

APPENDICES
For Health Records
Policy & Procedure
IT06, v1.4 (2016)

APPENDIX 1

Audit Tool

Mersey Care NHS Foundation Trust Annual Record Keeping Audit Tool

Date of data collection		Name of Auditor	
Name of CMHT / Ward		Division	
RIO/Epex/PACIS number			

Please complete one form for each health record audited. Please complete Part A and Part B of this form – Part B requires viewing the latest **10** written clinical entries. All forms **must** be completed by

PART A

Please indicate if the following information is within the Health Record where applicable				
Copy of recent Care Plan	Y/N		Copy of recent Letters	Y/N
PACIS – most recent care plan only	Y/N			

PART B

	Health Care Professional designation, eg Staff Nurse, CT1 Doctor	Written as: W = inpatient setting C = community clinic O = other (please state i.e. domiciliary visit)	Std One Has the entry been keyed in during the shift where the contact/visit took place? YES/NO if no, please indicate time delay, e.g. 3 days	Std Two (A) Does the entry reflect the purpose of the contact/ Intervention YES/NO if no, please record why	Std Two (B) Are the next steps/plan of care visible? YES/NO	Std Three Is the entry written in plain English including correct use of grammar and spelling? YES/NO if no, please record type of error	Std Four Does the record contain evidence of 'revoked' entries recorded in error YES/NO	Std Five Evidence of counter signature YES/NO/N/A	Std Six Did you understand all abbreviations used within all entries? YES/NO if <u>no</u> , please record unknown abbreviation
Eg	<i>Occupational Therapist</i>	<i>CMHT</i>	<i>Yes</i>	<i>No, unclear of medication changes</i>	<i>Yes</i>	<i>No, typing error in two entries</i>	<i>No</i>	<i>Yes</i>	<i>SOB</i>
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Ratified by Member of the Health Records sub-Committee at the Health Records sub-Committee Meeting on Wednesday 13th July 2016

APPENDIX 2 (a)

PROCEDURE FOR THE MANAGEMENT OF PATIENT HEALTH RECORDS HELD AT WARD LEVEL (High Secure Services):

1 STORAGE OF PATIENT INFORMATION:

The safe and secure storage and handling of patient information is paramount to maintaining patient confidentiality while ensuring that the information is available and fit for the purpose of facilitating patient care and treatment. **Please note: the ward records are currently being phased out to ensure that out of date information is not referenced and a greater reliance on the electronic record is encouraged**

- All patient information must be kept securely to maintain confidentiality and safeguard against unauthorised access.
- There should be no eating or drinking near patient information when there is the possible risk of damage.
- No other material that could be a risk to patient information (such as chemicals) is to be stored with them.
- In accordance with Trust Policy IT06, it is important that patient information is not retained at ward level beyond its purpose.

Further details can be found in the Mersey Care NHS Trust IT06 'Corporate Health Records Policy and Procedures'.

2 MANAGEMENT OF PRE-ADMISSION INFORMATION FOR A PATIENT NOT ADMITTED:

The Admission Wards will accumulate pre-admission information relating to a possible patient admission. When it is known that a patient is not to be admitted, the Ward Clerk is to confidentially destroy this information as it is duplicated on PACIS (scanned by the Referrals Manager).

In accordance with Trust Policy IT06, it is important that patient information is not retained at ward level when it is no longer needed.

3 MANAGEMENT OF EXTERNAL INFORMATION (Part 1s) WITH A PATIENT'S ADMISSION:

With a patient's admission, the Admission Ward may receive historical information to assist with the care and treatment of the patient, e.g. copy of other Hospital records or Prison In-Mate Records. These records are collectively known as 'Part 1s'. The Part 1s are not to be retained on the Admission Ward.

- The Admission Ward will take delivery of Part 1s.
- A member of the Mental Health Law Department (MHL) will retrieve the Part 1s when visiting the patient on admission. The MHL pass these records to the Health Records Department (HRD) for storage and to make available to other professionals, e.g. RC and Security Liaison Officer.

4 MAINTENANCE OF INDIVIDUAL PATIENT WARD RECORD: (*Please note: these records are currently being phased out to ensure that out of date information is not referenced and a greater reliance on the electronic record is encouraged*)

The individual patient ward record contains information relating to the mental health aspect of a patient's condition. The record is created on the Admission Ward and follows the patient when he transfers wards (this practice is currently under review. It is expected that only the Admission Wards will continue to create and keep a ward record. Other ward records are being scanned into the electronic record, WinDIP). It must be remembered that the ward record is a 'working' record to support staff with the care and treatment of patients on a day to day basis. It is not the patient's complete history.

The ward record is divided into sections for filing purposes and ease of access to information. Each section is denoted by a divider and is to contain the information indicated on the divider.

The ward record is to be kept in a closed cabinet / drawer in the Ward Office when not in active use. The room is locked when unoccupied as per Security Procedures Manual.

The record is not routinely to be taken off the ward therefore a 'tracer' system is not required.

4.1 On admission:

With a patient's admission, the Ward Clerk on the Admission Ward is to:

- Complete patient details on the front of the ward record.
- File relevant admission information.
- When the email is received from the MHL notifying the ward of the availability of the first Patient Front Information Sheet in PACIS, print the Sheet and file in the record as the first document viewed when opened.

4.2 Routine file maintenance:

Maintenance of the records includes:

- Hole punching and securely filing new and loose documents as soon as practically possible to ensure up to date and relevant information is available.
- Weeding records (see 'Weeding of Patient Information').
- When an email is received from the MHLD notifying the ward that an updated Front Information Sheet is available in PACIS, printing the Sheet and filing in the record as the first document viewed when opened. Confidentially destroy the previous Sheet.
- *Please note:* Plastic wallets are not to be used in the ward record due to the possibility of information being filed in them that is not visible to the user.

4.3 Patient name changes:

Patient name changes can occur frequently. It is important that a patient's name is only changed on the records when formally advised by the MHLD.

When notified of a patient name change the Ward Clerk is to:

- Score a single line through the patient's previous name on the front of the ward health record and any other patient-related information, e.g. physical health record and medication cards. The name is not to be obliterated but it is to be obvious that a line is scored through it. Record the date of the change.
- Record the new name clearly (in block capital letters) with the date.
- File health records under the most recent name to avoid more than one set of health record existing for the same patient.

5 MAINTENANCE OF WARD PHYSICAL RECORD:

The ward physical record is to contain information that relates to the physical condition of a patient.

- New / loose documents are to be securely filed in the correct section as soon as practically possible to ensure up to date and relevant information is available.
- The physical record is to be kept in a closed cabinet / drawer in the ward Treatment Room when not in active use. The room is locked when unoccupied as per Security Procedures Manual.

6 MANAGEMENT OF ORIGINAL DOCUMENTS:

The ward may acquire original documents that contain information unknown to the patient's RC e.g. letter written by the patient. It is important that an original document is not retained at ward level but is forwarded to the patient's RC for their information and filed in the main clinical health / legal record.

- Appropriate ward staff, e.g. Named Nurse, are to ensure that any necessary action required as a result of the document is undertaken.

- The document is then to be securely packaged and sent to the patient's RC (with an advice note detailing the sender and the reason for being sent).

7 WEEDING PATIENT INFORMATION:

It is expected that documents held at ward level are duplication, e.g. CPA minutes. Original documents should have been forwarded to the RC (see 'Management of Original Documents'). For the purpose of this Procedure the term 'duplicate' refers to information that is either:

- Print-out from PACIS.
 - An exact copy of information already held at ward level (scrutinise / cross check the documents to ensure a true duplication).
 - An exact copy of a document that will be in the main clinical health or legal record, e.g. copy of hospital letter.
- When a document no longer fits the criteria for retention at ward level and is identified as duplication, it is to be removed and confidentially destroyed.
 - If unsure whether a document is duplication:
 - Cross-reference with PACIS by checking the appropriate screen.
 - or*
 - Contact the relevant Health Records Administrator to establish if the information is in the main clinical health or legal record.

In accordance with Trust Policy IT06, it is important that patient information is not retained at ward level beyond its purpose.

8 MANAGEMENT OF MEDICATION CARDS:

- Medication cards are to be kept in a closed cabinet / drawer when not in use. The room is locked when unoccupied as per Security Procedures Manual.
- Full medication cards are to be retained by the ward for at least six months from the date of last entry.
- When a medication card is full, no longer required on the ward, the date of last entry is at least six months previous and the card is marked as 'cancelled', it is to be securely packaged and sent for storage (with an advice note attached detailing the sender and the reason for being sent) to the Health Records Department, OER Building, Ashworth Hospital via the internal mail.
- *Please note:* to assist with retrieval of data from the medication cards, it is important that ward staff put them in patient and date order prior to sending.

With a patient's trial leave, transfer or discharge please see 'Management of Patient Information with a Patient's Trial Leave' or 'Management of Patient Information with a Patient's Transfer / Discharge'.

8.1 Patient's visit to the Health Centre:

- When a patient has an appointment at the Health Centre, the escorting staff are to take the current medication card to the Health Centre with the patient. No other documents are to be taken (unless requested by the Health Centre which would be the exception rather than the rule).
- The medication card is to be shared with the health professional at the Health Centre.
- The escorting staff are to return the medication card to the ward on the patient's return.

8.2 Day Leave Prescription Sheet:

With a patient's expected Leave of Absence (LOA), the RC completes and signs the Day Leave Prescription Sheet (DLPS).

The DLPS is forwarded to Pharmacy who dispense the medication and send to the ward with the DLPS.

- The DLPS is signed by staff to indicate when medication has been dispensed.
- The DLPS is to be retained on the ward with the medication cards.
- The DLPS is to be retained at ward level for at least six months from the date of last entry.
- Following six months and when no longer required at ward level, the DLPS is to be securely packaged and sent for storage (with an advice note attached detailing the sender and the reason for being sent) to Health Records Department, OER Building, Ashworth Hospital via the internal mail.
- *Please note:* to assist with future retrieval of DLPS, it is important that ward staff put them in patient and date order prior to sending.

8.3 Emergency Leave of Absence:

On occasion a patient's emergency LOA may be necessary.

- With a patient's emergency LOA for medical treatment, the current medication card is to go in the LOA suitcase.
- When the medication card is no longer required by the receiving Hospital, it is of the utmost importance that escorting staff ensure it is returned to the ward promptly.

9 MANAGEMENT OF SECLUSION and OBSERVATION SHEETS:

- Seclusion and observation sheets are to be kept in a closed cabinet / drawer when not in active use. The room is locked when unoccupied as per Security Procedures Manual.
- Seclusion and observation sheets are to be retained on the ward for at least six months following completion.
- Seclusion (original white copies only) and observation sheets that are at least six months old and no longer required at ward level are to be securely packaged

and sent for storage (with an advice note attached detailing the sender and the reason for being sent) to Health Records Department, OER Building, Ashworth Hospital via the internal mail.

- With a patient's transfer or discharge, all the seclusion and observation sheets are to be securely package and sent to the HRD (as above).
- *Please note:* to assist with future retrieval, it is important that ward staff put seclusion and observation sheets in patient and date order prior to sending.

In accordance with Trust Policy IT06, it is important that patient related information, which is no longer required, is not retained at ward level.

10 MANAGEMENT OF PATIENT INFORMATION WITH A PATIENT'S INTER-WARD TRANSFER:

- With a patient's inter-ward transfer from an Admission Ward, the Admission ward record is to be securely packaged and sent to the Health Records Department, OER Building, Ashworth Hospital for scanning into WinDIP.
- Medication cards, seclusion and observation sheets that are full but not within the acceptable date range for sending to the HRD for storage are to be securely packaged and taken to the receiving ward at the time of the transfer.
- Other patient information required by the receiving ward, e.g. non-association list, is to be taken to the ward as above.

It is important that information relating to a patient who has transferred wards, is not left on the previous ward.

11 MANAGEMENT OF PATIENT INFORMATION WITH A PATIENT'S TRIAL LEAVE:

- When a patient is on trial leave, all patient information is to remain on the ward until the patient is formally transferred or returns to the Hospital.
- Should the patient return to the Hospital but be admitted to a different ward, their information (including medication cards, seclusion and observation sheets that do not fit the criteria for sending to the HRD for scanning or storage) are to be hand-delivered by a member of ward staff to the new ward as a matter of urgency.
- Should the patient be formally transferred their information is to be securely packaged and sent to the Health Records Department, OER Building, Ashworth Hospital in accordance with 'Management of Patient Information with a Patient's Transfer / Discharge'.

