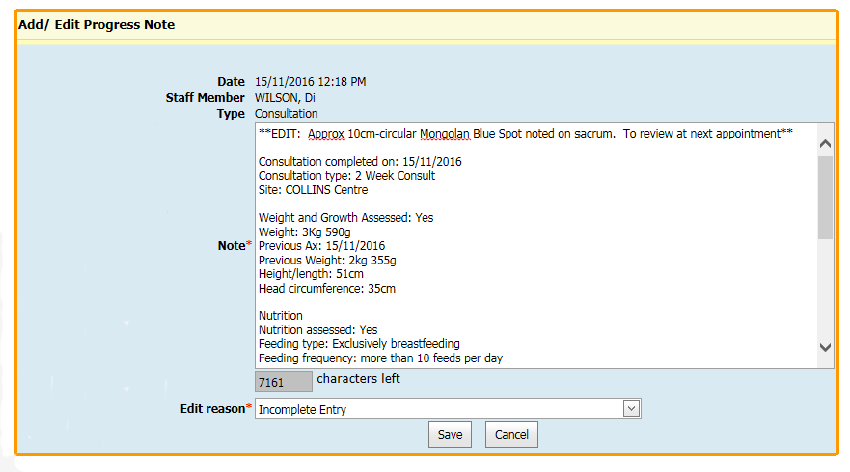


Figure 2: Updated progress note

Updated progress note. It begins 'Supersedes Progress Note previously entered on 15 Nov 2016
**EDIT: Approx 10cm-circular Mongolan Blue Spot noted on sacrum. To review at next appointment** 

# Appendix 1: Assessments

## Important information

**All** ‘assessments’ are to be recorded via the **child r**ecord.

All Assessments relevant to the KAS are populated in the consultation look-up list.

Any assessment can be attended at any KAS or additional consultation. If further assessments are required:

1. Complete and save current consultation first or open a ‘Duplicate tab’
2. Select ‘Assessments’ and then ‘Assessments/Interventions’
3. Select the ‘Complete Assessment’ button for the relevant assessment
4. Complete ‘Assessment pop-up box’
5. Select ‘Save’ and close ‘Duplicate tab’

All appropriate assessments as indicated for the KAS (as per MCH framework) are recorded against that KAS if they are:

* recorded in that KAS Consultation
* recorded in an ‘Additional Consultation’ up to seven days after the KAS consultation attended
* an extra assessment via ‘Assessment/Intervention’ screen up to seven days after the KAS Consultation

Exceptions to this are:

* Brigance: up to one month
* Maternal health: up to 20 days

**Note**: only **one** assessment type is counted for these KAS Reports.

## Assessment types

**Note:** If a referral is identified as required from one of these assessments, referrals must be made via ‘Referrals’ to be counted for reporting purposes.

* two week hearing screen
* eight month hearing follow up
* Brigance
* Edinburgh Postnatal Depression Scale
* Family violence assessment (MARAM)
* hips
* kindergarten enrolment
* maternal health
* MIST
* oral health
* Parent and carers psychosocial assessment
* Parent-child interactions scale – Infant and toddler (Brigance III)
* parent’s evaluation of developmental status (PEDS)
* physical assessment
* Pre home visit safety assessment
* QUIT
* SACS 12 month assessment (11-15 months)
* SACS 18 month assessment (16-21 months)
* SACS 2 year assessment (22-30 months)
* safe sleeping checklist
* safety plan (MARAM)
* Sleep pathways assessment form

# Appendix 2: Growth charts

Growth Charts graph both actual or chronological and corrected or adjusted age:

* : Actual or chronological age
* : Corrected or adjusted age.

Growth charts can be viewed and printed during a consultation via the consultation screen

* At present, it only graphs past measurements and not the current measurement until the consultation is saved.

To view or print a current or up-to-date growth chart:

1. Save the consultation
2. From the CDIS Details (child) screen, open the ‘History/Notes’ menu and select ‘Weight/Growth History’
3. Select ‘Growth Charts’
4. Select View
5. Select ‘Print’ button if required

# Appendix 3: Attachments

Attachments can be:

* Word documents (.doc or .docx)
* scanned documents (.pdf or .jpeg)
* photos (.jpeg or .png)
* PDF files (.pdf)

Primary caregiver consent must be given before uploading or attaching photographs.

