

Paper visit record

Sehnam Home Care
Form DT-1 · one form per visit

Use only when the app cannot be used. Phone the office when you arrive and when you leave if you can. Enter this form in Sehnam yourself as soon as the app works again (visit page -> "Enter from a paper form"), or hand it to the office within 24 hours.

Something urgent or unsafe? Phone the coordinator now. Do not wait to fill in or transcribe this form.

Medicines: chart them on the paper medication record (DT-2), never on this form.

Date	Patient number (PAT...)	Patient initials	Area
Your name	Staff number (EMP...)	Planned time	
Time arrived	Time left	Office phoned at (time) / spoke to	

Why paper?

☐ Sehnam unavailable (downtime) ☐ No mobile data or signal ☐ Phone not working or battery flat ☐ Could not sign in

Other (write it here)

Tasks

Outcome: D done · R refused · N not needed · W withheld · U unable to do · E escalated. Anything other than D needs a reason, and R, U and E need what happens next. Safety-critical tasks are never left blank.

Task (as on the care plan or run sheet)	Outcome	Time	Reason · what happens next · who you told

Short summary for the team (what went well, any change you noticed). Concerns go to the coordinator by phone as well.

Your signature	Entered in Sehnam by / date and time
Checked by coordinator / date	Differences found and how resolved

Confidential once completed. Keep it on you during the visit, then in the locked paper-records file at the office. It is kept until a coordinator has checked the Sehnam entry against it, and then handled under the paper-records rule in the downtime procedure.

Paper medication administration record

Sehlaam Home Care
Form DT-2 · nurses and doctors only

Give a medicine only as written on the current, approved medication order for this patient.

Never from memory or from the packet alone. If you cannot see the order, or it is unclear, do not give it: record M or N and phone the lead nurse. Check allergies before every dose.

Date	Patient number (PAT...)	Patient initials	Your name and role

Allergies (from the order or run sheet; write "none known, reviewed" only if that is what the record says)

Outcome: G given · R refused · W withheld (clinical reason) · M missed · N not available. Anything other than G needs a reason and who you told.

Medicine (as on the order)	Dose	Route	Due	Given at	Outcome	Initials	Reason · who you told

Your signature	Entered in Sehlaam (medication record) by / date and time

Checked by lead nurse / date	Differences found and how resolved

Confidential once completed. The person who gave the medicine enters it in Sehlaam from this form, as a late entry with the time given. A second clinician checks the entries against this form before it is filed.

Office call log: arrivals and departures

Sehlaam Home Care
Form DT-3 · office use

Write down every arrival or departure a worker phones in while Sehlam or their app is unavailable. When Sehlam works, record each one on the visit ("Record arrival/departure for the worker"), choosing "The worker phoned the office", with the time the worker gave you.

Date	Office staff on duty

[illegible]

Confidential once completed. File with the day's paper visit records. A visit with no call and no paper form by the end of the day is followed up as a possible missed visit.

When Sehlam is back: reconciliation checklist

Sehlam Home Care
Form DT-4 · coordinator

Downtime from (date, time)

Downtime to (date, time)

Coordinator

Date completed

Tick each step when done

- ☐ 1. Tell staff Sehlam is back (emergency message or phone round). Ask each worker to enter their own paper visit and medication records the same day.
- ☐ 2. From the office call log (DT-3), record each phoned-in arrival and departure on its visit. Each worker is notified automatically.
- ☐ 3. Collect every paper visit record (DT-1) and medication record (DT-2) covering the downtime. Count them against the run sheet for those days.
- ☐ 4. For each visit, check Sehlam against the paper form: arrival and departure times, every task outcome, medicines. Sehlam marks them "from a paper form" and as late entries.
- ☐ 5. Look for duplicates: a visit started both in the app and on paper, or entered twice. Correct times through "Correct start/finish times" with the reason; never delete. Raise an incident if a record cannot be reconciled.
- ☐ 6. Visits with no paper form, no call and no app record: follow up with the worker; record as missed if care did not happen, and tell the client's family.
- ☐ 7. Review and approve the visits only after the check. Sign each paper form ("Checked by") and file it in the locked paper-records file.
- ☐ 8. Write a short downtime note (start, end, cause if known, visits affected, problems found) and send it to the owner. Major or repeated downtime goes to the incident log.

Visits during downtime (run sheet)

Paper forms received

Phoned-in times recorded

Discrepancies / incidents raised

Notes

See the downtime procedure (in Sehlam: "If Sehlam is unavailable") for roles, contacts and the paper-records rule.