12 MANAGEMENT OF PATIENT INFORMATION WITH A PATIENT'S TRANSFER / DISCHARGE:

In accordance with Trust Policy IT06, it is important that information relating to a transferred / discharged patient, which is no longer required, is not kept on the ward.

12.1 Discharge or Transfer to a Non High Secure Hospital:

Within two weeks of a patient's discharge / transfer the Ward Clerk is to:

- Gather all patient information together.
- Put the information into order, including the medication cards and seclusion and observation sheets into date order.
- Attach an advice note to the records detailing the sender and the reason for being sent.
- Securely package and send to Health Records Department, OER Building, Ashworth Hospital via internal mail.

12.2 To another High Secure Hospital:

Prior to a patient's transfer to another High Secure Hospital, the Ward Clerk or, if unavailable, another member of ward staff is to:

- Gather all medication cards together but ensure that this does not interfere with the administration of the patient's medication.
- Check that each medication card has the correct patient details and put in date order.
- Identify how many medication cards there are and notify the Health Records Administrator of quantity when they deliver the patient's main health records to the ward.
- Attach an advice note to the medication cards detailing quantity and sender.
- Securely package the medication cards.
- Ensure that the ward staff who accompany the patient with the transfer, take the main health records and medication cards with them in Trust transport.

Within two weeks of the patient's transfer the Ward Clerk is to gather and send all other patient information in accordance with 12.1.

13 ACCESS TO PATIENT INFORMATION BY AN EXTERNAL VISITOR / PROFESSIONAL:

Should an external visitor / professional wish to seek access to patient information, this is arranged with the HRD (who can be contacted for further information).

- Patient information at ward level is not to be routinely viewed by an external visitor / professional due to its limited contents and the need to ensure that appropriate authority has been given for the access to take place.

- Should access to patient information by an external visitor / professional be assessed by ward staff and deemed necessary it is only to take place with the explicit prior consent of the RC or senior member of staff, e.g. Ward Manager.
- Authorised access by an external visitor / professional and the reason for it are to be recorded in PACIS Clinical Notes by the ward staff facilitating the access.

14 MISSING PATIENT INFORMATION / RELATED INCIDENTS:

The responsibility for the security of patient information lies with the member of staff accessing the information.

- Upon discovering that patient information is missing the Health Records Manager for High Secure Services or a senior member of staff is to be contacted immediately to enable implementation of the Mersey Care 'Procedure for "Missing" Health Records' (appendix 3 of IT06 'Corporate Health Records Policy and Procedures').
- Upon another type of incident occurring e.g. damage or unauthorised access, an Adverse Incident Form is to be completed and the matter reported immediately to the Health Records Manager for High Secure Services or a senior member of staff to instigate a formal investigation, if necessary.

15 MANAGEMENT OF DECEASED PATIENT INFORMATION:

- All patient information relating to a deceased patient is to be gathered and hand-delivered to the Health Records Manager / Supervisor (OER Building) as a matter of urgency (regardless of the time since the death).

It is **important** that information relating to a deceased patient is not retained on the ward.

APPENDIX 2 (b)

PROCEDURE FOR RECTIFYING ERRORS IN PACIS CLINICAL NOTES

1. INTRODUCTION

This document explains the following:

Why this Procedure is necessary (rationale);

To whom this Procedure applies, and guidance on where and when it should be applied (scope);

The underlying assumptions upon which the Procedure is based (principles);

The standards to be achieved in practice; and

How the standards will be met through working practices and audited

1.1 RATIONALE

The High Secure Services (HSS) recognises that there will be occasions when there are errors in the Clinical Notes of the Patient Administration and Clinical Information System (PACIS) and is committed to dealing with these as quickly and as effectively as possible.

1.2 SCOPE

The Procedure is to be followed by all staff who access PACIS Clinical Notes to enable them to act upon a Clinical Note they believe to be incorrect.

Should the author of a PACIS Clinical Note error no longer work within the High Secure site, a PACIS Database Administrator is to undertake the corrective action required.

1.3 PRINCIPLES

This Procedure is to ensure all identified inaccurate PACIS Clinical Note entries are rectified in accordance with the Procedure to assist with the continuity and accuracy of the manual and electronic health records, PACIS.

1.4 COMPLIANCE WITH HUMAN RIGHTS ACT 1998

Mersey Care NHS Trust recognises that all sections of society may experience prejudice and discrimination. This can be true in service delivery and employment. The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The Trust believes that all people have the right to be treated with dignity and respect.

The Trust is working towards, and is committed to the elimination of unfair and unlawful discriminatory practices. All employees have responsibility for the effective implementation of this Procedure. They will be made fully aware of this Procedure and without exception must adhere to its requirements.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998.

All public authorities have a legal duty to uphold and promote human rights in everything they do. It is unlawful for a public authority to perform any act which constitutes discrimination.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line with the Human Rights principles of dignity, autonomy, respect, fairness, and equality”.

Copies of this document are available in alternative formats and easy read version upon request.

2. PROCEDURE

Action will be taken when an incorrect PACIS Clinical Note has been identified in accordance with this procedure.

If, as a result of an identified error, a PACIS Clinical Note needs to be saved to a date more than two weeks previous (exceptional circumstances only) staff must contact the leading Professional, usually the Responsible Clinician (see 3.2).

Manual Health Records will be updated of identified errors, monthly.

At no time during this process are PACIS Clinical Notes in the manual health records to be removed / destroyed.

If it is thought that there are possible consequences as a result of a PACIS Clinical Note error, it is the responsibility of the person rectifying the Clinical Note to take further action considered necessary.

3. PROCEDURE

3.1 Correcting PACIS Clinical Note Errors

When an author is aware that they have made an incorrect PACIS Clinical Note they are to:

Open the incorrect Clinical Note (if of help, copy the text to avoid typing the majority of the entry again).

Click on the ‘Error Note’ check box.

Enter a clear reason for the error in the screen available. It is not sufficient to simply state 'written in error'.

Click on the 'OK' button to save the reason for the error.

Click on the 'OK' button to accept the Error Note.

If (as a result of the error) the author needs to create a new Clinical Note and the date of the Clinical Notes is within two weeks of corrective action being taken:

Paste the entry and / or edit / type the correct information into a new PACIS Clinical Note.

Ensure that it is attached to the correct patient.

Save to the correct date.

If the corrective action is being taken outside of two weeks, see the following:

3.2 Saving Clinical Notes to a date more than two weeks from the date the error is identified:

When entering a PACIS Clinical Note, it is only possible to save to a date within the previous two weeks. If, as a result of an identified error, a PACIS Clinical Note needs to be saved to a date more than two weeks previous (exceptional circumstances only) contact the leading Professional.

The leading Professional is to:

Assess whether it is appropriate for the Clinical Note to be backdated.

If the Clinical Note is to be backdated, inform a PACIS Database Administrator by email.

If the Clinical Note is not to be backdated, assess how the Clinical Note is to be recorded and advise the requestor.

The PACIS Database Administrator is to:

Update the Clinical Note with the requested date (PACIS will record the date the information became public).

Email details of Clinical Note and action taken to the Health Records Supervisor / Manager for HSS. The Health Records Supervisor / Manager will forward to the relevant Health Records Administrator.

The Health Records Administrator is to:

Print the relevant Clinical Note, note the date on the top and file in correct date order in the 'Clinical Notes' section of the Clinical Health Record.

3.3 Error Identified by another Member of Staff:

Whilst carrying out duties staff may come across a PACIS Clinical Note written by another member of staff which they believe to be inaccurate.

The person identifying such an error is to bring it to the attention of the Health Records Supervisor for HSS.

The Health Records Supervisor is to:

Ask the member of staff to report it in Datix in accordance with the Mersey Care NHS Trust 'Policy and Procedure for the Reporting, Management and Review of Adverse Incidents' (SA03).

Advise the author of the error and ask them to amend it in accordance with this Procedure (copy in their Line Manager / Department Lead). If the author no longer works for HSS, contact a PACIS Database Administrator to agree action to be taken.

Ask the member of staff to advise when corrective steps have been taken.

Check that there is an outcome for each error advised of.

If no response is received after two working weeks, contact the appropriate Department Lead for an update. If, after four weeks, the matter is not resolved, advise the Health Records Manager for HSS for further action.

3.4 Updating the Manual Health Records with Error Note Reports:

On a monthly basis the Information Department provide the Health Records Supervisor / Manager for HSS with Error Note Reports for errors that would not be captured in the monthly printing and filing of PACIS Clinical Notes.

On receipt of Error Note Reports the Health Records Supervisor is to sort and distribute to the Health Records Administrators.

On receipt of Error Note Reports the Health Records Administrator is to:

Identify the incorrect Clinical Note in the Clinical Health Record and cross through with a single diagonal line, being careful not to obliterate information.

Write 'Error Note' in the left hand margin.

Date and sign the amendment with name printed alongside.

File the Error Note Report on top of the incorrect Clinical Note.

To monitor this process for compliance the Health Records Supervisor is to:

Audit a sample of Error Note Reports in the Clinical Health Records.

Discuss the audit and raise issues of concern with the Health Records Manager for HSS.

4. DEVELOPMENT AND CONSULTATION PROCESS

4.1 Health Records & PACIS User Group

Implemented: September 2008

Reviewed: October 2009, December 2011, December 2014

Next Review: December 2016

Author: Health Records Manager for HSS

APPENDIX 2 (c)

HEALTH RECORDS DEPARTMENT - High Secure Services

HEALTH RECORDS LIBRARY & RECORD RELATED PROCEDURES

These Procedures are to be available for reference in the Health Record Libraries of Shakespeare House and the OER Building, Ashworth Hospital.

The Procedures detail the processes that Library users are to follow to ensure that good practice is adhered to and that consistency across the Libraries is achieved.

It is important that these Procedures are followed to ensure a complete up-to-date patient record with appropriately accessible information.

The term 'record', used throughout these Procedures, includes:

Clinical Health records
Legal records
Copy Statutory Documents
Documents within Part 1s including depositions
Judicial Reviews
Records prepared as a result of the treatment and care given to a patient by one of the High Secure Services.

Should you have a query regarding these Procedures, please contact:

Health Records Lead – Secure Division 471 2629

For other health record related queries contact a Health Records Administrator in the following area:

Shakespeare House 471 2308/2204

Archives is no longer manned regularly, therefore contact should be via one of the above numbers.

Mersey Care NHS Foundation Trust Health Record related Policies are available on the Trust website for reference.

Implemented: July 2006

Reviewed: January & August 2007, March 2008, March & October 2009, January 2010, July 2011, July 2012, July 2013, July 2015, June 2016

Next Review: July 2018

Author: Health Records Manager – High Secure Services

Impact Assessed: August 2009, July 2012

"Mersey Care NHS Trust recognises that all sections of society may experience prejudice and discrimination. This can be true in service delivery and employment. The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The Trust believes that all people have the right to be treated with dignity and respect. The Trust is working towards, and is committed to the elimination of unfair and unlawful discriminatory practices. For those staff who have physical disabilities, reasonable adjustments will be made to allow for tasks to be undertaken.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998. All public authorities have a legal duty to uphold and promote human rights in everything they do. It is unlawful for a public authority to perform any act which constitutes discrimination. Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line with the Human Rights principles of dignity, autonomy, respect, fairness, and equality".

All employees have responsibility for the effective implementation of these Procedures. They will be made fully aware of the Procedures policy and without exception must adhere to its requirements.

Copies of this document are available in alternative formats and easy read version upon request.