## Add attachments

1. ‘Save As’ document on a secure drive
2. From the CDIS Details (child) screen, open the ‘History/Notes’ menu and select ‘Attachments’
3. Select ‘Add Attachment’
4. In the ‘Add Attachment’ pop-up box:

* Electronic upload or physical location: Select (defaults to electronic upload)
* Attachment description: Enter in free text field
* Type: Select from look-up list
* Select ‘Browse…’ button
* Locate and select relevant file by double selecting on it (It will then be displayed in ‘File Name’)
* Select ‘Save’

1. Select ‘OK’ to successfully save. The attachment will now be added to list.
2. Delete electronic copy of document – as per internal Council policy.

## View attachments

1. From the CDIS Details (child) screen, open the ‘History/Notes’ menu and select ‘Attachments’
2. Select the expand button (plus sign) next to relevant attachment
3. Select the download button
4. Select ‘Open’ button on download pop-up

The attachment is now open to view.

**Note: Only management** can delete attachments.

# Appendix 4: Flags and alerts

Each professional has a responsibility to be aware of a client’s flags and alerts.

Flags and alerts can be recorded on **all** client records.

If a primary caregiver or caregiver requires flags or alerts, **also** place on the **child’s** record. Enter specific comments when adding a flag or alert. For example, a caregiver (father) undergoing chemotherapy:

* **Child** record:
  + Category: Risk – Family/Parental factors
  + Details: physical health problems
  + Comments: Father [Name] undergoing chemotherapy for throat cancer
* **Caregiver** (father) record:
  + Category: Risk – Family/Parental factors
  + Details: physical health problems
  + Comments: [Name] undergoing chemotherapy for throat cancer

The EMCH Program is responsible for adding and removing enhanced flags and alerts on **the child record and the primary caregiver record.** Refer to: *Enhanced MCH referral process*.

## Add flags and alerts

1. From the CDIS Details (child) screen, open the ‘Clinical Activity’ menu and select ‘Flags/Alerts’
2. Select ‘Add’ button
3. In the ‘Add Flag/Alert’ pop-up box:

* Category: Select from look-up list
* Details: Select from look-up list
* Start date: Enter using digits or calendar box - defaults to today’s date
* Comments: Enter in free text field if relevant

1. Select ‘Confirm’ button
2. Select ‘OK’ to successfully save

An active flag or alert is displayed as a square in every client record screen (on the right-hand side under the ‘Search’ button). The number inside the square indicates the number of flags or alerts in that category. For example:

03

## Remove flags and alerts

1. From the CDIS Details (child) screen, open the ‘Clinical Activity’ menu and select ‘Flags/Alerts’
2. Select ‘Edit’ button next to the flag or alert to remove
3. In the ‘Edit Flag/Alert’ pop-up box:

* End date: Enter using digits or calendar box – calendar box displays red square around today’s date
* Comments: Enter in free text field if relevant – such as outcome and/or recommendations

1. Select ‘Confirm’ button
2. Select ‘OK’ to successfully save.

A non-active flag or alert (that is, one that has been removed) is displayed as:

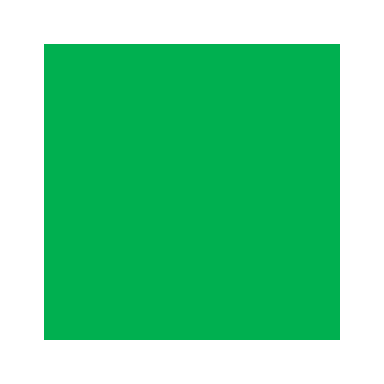
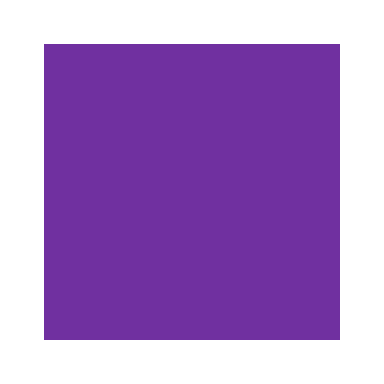
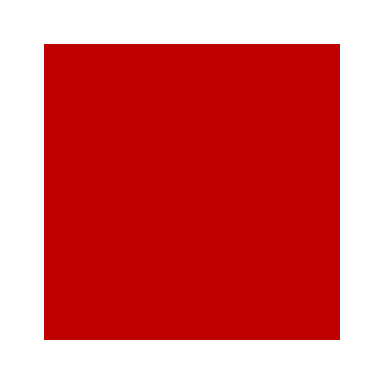
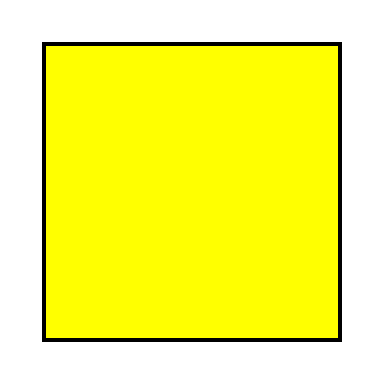
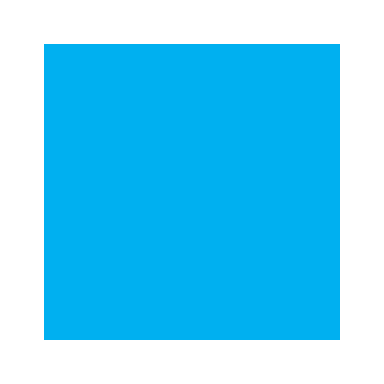
* a triangle in every client record screen (right-hand side under ‘Search’ button) if there are **no other flags or alerts** in that category
* a square with one less number if there are multiple other flags or alerts in that category.

02

In the client ‘Flags/Alerts’ screen, a non-active flag or alert is displayed as:

* Status: Inactive
* End date: [date].

## Flags and alerts colour legend

* **** Protective factors
* **** Enhanced MCH
* **** Risk factors
* **** Multiple DNA
* **** Referral follow-up

## Flags and alerts categories and details

### General

* Family known to child protection
* Multiple DNA - client no show, client cancelled
* Referral follow-up required

### Enhanced MCH

* Client

### EMCH Issues (Integrated EMCH program)

The primary focus for the EMCH program is families experiencing a period of vulnerability due to two or more of the following factors

* mother/parent is less than 20 years of age
* infant/child is identified as being of Aboriginal or Torres Strait Islander descent and is not actively attending the UMCH program
* family is socially isolated (housing, cultural group, transport, unemployment)
* parent expresses and/or demonstrates poor attachment towards their infant/child
* mental health issue currently impacting parenting capacity
* substance abuse related issues currently impacting parenting capacity
* family violence currently impacting safety, parenting and infant/child development
* current intervention from Child Protection
* infant/child born with congenital abnormalities
* infant/child with complex growth, health and developmental issues
* concern on the part of the assessing nurse, or
* families who are not currently engaged with the UMCH program.

### Individual child factors

| Risk factors | Protective factors |
| --- | --- |
| * Low birthweight * Disability * Serious physical or mental illness * Temperament * Aggressive behaviour * Attention deficits family and parental factors | * Good health * Positive peer relationships * Strong positive social networks * Hobbies and interests * High self-esteem * Independence * Secure attachment with parent * Social skills * Positive disposition |

### Family and parental factors

| Risk factors | Protective factors |
| --- | --- |
| * Parental substance abuse * Involvement in criminal behaviour * Family conflict or violence * Mental health problems * Physical health problems * History of child abuse or neglect * Parental disability * Large family size * High parental stress * Poor parent-child interaction * Low warmth or harsh parenting style * Separation or divorce * Low self-esteem * Teenage or young parents * Single parent * Non-biological parent in the home * Low level of parental education * Use of corporal punishment | * Secure attachment with child * Positive parent-child relationship * Supportive family environment * Extended family networks * High level of parental education * Parental resilience * Concrete support for parents * Sound parental coping skills * Awareness of stages in child development |

### Social and environmental factors

| Risk factors | Protective factors |
| --- | --- |
| * Socio-economic disadvantage * Parental unemployment * Social isolation * Inadequate housing * Homelessness * Lack of access to adequately resourced schools * Exposure to racism or discrimination * Stressful life events * Lack of access to school support, including childcare and social services | * Strong positive social networks * Stable housing * Employment * Family experience of pro-social behaviour * Well-resourced schools in neighbourhood * Access to health and social services |

|  |
| --- |
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