HEALTH RECORDS DEPARTMENT – High Secure Services

HEALTH RECORDS LIBRARY & RECORD RELATED PROCEDURES

LIST of ABBREVIATIONS:

Abbreviation:	Meaning
AMD	Associate Medical Director
CPA	Care Programme Approach
HRA	Health Records Administrator
HRD	Health Records Department
HRL	Health Records Library
HR Lead	Health Records Lead
LOA	Leave of Absence
MHLD	Mental Health Law Department

MHRT	Mental Health Review Tribunal
NHS LA	NHS Litigation Authority
PA	Personal Assistant
PACIS	Patient Administration Clinical Information System
RC	Responsible Clinician
SOAD	Second Opinion Appointed Doctor

**HEALTH RECORDS DEPARTMENT – High Secure Services
(Secure Division)**

HEALTH RECORDS LIBRARY & RECORD RELATED PROCEDURES

NUMBER	PROCEDURE TITLE
1	Generating records with a patient's admission
2	Storage and handling of records
3	Access to health records libraries
4	Tracing out records
5	Monitoring the contents of the health record libraries
6	Filing
7	Recording patient identification details on correspondence
8	Printing PACIS Clinical Notes
9	Updating Patient Front Information Sheets
10	Patient name change on the records
11	Destruction of duplicate information
12	Issuing of subsequent volumes

13	Correct Use Of Secure Storage Pouches
14	Relocation of records with the change of a patient's responsible clinician
15	Access to records by an external professional
16	Management of records with a patient's leave of absence
17	Management of records with a patient's transfer / discharge
18	Returning loaned records
19	Collation, storage and access to records of a deceased patient
20	Missing health records / record related incidents

1 PROCEDURE for GENERATING RECORDS with a PATIENT'S ADMISSION:

1.1 Issuing new health record folders:

With a patient's admission the Health Records Administrator (HRA) is to:

- Complete patient details clearly (in block capital letters with a black marker pen) on the front of the Clinical Health and Legal Record folders except for 'To' and 'Year of Transfer / Discharge'. If known, identify if it is a subsequent admission, e.g. 2nd Admission, 3rd Admission etc.
- In the Clinical Health Record:
 - File a 'Blood Results' notice behind the 'Physical Health & Investigations' divider. Remove mount sheets from this section. Please note: these two steps are not necessary in the new stock of folders.
 - Insert the 'Pre-Admission / Admission' divider on top of the 'Psychiatric Assessment Tools / Nursing Reports' divider. File the pre-admission documents (provided by the Referrals Manager prior to the patient's admission) by episode and in date order behind this divider. The 'Pre-Admission / Admission' divider is filed in the first volume only.
 - NB: It is the responsibility of the Responsible Clinician (RC) to advise the Health Centre of any alerts / allergies the patient may have (this information is recorded in the Health Centre database, Vision, and transfers to the electronic Patient Administration Clinical Information System (PACIS).
- In the Legal Record:

- When received from the Mental Health Law Department (MHL), file a copy of the Statutory Documents in date order in the 'Detention' section.

1.2 Patient Front Information Sheet:

With a patient's admission the MHL create a Patient Front Information Sheet and attach to PACIS. The MHL notify the HRA and the ward (by email) when the Sheet is available on PACIS (the Sheet may be attached to the email). When notified, the HRA is to:

- Print two copies of the Sheet onto card and file in the front of the Clinical Health and Legal Records as the very first document viewed when opened.

See the Procedure for 'Updating Patient Front Information Sheets' for further information re maintenance of the Front Information Sheet.

1.3 Filing the new health record folders / updating information systems:

The Clinical Health and Legal Records are to be filed in alphabetical order in the appropriate Health Records Library (HRL). The HRA is to:

- File the records in the correct location on the shelves, which may require redistribution of other records. It is vital that during the redistribution process all records remain in strict alphabetical order.
- Add the records details to the Patient Records spreadsheet, in the Health Records Department's (HRD) shared drive.
- Re-label the shelves and amend / replace the spreadsheet printout on the HRL wall to reflect the new admission / relocation of other records.

1.4 Part 1s:

Historical information, including Depositions, may be provided by NHS Trusts and / or outside Agencies around the time of a patient's admission. These records are collectively known as 'Part 1s'. It is important that the HRD are aware of what Part 1s exist to monitor their availability, integrity and security.

The MHL visit the ward at the time of a patient's admission. If the referring Agency has provided Part 1s at this time, the MHL will take them off the ward and pass to a HRA. The HRA is to:


- Pass the Part 1s to the RC. If the RC does not wish to keep the Part 1s they are to be stored in the Health Records Admin area, OER Building.
- Catalogue Part 1 details in the 'Part 1s in OER' spreadsheet (in the HRD shared drive). If the Part 1s are not being stored in the Health Records Admin area, use red font to indicate that the records are not

with the HRD. When the Part 1s are in the Health Records Admin area, the font is to be changed to black.

- Record 'Yes' on the Patient Records spreadsheet, with a 'Y' to indicate that Part 1s exist.
- If the records are passed to the HRA, the HRA is to enter '*Other records held by Health Records Department*' in the Additional Details box in the Patient Information screen in PACIS.

See Procedure for 'Storage and Handling of Records' for detailed guidance re Part 1s.

1.5 Ashworth Hospital Records – previous admission:

Ashworth Hospital health records, relating to a patient's previous admission, are available in the electronic health record WinDIP,  which is accessible to staff via the WinDIP icon in PACIS.

1.6 Patient Identification Labels:

See Procedure for 'Recording Patient Identification Details on Correspondence' to ensure the prompt availability of labels.

2 PROCEDURE for STORAGE and HANDLING of RECORDS:

The safe and secure storage and handling of records is paramount to maintaining patient confidentiality while ensuring that the information is available and fit for the purpose of facilitating patient care and treatment.

2.1 The Storage and Handling of Records:

The following guidance is to be adhered to by all users of all records:

- The records must be filed in the appropriate HRL when not in current use.
- All records must be kept securely to maintain confidentiality and safeguard against unauthorised access.
- All staff borrowing a record are responsible for recording the movements / whereabouts of the records in accordance with the Procedure for 'Tracing Out Records'.
- Records being carried on site should be securely enclosed in an envelope / storage bag, e.g. Envopak. Due to the large quantity of some records it may be necessary to transport them using a trolley / suitcase available in each HRL. Do not attempt to carry a number of volumes. If the volume of records is still too bulky, package securely and arrange collection and delivery by the Portering Service.
- No other material that could be a risk to records (such as chemicals) should be stored / transported with them.
- Records should never be thrown and must be secure when in transit.

- Records with torn covers must be brought to the attention of the HRA for the cover to be replaced before re-filing.
- There should be no eating or drinking near records to reduce the risk of possible damage.
- To comply with Health & Safety regulations, all those using a HRL must ensure that it is kept tidy and orderly at all times including the omission of clutter, blocking or tripping hazards to ensure that there is a clear pathway.
- Mersey Care NHS Foundation Trust is a smoke free Trust and operates a smoke free Policy. Smoking is not permitted on any site (see the Trust Smoke Free Policy SA20).

For further details refer to the Trust's Health Records Policy & Procedures (IT06).

2.2 Part 1s:

It is important that the HRD is aware of the existence of all Part 1s to ensure their availability, integrity and security.

The RC may receive Part 1s at the time of a patient's admission or when requested from other sources, e.g. Hospital and Prison records. The RC may wish to keep these records temporarily (and securely) in their office. When the RC no longer wishes to keep the Part 1s they are to be forwarded to the appropriate HRA or HR Lead. On receipt the HRA / HR Lead is to:

- Cross reference the Part 1s received with details in the 'Part 1s in OER' spreadsheet (in the HRD shared drive). Some Part 1s received may be detailed on the spreadsheet, (recorded at the time of the patient's admission), therefore change the colour of the font from red to black to indicate that the HRD are in possession of the Part 1s.
- Add any other Part 1s to the spreadsheet.
- Place the Part 1s in sturdy transparent plastic bags / large robust envelopes and file alphabetically by patient surname in the records storage area, OER Building.
- Enter '*Other records held by Health Records Department*' in the Additional Details box in the Patient Information screen in PACIS.
- If necessary, update the spreadsheet print-out on the appropriate HRL wall.
- Raise any discrepancy, issue or concern with the HR Lead.

It is important that Part 1s sent by an external Agency to another department in Ashworth Hospital, e.g. Social Care, are shared with the RC and passed to the HRD for storage and updating of information systems (as above).

A member of the HRD is to return original Part 1s to source (see Procedure for 'Returning Loaned Records').

Part 1s are subject to Mersey Care NHS Foundation Trust Health Record related Policies and Procedures.

2.3 Judicial Reviews:

Judicial Reviews are in a clearly marked folder and filed with the Clinical Health and Legal Records in the HRL. Judicial Reviews are maintained by the RC's Personal Assistant (PA).

With a patient's transfer to another High Secure Hospital, Judicial Reviews are retained by the transferring hospital unless requested by the receiving hospital.

2.4 Summary of Records Storage locations:

RECORD TYPE:	LOCATION:
Copy Statutory Documents (previous filing system):	In the HRL where the Clinical Health & Legal Records are stored.
Clinical Health and Legal Records and Judicial Reviews for RC's and AMD	Rotating filing cabinets in the appropriate HRL in Shakespeare House
Part 1s – All HRLs	Filing cabinets, Health Records Storage area, 1 st Floor, OER Building

3 PROCEDURE for ACCESS to HEALTH RECORDS LIBRARIES:

3.1 Access during working hours:

Due to the nature of Ashworth Hospital, the HRLs are only open to staff who are part of the patient's clinical team or who need access to the records to carry out their role and provide a service to the patient. A HRA is located in the HRL and is on hand for staff to consult.

- The HRL is opened in the morning and closed at the end of the working day by either the HRA or an appropriate member of staff who knows access arrangements to the HRL, e.g. PA.
- The staff member closing the HRL is to ensure that the rotating cabinets are closed and that the Tracing Out Sheets are in a prominent position should the Duty Manager require access to any records out of hours.

3.2 Access out of hours:

In exceptional or urgent circumstances a record may be required out of hours.

- A request / authority from the RC, Medical Director, AMD or senior member of staff is required before records can be accessed. HRL keys are available in North Control via the Duty Manager.
- It is anticipated that the records required will be in the HRL as staff are encouraged to return records by the end of the working day. The Tracing Out Sheets are available in the HRL to identify the location of a record not in filing. See Procedure for 'Tracing Out Records' for further information.

3.3 Access to Part 1s:

It is anticipated that Part 1s will not be required outside normal office hours.

Access to Parts 1s during normal office hours is via Health Records staff based in Shakespeare House.

4 PROCEDURE for TRACING OUT RECORDS:

4.1 Borrowing Records from a Health Records Library:

The removal of records from a HRL, regardless of the loan period, is termed as 'borrowing'. When borrowing records from a HRL the following details must be recorded on the 'Tracing Out' Sheet (in PRINT):

- The date borrowed
- Patient name
- The type and number of records borrowed (to enable the cross referencing of records returned)
- The name of the borrower and a contact tel. no.
- Any difficulty experienced locating the record(s)

It is important to capture the above details on the Tracing Out Sheet (even in urgent or exceptional circumstances) to ensure that the location of records is known at all times.

4.2 Returning Records to the Health Records Library:

When returning records to a HRL, the following details must be recorded on the Tracing Out Sheet (in PRINT):

- The date returned
- The name of the returnee
- The type and number of records returned

It is important to capture the above details on the Tracing Out Sheet to ensure that there is an audit trail should there be a future query.

It is the responsibility of the borrower to return records to their correct location in filing. This is done by checking the name of the records either side of the records returned.

4.3 Additional Considerations:

- The majority of records are stored in Shakespeare House. Routinely the records are not to leave this location. In exceptional circumstances this may be considered necessary and the borrower would be expected to justify their action.
- The keeping of records overnight is not to be encouraged and is to be the exception rather than the rule. It is the responsibility of the borrower to ensure that the records' exact location is recorded on the Tracing Out Sheet and that it is safe and secure but accessible should it be required out of hours by the Duty Manager.
- If records cannot be returned before the locking of the HRL they should be posted through the letterbox in the HRL door.
- As a general rule, records for current patients do not leave Ashworth Hospital unless there are extenuating circumstances (and appropriate authority is in place). The HRL is to have full knowledge of such a transfer.
- The taking of records onto a ward is to be strongly discouraged due to patient information being readily available on PACIS and WinDIP. A borrower taking records onto a ward would be expected to justify their action.
- The borrower of records is not to pass them to another member of staff without ensuring that the Tracing Out Sheet reflects this transfer.

4.4 Borrowing Part 1s:

- The Patient Records List, in each HRL, will identify which patients have Part 1s stored in the OER Building.
- Part 1s are traced out from the Health Records Department in Shakespeare House via this Procedure.
- It is not necessary to return Part 1s at the end of the working day but it is important that they are kept safe and secure in their location and that transfer to another member of staff is reflected on the Tracing Out Sheet.

For further information regarding the tracking of records see the Trust's Health Records Policy & Procedures (IT06).

5 PROCEDURE for MONITORING the CONTENTS of the HEALTH RECORD LIBRARIES:

It is important that the contents of the HRLs are monitored regularly for accuracy.

According to the Procedures in this manual, the HRA is to:

- Promptly and accurately update spreadsheets (in the HRD shared drive), e.g. new volume opened.
- Keep the contents of the HRL in strict alphabetical order.

- (As and when required) replace the spreadsheet printout on the HRL wall.
- (As and when required) remove / replace labels on the HRL shelves.
- Ensure availability of Tracing Out Sheets in the HRL (template in the HRD shared drive). The HRA is also to:
 - Record the number and year in the top right-hand corner of each Sheet i.e. 01/15, 02/15, 03/15 etc. At the start of a new year the numbering process is to restart, i.e. 01/16, 02/16, 03/16 etc.
 - Review the Sheets at the start of the working day, contacting the borrower of a record if it is not returned and the reason for the extended loan is not clear.
 - Complete the final column of a full Sheet to monitor that the details of items borrowed tally with the details of items returned.
 - Score a single line through the Sheet when full, checked as above and all records returned.
 - Seek to resolve any discrepancies. Keep a record of issues and action taken should there be a future query. If unable to resolve an issue contact the HR Lead.
 - Ensure full Sheets are filed securely in correct order.
 - At the start of the year, destroy Sheets for two years previous, e.g. on 1st January 2012 destroy all Tracing Out Sheets for 2010.

On a four monthly basis the HR Lead is to:

- Check that the Tracing Out Sheets are being completed correctly.
- Undertake an audit to check that the information recorded in the following tallies with the number of records in the HRL:
 - Patient Records spreadsheets (in the HRD shared drive)
 - Patient Records print-out (on the HRL wall)
 - Shelf labelling
- Share the results of the audit with the Trust Health Records Manager, and the HRAs. Identify any further action required.
- Highlight issues for further consideration, e.g. a reoccurring problem.

If, at any time, a record cannot be located, refer to the 'Missing Health Records / Record Related Incidents' Procedure.

6 PROCEDURE for FILING:

6.1 Filing documents:

For filing instructions, see the front inside cover and dividers in the Clinical Health and Legal Records. Also refer to the Trust's Health Records Policy & Procedures (IT06).

Remember that patients can, and often do, change their name. If it is not possible to locate a record, it could be that the patient has changed their

name, see the Procedure for 'Patient Name Change on the Records' for further information.

6.1.1 Test Results:

Test Results are no longer filed in the 'Physical Health & Investigations' section of the Clinical Health Record – the results are recorded in PACIS Clinical Notes and can be found in the Clinical Notes section. A summary of test results can be printed from PACIS (refer to the 'Finding Health Centre / Vision entries on PACIS' guidance in the Document Templates Shared Folder - icon on PC Desktops).

- The HRA is to ensure that Clinical Health Records have filed, as the first document in the 'Physical Health & Investigations' section, the 'Blood Results' notice. All documents for this section are to be filed behind this notice. Please note: this step is not necessary in the new stock of folders.

6.1.2 Copy of a patient's Will:

An original patient's Will is not to be retained by the HRD. Should a copy of a Will be received, the member of Health Records staff in receipt is to:

- Check that the MHLD have a copy. If not, send a copy to them.
- Complete details on the 'List of Wills' spreadsheet in the HRD shared drive.
- File the copy in the specific drawer for this purpose in the HR Leads office.
- With a patient's transfer / discharge, see the Procedure for the 'Management of Records with a Patient's Transfer / Discharge'.
- Contact the HR Lead with any queries.

6.2 Filing Order of Clinical Health & Legal Records:

- All records are filed alphabetically by patient surname.
- The records for each patient are grouped together by type, i.e. Clinical Health or Legal, and are in volume order.
- The oldest volume is filed to the left and the most recent to the right.
- Both the 'old' ('red and green') and 'new' (Clinical Health and Legal) records are filed in alternate directions, i.e. one spine up, one spine down, to ensure the best use of available space. The label on the spine of the old records is to be visible.

6.3 Additional Filing Order Considerations:

6.3.1 'Mac' or 'Mc':

Surnames beginning with 'Mac' or 'Mc' are to be filed at the start of the 'M's, with Mac filed first followed by Mc.

6.3.2 'O':

All names preceded by "O" are to be treated as if there were no apostrophe and filed in normal alphabetical order. The following examples are in correct filing order: O'Donnell, Okocha, O'Leary, Osman, O'Toole.

6.3.3 Double surnames:

Double surnames, hyphenated or not, are to be filed according to the first of the two names. Establish that this is not a middle name by reviewing Statutory Documents.

7 PROCEDURE for RECORDING PATIENT IDENTIFICATION DETAILS on CORRESPONDENCE:

This process has been introduced to reduce the risks associated with documents that lack adequate information to ensure identification of the correct patient. It will meet National and Trust standards, e.g. Information Governance - ensuring that the NHS number is used on internal and external clinical / care correspondence.

All staff who receive documents for filing, in the Clinical Health and Legal Records, are to ensure that the following information is available on every side of a page:

Patient Name	Hospital Number	NHS Number
--------------	-----------------	------------

7.1 Internally created documents:

- Staff creating a document are to ensure that the first page contains the following:
 - Patient name
 - Patient date of birth
 - Patient Hospital number (four digits)
 - NHS number (ten digits in the format of three, three and four numbers, e.g. 123 456 7890)
 - Page number in the following format - page 1 of 6
- Subsequent pages are to contain the following information:
 - Patient name
 - Hospital number
 - NHS number
 - Page number (in the above format)

An efficient way to ensure that this information is repeated on every page of a 'Word' document is to use a 'header' or 'footer' to record this information. Many documents in the Document Templates Shared Folder (icon on PC desktops) have headers / footers in the template to record this information.

7.2 Patient Identification Labels:

Patient Identification Labels are available in the most recent Clinical Health and Legal Records – behind the first clip on the second spine.

They are to be used on pages lacking patient name, hospital number and NHS Number.

The HRAs are responsible for providing Patient Identification Labels.

7.2.1 Printing Patient Identification Labels with a patient's admission:

To print sheets of Labels the HRA is to:

- *'Double Click'* the 'Patient ID Labels' icon on the PC Desktop.
- In the 'Label Printing' window use the down arrow to find the patient's name.
- *'Click once'* to select the patient.
- *'Click once'* on the 'Preview Labels' option to open the 'Labels Single Patient: Report' window.
- *'Click once'* in the 'Labels Single Patient: Report' window (to magnify and confirm patient details are correct).
- Load the printer with sheets of Labels and print. To avoid waste, only print six sheets – two for each record and two for the PA.
- Close all windows by *'Clicking'* on the crosses in the top right-hand corner.
- Print onto card the Reordering of Patient ID Labels Notice for the PA and the Reordering Notices for the Clinical Health and Legal Records (templates in the HRD shared drive).
- Stick a Label onto the Reordering Notices, where indicated.
- Place the Health Records Reordering Notices in-between two sheets of Labels and file behind the first clip on the second spine of the Clinical Health and Legal Records. It is important that the sheets are securely bound so that loss of patient identifiable information is minimised.
- Give two sheets of Labels and the PA Reordering Notice to the RCs PA.

7.2.2 Using Patient Identification Labels:

- A Label is to be stuck at the top of a page that lacks patient identification details.
- If there is no space at the top of the page, it is to be stuck at the bottom of the page or on either the left or right side, where space is available.
- It is important that the label does not obliterate information in the document.

7.2.3 Using the 'Reordering of Patient ID Labels' Notices:

- When a member of staff is using the second sheet of Labels in a record, or the PA is running low of Labels, they are to pass the Reordering of Patient ID Labels Notice to the HRA.
- The HRA is to print two more sheets of Labels (7.2.1) and either file in the correct record or return to the PA with the Reordering Notice.

HRAs are to request more Labels from the HR Lead when their supply runs low.

7.3 In the absence of Patient Identification Labels:

The majority of filing in the Clinical Health and Legal Records is undertaken by the HRAs and the RCs PA.

- Should Labels not be available in a record it is acceptable to clearly and accurately PRINT the required patient identification details on the document.
- Promptly advise the HRA that Labels are needed for that record.

NB: This practice should be the exception rather than the rule. If a HRA finds that it is a regular occurrence they are to contact the HR Lead to enable the issue to be addressed.

7.4 Copy documents for the Clinical Health and Legal Records:

- Before circulating copy documents to colleagues or external agencies, staff are to ensure that the required patient identification details are on each side of the document prior to photocopying.

7.5 Patient's change of name:

With a patient's change of name, it is important that the Patient Identification Labels are replaced as soon as possible. The HRA is to:

- Remove the Labels and the Reordering Notices from the Clinical Health and Legal Records and confidentially destroy (in accordance with the Trust's 'Confidential Waste Collection Procedure').
- Print off new Labels and Reordering Notices, with the new name, in accordance with 7.2.1.
- File, in accordance, with 7.2.1.
- Pass new Labels and Reordering Notice to PA.

If the relevant HRA is absent, the HR Lead arrange the necessary cover to ensure that this task is undertaken promptly.

See Procedure for 'Patient Name Change on the Records' for further information regarding the process to follow when a patient changes their name.

7.6 Issuing subsequent volumes of the Clinical Health and / or Legal Records:

- When a new volume of the Clinical Health and / or Legal Record is required the HRA is to transfer the Labels and Reordering Notice in accordance with the Procedure for the 'Issuing of Subsequent Volumes'.

8 PROCEDURE for PRINTING PACIS CLINICAL NOTES:

Spreadsheets, in the 'Patient Records' folder of the HRD shared drive, detail the records held in each HRL (including patients on Leave of Absence [LOA]).

The HRA is to:

- As from 1/1/16 clinical notes are no longer printed and filed on a monthly basis. Professional can view the records on screen through Pacis, external professionals are assisted in doing this by the HRA. If printed notes are requested this can be facilitated, see below.
- Print PACIS Clinical Notes as follows:
 - Log in to PACIS.
 - Click on 'File'.
 - From the menu click on 'Database Reports'.
 - In the 'Report Options' window, ensure that the 'Individual Discipline' button of '1.Select Report by' is selected.
 - In '2.Select Option' click on 'All'.
 - In '3.Select Report' click on 'Clinical Notes Report'. Click OK.
 - In the 'Clinical Notes Report' window click in the 'Start Date' field, press F10 and find and click on the first day of the previous month. Click OK.
 - Click in the 'End Date' field, press F10 and find and click on the last date of the previous month. Click OK.
 - In 'Patient Selection' check that the button is selected for 'One Current Patient'. Click in this field, press F10, scroll down and click on the required patient. Click OK.
 - Check that the duplex (double-sided) print facility is selected. To check - click on 'Print Setup'. In the 'Printer Setup' window click on 'Setup' – the printer window will open enabling the printing properties to be checked / changed. Click 'OK' twice to return to the 'Clinical Notes Report' window.
 - Click 'Print'

8.1. Patient on Leave of Absence (LOA):

Clinical Notes for a patient on LOA, can be viewed or printed as above.

9 PROCEDURE for UPDATING PATIENT FRONT INFORMATION SHEETS:

9.1. Patient Front Information Sheet:

When patient details change, the MHLD amend the Patient Front Information Sheet and attach to PACIS. The MHLD advise staff, by email, of the change and the availability of a new Sheet. When notified of such a change the HRA is to:

- Remove the existing Sheets from the front of the Clinical Health and Legal Records.
- Confidentially destroy one Sheet and strike through the other with a single line recording the date (being careful not to obliterate any information).
- File this Sheet in the General Correspondence Section of the Legal Record.
- From PACIS, print onto card two copies of the new Sheet and file in the front of the Clinical Health and Legal Records as the very first document viewed when opened.

Should the amendment refer to a change of patient name, see the Procedure for 'Patient Name Change on the Records' for further information.

10 PROCEDURE for PATIENT NAME CHANGE on the RECORDS:

Patient name changes occur frequently. The MHLD will notify the HRA of a patient name change via email and will provide an updated Patient Front Information Sheet (see Procedure for the 'Updating of Patient Front Information Sheets' within the Records'). The patient's name on the records is only to be changed when notified in this way.

When notified of a patient name change the HRA is to:

- Score a single line through the patient's previous name on the front of all the Clinical Health and Legal Records, Copy Statutory Documents Folder and Secure Storage Pouch, if applicable. The name is not to be obliterated but it is to be obvious that a line is scored through it.
- Record the new name clearly (in block capital letters with a black marker pen) in the 'Forename' and / or 'Surname' box (or as near as possible to it) and the date of the change on the front of all the Clinical Health Records, Legal Records, Copy Statutory Documents Folder and Secure Storage Pouch, if applicable.
- If there is a copy Will, staple an updated Patient Front Information Sheet to clearly identify the change of name. File according to the new name and amend the details on the 'List of Wills' spreadsheet (in the HRD shared drive). Do not write on the copy Will.
- Refer to the Procedure for 'Recording Patient Identification Details on Correspondence' to ensure that the correct Labels are in the Clinical Health and Legal Records.

- File all Clinical Health and Legal Records under the most recent name to avoid more than one set of health record existing for the same patient.
- Redistribute other records in the HRL to accommodate the relocation of records. Ensure that the records remain in strict alphabetical order.
- Arrange with colleagues, the name change on the Part 1s and Medication Cards (in the storage area in the OER Building). These records will need to be re-filed in their location and other records may need to be redistributed (whilst keeping in strict alphabetical order).
- Update details on relevant spreadsheets (in the HRD shared drive) ensuring that the data remains in alphabetical order. Remember to update the Secure Storage Pouches spreadsheet, if applicable.
- Re-label the shelves and amend / replace the spreadsheet printout on the HRL wall to reflect the update.
- File the Change of Name Deed (when received) in the 'Detention' section of the Legal Record.

11 PROCEDURE for DESTRUCTION of DUPLICATE INFORMATION:

To reduce the possibility of the manual health records becoming too large and unmanageable, maximise the space in the HRLs and avoid confusion amongst users, it is important that unnecessary duplication in the records is destroyed.

For the purpose of the 'Health Records Library & Record Related Procedures', the same information on PACIS is not classed as duplication.

11.1 On identification of duplicate documents it is important to:

- Scrutinise / cross check the documents to ensure a true duplication.
- Identify the purpose of the duplication e.g. is it a relevant attachment to a report?
- Identify the location of the duplication and consider whether this could reflect the reason for the duplication.
- If the duplication is surplus ascertain whether either is an original – if so the original document is to be kept.
- If both documents are copies, the superior quality document is to be kept.
- File the document within the relevant section.
- Confidentially dispose of the duplication in accordance with the Mersey Care NHS Foundation Trust Confidential Waste Collection' Procedure.

Important: Original documents must not to be destroyed during this process. If unsure, do not destroy the document but seek advice from the HRD or the appropriate Professional or a PA.

12 PROCEDURE for the ISSUING of SUBSEQUENT VOLUMES:

The HRA is to issue a subsequent volume when a Clinical Health or Legal Record is full. Should the HRA or another member of the HRD not be on hand and the issuing of a new volume is urgent, the colleague who requires the new volume can undertake the task in line with this Procedure.

12.1 Closing a full volume:

To close a full volume the HRA is to:

- Complete the 'To' details on the front of the folder in black marker pen.
- Remove Patient Identification Labels and the Reordering of Patient ID Labels Notice.
- Store the closed volume in the correct location on the shelves in the HRL.

NB: Do not remove the Patient Front Information Sheet from the closed volume.

12.2 Opening a new volume:

It is not necessary to transfer any information from the full volume to the new due to the accessibility of all volumes and information being readily available in PACIS.

To open a new volume the HRA is to:

- Complete patient details clearly (in block capital letters with a black marker pen) on the front of the folder except for 'To' and 'Year of Transfer / Discharge'. If known, identify if it is a subsequent admission, e.g. 2nd Admission, 3rd Admission etc.
- Print onto card the most recent Patient Front Information Sheet in PACIS and file in the front of the new volume as the first document viewed when opened.
- Ensure that the Reordering of Patient ID Labels Notice is in-between the two sheets of Patient Identification Labels and file behind the first clip on the second spine.
- If issuing a Clinical Health Record:
 - File an 'Alert Signpost Notice' behind the Patient Front Information Sheet.
 - File a 'Blood Results' notice in the 'Physical Health & Investigations' section. Remove any mount sheets and destroy. Please note: these two steps are not necessary in the new stock of folders.

12.3 Updating Information Systems:

It is important that the HRA is aware that a new volume has been issued to enable an update of information systems.

The HRA is to:

- File the new volume in the correct location on the shelves in the HRL and, if necessary, redistribute other records to accommodate this growth ensuring that they remain in strict alphabetical order.
- Update volume details on the relevant spreadsheet (in the HRD shared drive).
- Re-label the shelves and amend / replace the spreadsheet printout on the HRL wall to reflect the additional volume / relocation of other records.

13 PROCEDURE FOR THE CORRECT USE OF SECURE STORAGE POUCHES

There is the occasional need to file small or awkward items in the manual health record, e.g. photographs, newspaper cuttings and patients' drawings. The use of NHS Litigation Authority (NHS LA) approved secure storage pouches enables the filing and availability of these items and contributes to a full manual health record.

The HRAs maintain a list of pouches distributed on the Secure Storage Pouches spreadsheet in the HRD shared drive. The HRAs have a supply of pouches and are to request more from the Health Records Lead when running low.

13.1 With an appropriate request for a secure storage pouch, e.g. from a PA, the HRA is to:

- Record the following patient information on the front cover of the pouch:
 - PACIS Hospital number
 - Surname
 - First name
 - Date of Birth
 - NHS Number

If a patient ID label is used, it should be stuck over where the information would be manually recorded.

- Add all the following details to the Secure Storage Pouches spreadsheet (in the HRD shared drive):
 - The date the pouch is issued
 - Full patient name
 - PACIS Hospital number
 - The recipient of the pouch

13.2 The person filing the item is to:

- Ensure that the item is appropriate for storage in the pouch i.e. small, slim and not suitable for hole-punching and filing in a section of the health record.
- Record the following information on the front cover of the pouch:
 - The date the item is filed
 - A description of the item filed
 - Signature of the person filing the item
- Insert the item into the pouch.
- Ensure that the Velcro at the top of the pouch is securely fastened.
- File the pouch at the front of the General Correspondence section (Legal Record)

13.3 Do Not:

- File items with Health & Safety implications, e.g. a sharp item.
- File heavy items, e.g. thick notebooks.
- Overfill the pouch or file more than ten items.
- Damage anything already in the pouch whilst filing subsequent items.
- File anything in the pouch that is not detailed on the front cover.
- Use the pouch as a shortcut to filing documents that would otherwise be hole-punched and filed within a section.
- Insert the pouch in any section other than General Correspondence.
- Use any securing method with the pouch e.g. sticky tape or staples.
- File discs in the pouch long term. Radiology discs are to be filed with the Health Centre. Discs containing pre-admission information are to be filed with 'Part 1s', first establishing that they are no longer routinely required by the Responsible Clinician.
- Destroy the pouch or its contents.

Please note: Once an item is in the secure storage pouch it is subject to the local Procedures contained in this manual and the Trust's Health Records Policy & Procedures (IT06).

13.4 Audit:

To monitor the correct use of the pouches, adherence with this Procedure and to provide evidence that the Trust is complying with NHS LA standards, the Health Records Department will audit the pouches and their contents annually. Should problems be identified the pouches and their contents will be audited more frequently.

- Should any patient identifiable information be missing from the secure storage pouch cover, the HR Lead will raise with the appropriate HRA for corrective action to be undertaken.
- Should an item be found in the pouch that is not listed on the front cover or considered unsuitable, the following steps will be taken by the HR Lead:
 - If necessary, report in Datix in accordance with Mersey Care NHS Foundation Trust 'Policy & Procedure for the Reporting, Management & Review of Adverse Incidents' (SA03).
 - Attempt to identify the person who filed the item, e.g. who the pouch was originally given to or who has filed in the pouch since.
 - If it is appropriate for the item to be filed in the pouch the details on the front cover are to be completed in line with this Procedure.
 - If it is not appropriate for the item to be filed in the pouch, consider alternative storage and, if necessary, consult with the RC and / or the Trust's Health Records Manager.
 - Share issues and outcomes with the Health Records Department and, if necessary, advise the appropriate line Manager to discuss with their staff to avoid a recurrence of the problem.
 - All action is to be recorded for possible future reference.

14 PROCEDURE for the RELOCATION of RECORDS with the CHANGE of a PATIENT'S RESPONSIBLE CLINICIAN:

Legal and Clinical health records files are all located in one location (Shakespeare House) therefore no move is necessary as was previous practice.

Part 1's and medication cards have always been intergrated and not filed according to RC location.

15 PROCEDURE for ACCESS TO RECORDS by an EXTERNAL PROFESSIONAL:

15.1 General Process for all visits:

For several reasons, an external professional may need to view patient records (see 'External Professional Visit Arrangements' in HRD shared drive). The facilitator of a visit is to:

- Ensure the external professional has appropriate authority to view records for the purpose of the access. Details include:
 - Enough patient information to enable identification.
 - Whom the patient is authorising i.e. Mersey Care NHS Foundation Trust.
 - What the patient is authorising i.e. access to their health records.
 - To whom the patient is giving access e.g. Solicitor's name. Access is only to be given to those named on the authority.

- The patient’s signature with date, which is to be within the last twelve months. Please note: the authority for a Mental Health Review Tribunal (MHRT) may have been signed when the Application was submitted – this could be more than twelve months previous.
- Advise relevant colleagues of the visit via email asking the PA to ensure that the filing is up to date for the visit.
- Log details of the visit in Outlook.
- Note details of the visit on the request, scan, attach to PACIS and file.
- On the day of the visit make available all the Clinical Health and Legal Records.
- Escort the external professional to the HRL to view the records (the external professional is not to be left alone with the records).
- Should the external professional ask to see a summary of blood results, provide in accordance with ‘Finding Health Centre / Vision entries on PACIS’ guidance in the Document Templates Shared Folder (icon on the PC Desktop).
- Return the records to the HRL when no longer required.
- If the external professional is seeing the patient, ring the ward to advise that the visitor is being escorted to the ward.
- Escort the visitor to the ward.
- Record details of the visit, i.e. name, profession, reason for accessing and time spent viewing the records, in PACIS Clinical Notes.

The HR Lead will arrange cover during periods of absence for visits facilitated by a HRA. On occasion it may be necessary to ask for assistance from the RC’s PA.

15.2 Additional considerations

15.2.1 Access to records by a Second Opinion Appointed Doctor (SOAD)

SOAD visits are arranged by the MHL D who notify relevant colleagues of the date. The SOAD may access several patients’ records during the visit. Patient authority to access records is not required.

The HRA is to:

- Ensure that with the up to date Clinical Health and Legal Records the following documents are available on the day of the visit:
 - Copy Statutory Documents folder (if applicable).
 - Second Opinion Request Form (if this is not in the Legal Record, ask the RCs PA).
 - T5 or T6 (occasionally requested).

15.2.2 Access to records for a MHRT:

On receipt of the MHRT Application (forwarded by the MHLD for filing) the HRA is to:

- Record the Application in the 'MHRT Workbook' spreadsheet (in the HRD shared drive). Update this spreadsheet when other information needed is available.
- Send the following text in the body of an email to the RC, copying in the PA:

'The above named patient has applied / been referred for a MHRT. I would be grateful if you could confirm, which records can be released should an external professional, e.g. independent Dr or Solicitor, wish to view them for this purpose.

Please confirm by completing the form 'MHRT / RC Authority: External Professional Accessing Health Records'. This can be found in the Document Templates Shared Folder (on PC desktop), in the 'Mental Health' heading under the sub-heading 'MHRT'. This form has been introduced due to a change in Tribunal Rules and recent case law. The process was agreed at the Drs Meeting 04/11/09.

I would be grateful if the completed form could be returned to me promptly.'

- Pursue a response to the email if not received within seven working days.

For an MHRT the following professionals may require access to patient records:

- MHRT Dr. The MHLD will arrange a visit by a MHRT Dr and notify the HRA of this date. Under MHRT Rules, patient authority to access records is not required.
- External Professional e.g. Dr, Solicitor, Psychologist and Social Worker. When contacted by an external professional to access records, the HRA is to:
 - Confirm appropriate patient authority – usually attached to the copy of the MHRT Application form. It is the responsibility of the external professional to provide patient authority; without it access to the records cannot take place.
 - Arrange a suitable date for the external professional to visit.
 - If the external professional wishes to see the patient, let the ward know the date. If the arranged date is inconvenient, rearrange as necessary.
 - Email details of the visit to the RC and their PA, Reception, the ward and Health Record colleagues.
 - Note details of the visit on the request, scan, attach to PACIS and file.

With the visit the HRA is to:

- Refer to the 'MHRT / RC Authority: External Professional Accessing Health Records' form and carry out any instructions necessary. If this form has not been returned, pursue from the RC or their PA.
- Ask the external professional to complete Part 2 of the form (reverse side) to enable access to the records to take place.
- Scan the form, attach to PACIS and file.

If the external professional requests a copy of information the HRA is to:

- Explain that the copy cannot be provided immediately.
- Give a 'Visiting Professional's Request for Copy of Information' form to the external professional to complete (template in the HRD shared drive).
- As soon as practically possible copy the requested information.
- Give the copy of information and the Visiting Professional's Request for Copy of Information form to the RC to sign.
- With their return, undertake any action requested, e.g. remove third party information, and, if necessary, re-copy.
- Forward the copy information and the appropriate covering letter (template in the HRD shared drive) to the requestor.
- When the process is complete, scan paperwork, attach to PACIS and file the paperwork in the manual records.

15.2.3 Access to records by an External Professional with a view to patient transfer:

The RC's PA will arrange the visit by an external professional in relation to a patient's possible transfer. The HRA will be notified of this date. Patient authority to access records is not required

The PA will escort the external professional on site to the HRL. The HRA is to:

- Make available all Clinical Health and Legal Records required. (it is expected that the PA will have filed their documents to ensure that the record is up to date).
- Ensure Pacis is available for clinical notes to be viewed .
- Facilitate the visit in the HRL.
- Escort the visitor either to the ward or off site.

If, during the visit, the external professional requests a copy of information the HRA is to:

- Explain that the copy cannot be provided immediately.
- Ask the visitor to identify which documents they want a copy of.
- Advise the PA that copies are requested. This may include detailing the document to enable retrieval from PACIS.

The PA is to

- As soon as practically possible copy the requested information or print it from PACIS.
- Seek RC authority to release the information
- Forward to the requestor with an appropriate covering letter.
- When the process is complete, scan paperwork, attach to PACIS and file the paperwork in the records.
- Please note: no fee payable.

15.3 Any issue / concern identified during the process is to be raised with the HR Lead.

16 PROCEDURE for the MANAGEMENT of RECORDS with a PATIENT'S LEAVE OF ABSENCE (LOA):

When a patient is on LOA their records are to remain in the HRL – they are not to be scanned.

The HRA is to:

- Update the relevant spreadsheet (in the HRD shared drive) to reflect the LOA.

Should the LOA result in the patient's readmission, the HRA is to:

- Update the relevant spreadsheets in the HRD shared drive to reflect the readmission.

Should the LOA result in the patient's transfer:

- The Procedure for the 'Management of Records with a Patient's Transfer / Discharge' is to be implemented.

17 PROCEDURE for the MANAGEMENT of RECORDS with a PATIENT'S TRANSFER / DISCHARGE:

It is important to manage the movement and tracing out of records so their location is known at all times and discrepancies can be investigated.

17.1 Original Statutory Documents:

With all patient transfers the MHLD send the original Statutory Documents to the receiving establishment. With a patient's discharge, the original Statutory Documents are retained by the Secure Division.

17.2 Patient transfer to another High Secure Hospital:

A Generic Health Records Sharing Protocol between the Three High Secure Hospitals was introduced in March 2014. The complete record is no longer loaned. An agreed proportion of the record will be copied and forwarded to the receiving hospital

- Remove patient labels from the HRL shelves and, if of benefit, redistribute other records (ensuring that they remain in strict alphabetical order) and relabel the shelves.
- Amend / replace the spreadsheet printout on the HRL wall.
- Arrange the scanning of the health records. For further details of the scanning process see local 'Scanning Documents Guidance' and 'Scanning Records with a patient's Transfer / Discharge'.

17.3 Archiving Records with a Patient's Discharge / Transfer (to a non-High Secure Hospital):

When advised of such a discharge / transfer the HRA is to:

- Check the 'List of Wills' spreadsheet (in the HRD shared drive) to ascertain if the Department holds a copy Will. If one exists, inform the MHLD and send the copy to them for forwarding with the original Statutory Documents). If the MHLD paperwork has already been forwarded advise the HR Lead. Update the List of Wills in the shared drive.
- On the front of all the Clinical Health and Legal Records record (in black marker pen) the 'Year of Transfer / Discharge'.
- Check Part 1s for original records e.g. Inmate Records. Return in accordance with Procedure for 'Returning Loaned Records'.
- Should there be a Judicial Review Folder, pass to the Secure Division Administrator.
- Retain the records in the HRL for one month to allow outstanding filing to be completed.

At the end of the month the HRA is to:

- On the front of the latest Clinical Health and Legal Records record (in black marker pen) the 'To' date.
- Remove the records from the HRL shelves.
- Place the records in the HRL scanning draws For further details of the scanning process see local Scanning Guidance.
- Update relevant spreadsheets (in the HRD shared drive). Remember to update the Secure Storage Pouches spreadsheet, if applicable.
- Remove patient labels from the HRL shelves, and if of benefit, redistribute other records (ensuring that they remain in strict alphabetical order) and relabel the shelves.
- Amend / replace the spreadsheet printout on the HRL wall.

17.4 Any issue / concern identified during the process is to be raised with the HR Lead.

- If the records cannot be located at any time or for further details regarding secure package and transportation of records please refer to the Trust's Health Records Policy & Procedures (IT06).

18 PROCEDURE for RETURNING EXTERNAL LOANED RECORDS:

A request may be received or the Hospital may be required to return original records to source e.g. Prison Inmate Records. The HRD are responsible for this process to ensure that appropriate measures are taken and information systems are updated.

18.1 The HRA is to:

- Ensure that an appropriate request is received, e.g. in writing, or it is known that the records need returning to source.
- Advise the RC of the plan to return the records should they wish information photocopying or scanning into PACIS / WinDIP.
- Type a covering letter (asking the recipient to acknowledge safe receipt) and attach to PACIS. Print a copy and attach to the records.
- Establish how the records are to be returned by first asking Trust Transport if they are visiting the location in the near future and if they could assist by taking the records.
- If a copy of the information is not kept:
 - Update the 'Part 1s in the OER' spreadsheets (in the HRD shared drive).
 - Remove '*Other records held by Health Records Department*' in the Additional Details box in the Patient Information screen in PACIS.

18.1.1 If returning by Trust Transport the HRA is to:

- Package the records using an Envopak (with an Envoseal) if it is known that Transport will return the Envopak. If not, securely parcel the records.
- Advise the recipient of transport arrangements and staff details.
- Note delivery details in PACIS Clinical Notes.
- When the recipient confirms delivery by letter, scan and attach to PACIS. If verbal or email confirmation is received, record details in PACIS Clinical Notes (copy and paste the contents of an email into the Note).
- If confirmation of delivery is not received in seven working days contact Trust Transport and the recipient to establish the records whereabouts.

18.1.2 If returning by Post the HRA is to:

- Securely package the records.
- Attach a Postal Receipt, for the Mail Room, detailing the postage required, i.e. special delivery.
- When the recipient confirms delivery by letter, scan and attach to PACIS. If verbal or email confirmation is received, record details in PACIS Clinical Notes (copy and paste the contents of an email into the Note).
- If confirmation of delivery is not received within seven working days contact the recipient and / or the Mail Room to establish the records whereabouts.

18.2 The HRA is to record any relevant actions / outcomes in PACIS Clinical Notes to evidence the process and steps taken. Any issue / concern is to be raised with the HR Lead.

- If the records cannot be located at any time or for further details regarding secure package and transportation of records please refer to the Trust's Health Records Policy & Procedures (IT06).

19. PROCEDURE for the COLLATION, STORAGE and ACCESS to RECORDS of a DECEASED PATIENT:

19.1 Clinical Health and Legal Records:

Health Records staff are on the Distribution List that advises when a patient has passed away. It is important that following the death of a patient, all of the records are passed to the HRLead in Shakespeare House as a matter of urgency.

The integrity of the record collection is to be maintained. At no time is any part of the collection to be removed or destroyed.

On learning of a patient's death the HRA is to:

- Contact the relevant RC's PA to ensure that filing is up to date. This must not delay the delivery of records to the HR Lead. Ask the PA to forward documents they receive at a later date to the HR Lead.
- Gather together patient records from the HRL including separate Copy Statutory Documents and Judicial Review folders, if applicable.
- On the front of all the Clinical Health and Legal Records record (in black marker pen) the date of death in 'Year of Transfer / Discharge' and quantity of records in 'Volume No' e.g. 1 of 6, 2 of 6, 3 of 6 etc.
- Trace out the records on the Tracing Out Sheet including their destination and the reason, e.g. 'HR Lead Shakespeare House – patient passed away'.
- Contact the ward for their file if they have one and medication cards (collecting them from the ward if necessary). This must not delay the delivery of records to the HR Lead.
- Contact Pharmacy and the Health Centre for any other information that may need to be collated. Again, this must not delay the delivery of records to the HR Lead.
- Retrieve Medication Cards from the storage area in the OER Building. Check there are no obvious date gaps.
- Pass all records to the HR Lead as a matter of urgency
- Update the spreadsheets (in the HRD shared drive) – including, if necessary, the Secure Storage Pouches spreadsheet. Replace the spreadsheet printout on the HRL wall and remove the relevant labels from the HRL shelves.

- Any issue / concern to be raised with the HR Lead.

The HR Lead is to:

- Check the 'List of Wills' spreadsheet (in the HRD shared drive). If a copy Will exists notify the RC and the Social Worker. Update the 'List of Wills' spreadsheet if the copy Will is removed and passed to a colleague.
- Detail records received on designated Tracer Card (template in the HRD shared drive). The Tracer Card lists the possible location of patient information - seek missing information and update the Tracer Card.
- If necessary, print off and file any outstanding PACIS Clinical Notes in accordance with the Procedure for 'Printing PACIS Clinical Notes'. Please note: the patient may be in PACIS as a 'Previous Patient'.
- Keep records and Tracer Card in designated case. Do not include Part 1s - these can be provided separately should they be requested.
- Update the Tracer Card when records are loaned, e.g. to the RC, and returned. Check that records returned correspond with records loaned - investigate any discrepancies.
- When the records are no longer required (usually following the outcome of the Inquest), establish the date of the last entry in the most recent Clinical Health and Legal Records and complete the 'To' on the front of each cover.
- Seek agreement from the RC to return any Broadmoor or Rampton records. Return in accordance with Procedure for 'Returning Loaned Records'.
- Remove '*Other records held by Health Records Department*' in the Additional Details box in the Patient Information screen in PACIS.
- Confirm with the RC that the records can be scanned into WinDIP. For further details of the scanning process see local Scanning Guidance.
- Update the relevant Patient Record spreadsheet (in the HRD shared drive).
- On receipt, scan the Trust's Legal Team record into 'Deceased Patient File' section in WinDIP

19.2 Post Mortem:

The Trust's Legal Team will contact the HR Lead to arrange collection of the records for the Post Mortem.

The Legal Team will arrange return of the records. The Loaning and returning of records is to be carried out in accordance with the instructions in this Procedure.

If the records cannot be located at any time please refer to the Procedure for 'Missing Health Records / Record Related Incidents '.

20 MISSING HEALTH RECORDS / RECORD RELATED INCIDENTS:

The responsibility for the safety and security of a borrowed records lies with the borrower.

- Upon discovering that a record is missing the HR Lead or appropriate senior member of staff is to be contacted immediately to enable implementation of the Missing Health Records process (appendix 3) in the Trust's Health Records Policy & Procedures (IT06).
- Should another type of incident occur, e.g. damage or unauthorised access, it is to be recorded as an incident in Datix and reported immediately to the HR Lead or appropriate senior member of staff to instigate, if necessary, an investigation. Note: through Datix an investigation may be triggered.

APPENDIX 2 (d)

LOCAL INDUCTION ~ ASHWORTH HOSPITAL (SECURE DIVISION) HEALTH RECORD LIBRARIES

AIM:

The aim of this Induction is to welcome staff working on the Ashworth Hospital site who, during the course of their duties, will need to access Ashworth Hospital Health Records Libraries, e.g. Junior Drs and Secretaries. The Induction is also to ensure that relevant staff are aware of Trust Health Record Policies and local Procedures.

It is hoped that the Induction will reduce:

- Ambiguity
- Avoidable mistakes
- A lack of awareness regarding current practice
- The potential risk of missing health records
- Possible confusion regarding the role of the Health Records Department and its staff

For those staff who have a physical disability, reasonable adjustments will be made to allow for tasks to be undertaken.

The Health Records Library is located in Shakespeare House and staffed by members of the Health Records Department. Contact details are as follows:

Health Records Administrators Shakespeare House: 471 2204 / 2308
Health Records Lead: 471 2629

LOCAL INDUCTION PROCESS:

1. Line Managers will notify the Health Records Department of new members of staff as early as possible following commencement of employment.
2. A date to attend the Induction will be arranged with the member of staff.
3. The Health Records Lead / Administrator and attendee will complete the Induction Checklist at the Induction.
4. The completed Checklist is to be signed by the Health Records Lead / Administrator and attendee.
5. The attendee will be given the opportunity to ask questions / discuss issues.
6. The completed Checklist will be sent to the attendee's Line Manager for their record.

NB: To keep abreast of current practice, staff already working in the Secure Division may benefit from attending an Induction session.

Implemented: November 2005
Reviewed: November 2006, August 2007 January & August 2008, July & October 2009, January 2010, January 2012, August 2014, August 2015
Next Review Date: August 2018
Author: Health Records Lead, Secure Division

LOCAL INDUCTION CHECKLIST~ ASHWORTH HOSPITAL HEALTH RECORD LIBRARIES

Employee's name / position: **Date:**

Health Records Lead / Administrator:

ISSUES EXPLAINED / DISCUSSED	Attendee '✓' when understood
Health Records Department - staffing details	
Access to the Health Record Libraries & responsibility to close after normal office hours	
Records held, i.e. current records only, Part 1s (including depositions and some previous admissions) and Copy Stat Docs files (up to Aug 2007)	
Storage location of above records	
The electronic health records, i.e. PACIS and WinDIP, their contents and the link between PACIS and Windip	
Use of storage cabinets (don't whiz – feed) & availability of kick stool or steps. Warning: - do not attempt to climb in the cabinets!	
Correct way to file records on shelves i.e. alphabetical, green left & red right, one spine up, one down (plastic files) or all spines down (card files)	
Previous practice of 'splitting' records	
Review of a Clinical Health record (red) – plastic & card files	
Review of a Legal record (green) – plastic & card files	
The tracing out of records, the records preferred return by 5pm & the letter-box facility. Incident: Jnr Dr left a file on his desk over-night - reported in Datix	
Filing responsibilities & implications of misfiling including management of original documents, e.g. Physical Examination on Admission form (required for audit)	
Areas where records should /should not be taken. Incident: Jnr Dr took INR card off a ward, staff unaware & wasted time searching for it - reported in Datix	
The File Number List on the wall	

Patient name changes		
Health Record Policies / Procedures & where to find them		
Access to WinDIP & MCNT website 'EDMS Training Videos' (in 'Favourites' under 'Mersey Care Links')		
'Shared Folder' - access to be arranged		
ADDITIONAL COMMENTS:	SIGNATURES:	
	Attendee: Health Records Lead / Administrator:	

APPENDIX 2 (e)

A - Z GUIDE: ATTACHING DOCUMENTS TO PACIS

Attach documents to PACIS in either the **MAIN FOLDER (blue)** or, if a relevant folder exists, in **SUB FOLDER (green)**. The correct folder to use is shown in **BOLD CAPITAL LETTERS** in the following table.

<u>CONTENTS</u>	<u>MAIN FOLDER</u>	<u>SUB FOLDER</u>
A		
Access to Health Records Application	General Correspondence	HEALTH RECORDS DEPARTMENT
Access to Health Records Correspondence	General Correspondence	HEALTH RECORDS DEPARTMENT
Admission Panel Decision (see 'Pre-Admission')	PRE-ADMISSION	
Advanced Decision	ADVANCE STATEMENT/DECISION	
Advanced Statement	ADVANCE STATEMENT/DECISION	
Advocacy Information	Under subject heading or General Correspondence	
Annual Physical Health Summary/Report	PHYSICAL HEALTH	
Annual Statutory Report (ASR)	Mental Health Law Department	MHLD STAT DOCS
ASR - Acknowledgement from Home Office	Mental Health Law Department	MHLD REVIEW OF DETENTION
AWOL Notification Form (CQC)	LEAVE OF ABSENCE	
B		
Becks (various e.g. Anxiety Rating, Hopelessness Scale, Depression Inventory, Suicide Scale)	PSI Assessments	PSI OTHER ASSESSMENTS
Benefit Agency Correspondence	GENERAL CORRESPONDENCE	
Birchwood Early Warning Signs	PSI Assessments	PSI CORE ASSESSMENTS
BMI Care Plan	NURSING CARE PLANS	
Borderline Personality Disorder Care Plan	NURSING CARE PLANS	
Broadmoor Hospital Records	Part 1s	OTHER HSS HOSPITAL RECORDS

C

C1- C9 Child Contact forms Disclosure)	Third Party / Non-Disclosure	TP CHILD CONTACT ONLY (Non-
Care Quality Care Commission (previously MHA Commission)	File by topic of correspondence	
Change of Legal Status	Mental Health Law Department	MHLD LEGAL CHANGES
Change of Name Deed Only	Mental Health Law Department	MHLD STAT DOCS
Change of Name Correspondence	Mental Health Law Department	MHLD LEGAL CHANGES
Choosing Health Assessment Tool	Physical Health	HEALTH PROMOTION
Clozapine Care Plan	NURSING CARE PLANS	
Clozaril letter	Consent to Treatment	CORRESPONDENCE - TREATMENT
Clozaril Patient Registration / Re-Registration	PHARMACY MEDICATION HISTORY	
Cognitive Assessment of Voices	PSI Assessments	PSI OTHER ASSESSMENTS
Cognitive Rehabilitation Service Referral	PSYCHOLOGY	
Complaint Notification (do not attach in-depth details)	COMPLAINT NOTIFICATION ONLY	
Confinement (Night) Record Information Sheet	RISK ASSESSMENTS	
Confinement (Night) Review Record	RISK ASSESSMENTS	
Confinement Obs Record Information Sheet	RISK ASSESSMENTS	
Consent Form (Psychology Dept)	PSYCHOLOGY	
Copying Letters to Patients Initiative	GENERAL CORRESPONDENCE	
Court Correspondence	COURT / LEGAL REPORTS & CORRESPONDENCE	
Court Order	Mental Health Law Department	MHLD STAT DOCS
Court Report	COURT / LEGAL REPORTS & CORRESPONDENCE	
CPA Admission / Social History Report (Social Care)	Social Work Care Programme Approach	SW SOCIAL HISTORY AND CPA REPORTS
CPA Agenda	Care Programme Approach	CPA AGENDA
CPA Correspondence	Care Programme Approach	CPA CORRESPONDENCE
CPA Minutes	Care Programme Approach	CPA MINUTES
CPA Reports (all disciplines)	Care Programme Approach	CPA REPORTS

D

Death of a Detained Person Notification (CQC)	DEATH OF A PATIENT	
Delusional Rating Scale	PSI Assessments	PSI OTHER ASSESSMENTS
Depositions	Part 1s	DEPOSITIONS
Depot whilst in Seclusion Care Plan	NURSING CARE PLANS	
Detention Documents	Mental Health Law Department	MHLD STAT DOCS
Dietician/Nutrition Information	PHYSICAL HEALTH	
Diabetic Care Plan	NURSING CARE PLANS	
Discontinuance confirmation (Police / CPS)	POST INCIDENT REVIEWS / INVESTIGATIONS	
Domestic Violence Crime & Victims Act 2004 info	THIRD PARTY/NON-DISCLOSURE	
Do Not Attempt Cardiopulmonary Resuscitation form	Physical Health	RESUSCITATION ORDERS
Dyslexia Assessment	Rehabilitation Services	REHAB EDUCATION

E

ECT Referral	Consent to Treatment	CORRESPONDENCE - TREATMENT
Education Assessment	Rehabilitation Service	REHAB EDUCATION
Education Referral	Rehabilitation Service	REHAB EDUCATION
Education Report	Rehabilitation Service	REHAB EDUCATION
Education Documents Prior to Admission	Part 1s	PART 1 LOCAL AUTHORITY
Education Risk Assessment	Risk Assessments	REHABILITATION RISK
Environment Checklist	Rehabilitation Service	REHAB OCCUPATIONAL THERAPY
Examination on Admission	ADMISSION	
External Course Information	Rehabilitation Service	EDUCATION
External Reports requested from MSU	LEAVE OF ABSENCE	

F

Form H5 (prev. Form 30)	Mental Health Law Department	MHLD STAT DOCS
Form T1	CONSENT TO TREATMENT	
Form T2 (prev. Form 38)	CONSENT TO TREATMENT	
Form T3 (prev. Form 39)	CONSENT TO TREATMENT	

Form T4	CONSENT TO TREATMENT	
Form T7 (prev. Section 62)	CONSENT TO TREATMENT	
Form 500	ADMISSION	
Family Correspondence	GENERAL CORRESPONDENCE	
Functional Skills Assessment	Rehabilitation Service	REHAB OCCUPATIONAL THERAPY

G – Garden Access same as grounds access

Garden Access Information	Security Documents	SECURITY GROUNDS ACCESS
GP Records (copy)	PHYSICAL HEALTH	
Grounds Access Information	Security Documents	SECURITY GROUNDS ACCESS

H

Hallucinations Rating Scale	PSI Assessments	PSI OTHER ASSESSMENTS
HCR – 20 (Psychology Risk Assessments)	Risk Assessments	RSVP, HCR-20 & SVR-20
High Dose Peer Review	Consent to Treatment	TREATMENT CORRESPONDENCE
Home Visit Report (clinical)	GENERAL CLINICAL REVIEW OF CARE	
HoNOS Secure Score Sheet	Care Programme Approach/S117	HONOS SECURE
Hospital Order	Mental Health Law Department	MHLD STAT DOCS
Hospital Records Prior to Admission	Part 1s	OTHER HEALTH RECORDS

I

Incident Medical form	POST INCIDENT REVIEWS / INVESTIGATIONS	
Independent M.H.R.T Report	MHRT	MHRT REPORTS
Individuals who Present a Risk to Children form	Risk Assessments	RISK TO CHILDREN
Interest Checklist	Rehabilitation Service	REHAB OCCUPATIONAL THERAPY
Inter-Ward Transfer Assessment form	GENERAL CLINICAL REVIEW OF CARE	
Investigations (Physical Health)	PHYSICAL HEALTH	
Investigation Reports, e.g. Independent Enquiry	POST INCIDENT REVIEWS / INVESTIGATIONS	

J

Joint Child Protection Panel Correspondence Disclosure	Third Party / Non-Disclosure	TP CHILD CONTACT ONLY (Non-
Judicial Review	PA TO maintain specific file (DO NOT ATTACH TO PACIS)	

K

Kitchen Assessment	Rehabilitation Service	REHAB OCCUPATIONAL THERAPY
KGV Data & Score Sheet	PSI Assessments	PSI CORE ASSESSMENTS
Knowledge & Schizophrenia Interview	PSI Assessments	PSI OTHER ASSESSMENTS

L

Leave of Absence (LOA) M of J Application	LEAVE OF ABSENCE	
LOA Care Plan	LEAVE OF ABSENCE	
LOA Checklist	LEAVE OF ABSENCE	
Local Authority Records Prior to Admission	Part 1s	PART 1 LOCAL AUTHORITY
Letters to / from MSU with view to patient transfer	LEAVE OF ABSENCE	
LUNTERS	PSI Assessments	PSI CORE ASSESSMENTS

M

Managers Review	Mental Health Law Department	MHLD REVIEW OF DETENTION
MAPPP / MAPPA Form A & G & Notification letters	RISK ASSESSMENT	
MAPPP / MAPPA Minutes	THIRD PARTY/NON-DISCLOSURE (marked as PRIVATE)	
MAPPP / MAPPA Executive Summary	THIRD PARTY/NON-DISCLOSURE	
Medication Review	Consent to Treatment	TREATMENT CORRESPONDENCE
Medium Secure Assessment/Correspondence	LEAVE OF ABSENCE	
Mental Capacity Act Assessment Form	MENTAL CAPACITY ACT	
Mental Health Awareness Group Report	PSYCHOLOGY	
MHRT Application	MHRT	
MHRT Reports	MHRT	MHRT REPORTS

MHRT / RC Authority: External Professional Accessing Health Records	MHRT	
MHRT Decision	MHRT	MHRT DECISIONS
M of J Correspondence	LEAVE OF ABSENCE	
M of J Permission (including Hospital appts)	Leave of Absence	LOA M of J PERMISSION
M of J Remission to Prison	LEAVE OF ABSENCE	
M of J Report on Completed Leave	LEAVE OF ABSENCE	
M of J Report on Conditional Patient	LEAVE OF ABSENCE	
M of J Transfer Confirmation	Leave of Absence	LOA M of J PERMISSION

N

Neuropsychological information	PSYCHOLOGY	
--------------------------------	-------------------	--

O

Ophthalmic information	PHYSICAL HEALTH	
Obsessional Presentation Assessment	PSYCHOLOGY	
OT Report	Rehabilitation Service	REHAB OCCUPATIONAL THERAPY
OT Care Plan	Rehabilitation Service	REHAB OCCUPATIONAL THERAPY

P

Part A	MHRT	
PANSS Assessment	Psychology	
Patient Crisis Profile Disclosure)	Third Party / Non-Disclosure	TP PATIENT CRISIS PROFILE (Non-
Patient fit to be interviewed Statement for Court	COURT / LEGAL REPORTS & CORRESPONDENCE	
Patient fit to be interviewed Statement re Internal Incident	POST INCIDENT REVIEWS / INVESTIGATIONS	
Patient letters (written by patient)	General Correspondence	PATIENT CORRESPONDENCE
Patient Drawings	General Correspondence	PATIENT CORRESPONDENCE
Pharmacy Information	PHARMACY MEDICATION HISTORY	
Pharmacy Hand Written Note	PHARMACY NOTES	

Pharmaceutical Scanned Information	PHARMACY NOTES	
Physical Health Information	PHYSICAL HEALTH	
Physical Observation Chart	PHYSICAL HEALTH	
PIP Assessment	Seclusion Review	POSITIVE INTERVENTION PROGRAMME
PIP Care Plan	Seclusion Review	POSITIVE INTERVENTION PROGRAMME
PIP Referral	Seclusion Review	POSITIVE INTERVENTION PROGRAMME
PM 1 Form	THIRD PARTY/NON-DISCLOSURE	
PM Forms (except PM1)	SECURITY DOCUMENTS	
Police / CPS Discontinuance Confirmation	POST INCIDENT REVIEWS / INVESTIGATIONS	
Police Records	Part 1s	POLICE / PRISON RECORDS
Police Referral Proforma	DO NOT ATTACH TO PACIS OR FILE IN THE RECORDS	
Post Incident Review (local)	POST INCIDENT REVIEWS / INVESTIGATIONS	
Post LOA Report	LEAVE OF ABSENCE	
Pre-Admission Information, Letters	PRE-ADMISSION	
Pre -Admission Reports (external)	Pre-Admission	PRE-ADM REFERRAL DOCUMENTS
Pre -Admission Reports (internal)	Pre-Admission	PRE-ADM ASSESSMENT REPORTS
Pre-Admission Referral Documents	Pre-Admission	PRE-ADM REFERRAL DOCUMENTS
Pre-LOA Home Assessment (Day Leave)	LEAVE OF ABSENCE	
Pre-LOA Home Assessment (Trial Leave)	LEAVE OF ABSENCE	
Prison & Prison Health Centre Records	Part 1s	POLICE / PRISON RECORDS
Psychology Therapy Groups/Programmes	PSYCHOLOGY	
Psychology Information	PSYCHOLOGY	
Psychology Referral	PSYCHOLOGY	
Psychology Risk Assessment	RISK ASSESSMENTS	
Psychometric Summary report	PSYCHOLOGY	

Q

R

Rampton Hospital Records	Part 1s	OTHER HSS HOSPITAL RECORDS
--------------------------	---------	-----------------------------------

RC to RC Handover	GENERAL CLINICAL REVIEW OF CARE	
Reasoning & Rehab Report	PSYCHOLOGY	
Recovery Star Care Plan	MULTI-DISCIPLINARY CARE PLANS	
Rehabilitation Referral	Rehabilitation Service	REHAB REFERRALS
Rehabilitation Exercise Assessment	Rehabilitation Service	REHAB REFERRALS
Relative Assessment Interview	PSI Assessments	PSI OTHER ASSESSMENTS
Renewal Letters	Mental Health Law Department	MHLD REVIEW OF DETENTION
Review of Detention Report	Mental Health Law Department	MHLD REVIEW OF DETENTION
Referral information (see 'Pre-Admission')	Pre-Admission	PRE-ADM REFERRAL DOCUMENTS
Resettlement Referral Form	LEAVE OF ABSENCE	
'Risk of Absconding' Assessment	RISK ASSESSMENTS	
'Risk of Suicide' Assessment	RISK ASSESSMENTS	
Risk to Children form	Risk Assessments	RISK TO CHILDREN
Risk to Children Letter Short Outings	LEAVE OF ABSENCE	
Risk to Children Letter Transfer/Discharge	LEAVE OF ABSENCE	
RSVP Appendix	Risk Assessments	RSVP, HCR-20 & SVR-20

S

Seclusion Reviews 7 day	SECLUSION REVIEW	
Seclusion Care Plan	NURSING CARE PLANS	
Seclusion Observation Chart Part 1	Seclusion Review	SECLUSION SHEETS
Seclusion Observation Chart Part 2	Seclusion Review	SECLUSION SHEETS
Seclusion Management Plan	SECLUSION REVIEW	
Seclusion Review (Multidisciplinary)	SECLUSION REVIEW	
Seclusion Update Report	SECLUSION REVIEW	
Section 17 documents	LEAVE OF ABSENCE	
Section 19 documents	LEAVE OF ABSENCE	
Section 61 (prev. MHAC 1)	CONSENT TO TREATMENT	
SESCAM	PSI Assessments	PSI CORE ASSESSMENTS

Sharing Information with Carers / Relatives form	CARERS – SHARING INFORMATION	
SOAD Request (prev. Treatment Plan)	Consent to Treatment	TREATMENT CORRESPONDENCE
Social Care Agency & Family Letters	Social Work	SW GENERAL LETTERS
Social Care Child Protection Panel letter (Disclosure)	Third Party / Non-Disclosure	TP CHILD CONTACT ONLY (Non-Disclosure)
Social Care Home Visit	Social Work	SW HOME VISIT
Social Functioning Assessment	PSI Assessments	PSI CORE ASSESSMENTS
Social Care S17 (Children's Act) (Non-Correspondence & Referral)	Third Party / Non-Disclosure	TP SAFEGUARDING CHILD / ADULT Disclosure)
Social Care S47 (Children's Act) (Non-Correspondence & Referral)	Third Party / Non-Disclosure	TP SAFEGUARDING CHILD / ADULT Disclosure)
Solicitors Letters	Under subject heading or General Correspondence	
SOTP Report/Documents	PSYCHOLOGY	
Speech Therapy	Physical Health	SPEECH & LANGUAGE THERAPY
Sports Day Referral for Exercise Assessment	Rehabilitation Service	REHAB REFERRALS
START	Risk Assessments	START
Suicide Risk Assessment Worksheet	RISK ASSESSMENTS	
SVR – 20 (Psychology Risk Assessment)	Risk Assessments	RSVP, HCR-20, SVR-20

I

Task Observation Scale Form	Rehabilitation Service	REHAB OCCUPATIONAL THERAPY
Telephone Monitoring Letter to Patient	RISK ASSESSMENTS	
'Tilt' Assessment	Risk Assessments	TILT
Time Line Psychology	PSYCHOLOGY	
Time Line PSI	PSI Assessments	PSI CORE ASSESSMENTS
Transfer Confirmation	LEAVE OF ABSENCE	
Transfer Direction	Mental Health Law Department	MHLD STAT DOCS
Transfer Information	LEAVE OF ABSENCE	
Transfer Note (Clinical)	LEAVE OF ABSENCE	

Trial Leave Application	LEAVE OF ABSENCE
Trial Leave Extension Information	LEAVE OF ABSENCE

U

Unlicensed Medication Individual Patient Request	PHARMACY MEDICATION HISTORY
Unescorted Garden Access Form	Security Documents SECURITY GROUNDS ACCESS

V

W

Witness Statement (fit to plea) by RC	COURT / LEGAL REPORTS & CORRESPONDENCE
Witness Statements (pre-admission)	Part 1s DEPOSITIONS
Witness Statements (staff)	DO NOT ATTACH TO PACIS OR FILE IN THE RECORDS
Workshop Report	Rehabilitation Service REHAB REHABILITATION

X, Y and Z

APPENDIX 2 (f)

PROCEDURE FOR THE MANAGEMENT OF PATIENT HEALTH RECORDS Carenote Care Records System (CRS) – Specialist LD Division

The Creation of Care Records

CARENOTES Care Records System

The Service Users/Patients Specialist Clinical Care information will be captured by Clinicians, Medical Records and the Referrals, Capacity and Flow Administrator into CRS. CRS is the principal data collection system for the Specialist Clinical Service offered by the Specialist LD Division.

- Full Demographics
- Referrals
- Admissions, Discharges and Transfers
- Mental Health Act and Ministry of Justice Documentation
- Care Programme Approach (CPA)
- MDT Treatment and Care Plan and Monitoring
- Individual Risk Management
- Formulation
- Specialist Services Interventions
 - Psychological Treatment Service
 - Life Skills
 - Psycho Education
 - Speech and Language
 - Behavioural Nurse Therapist
- Adult Learning Service (ALS)
- Medical Alerts
- General Alerts
- Clinical Assessments
- Clinical Notes
- Clinical Reports and Attachments
- Ward Round Summaries
- Contacts/Agencies

1. Access to Care Records

Access to the Carenotes Care Records System (CRS) is limited to staff involved in the direct provision of care or the administrative or management processes supporting care. All access to the system feeds into a comprehensive audit trail which will be made available for analysis as appropriate by the ICT Department for the purposes of audit or investigation.

1.2 Pre Admission

The referral record is created by the Carenotes Care Record System (CRS) by the Trust Referrals, Capacity and Flow Team Administrator prior to a patient's/service user's admission. At this time, Medical Records Department staff will input all details available to them.

On transfer of a patient/service user from one ward to another, the Ward Manager is responsible for co-ordinating the necessary movement of any non-electronic files.

1.2.1 **Ward Manager**

The Ward Manager is responsible for the safe storage, tracking and maintenance of both electronic and written records within their area of responsibility.

1.2.2 **Professional Clinical Staff**

Professional clinical staff are personally and professionally responsible for ensuring their practice with regards to record keeping is in line with respective professional code of practice, e.g. Registered Nurses – NMC Standards on Record Keeping.

1.3 **Clinical Notes and Activity Notes**

1.3.1 Clinical Notes/Activity Notes should be created on a daily basis or more frequently as they are required.

1.3.2 Clinical Notes/Activity Notes can be entered by all grades of clinical/care staff.

1.3.3 Level 3 or 4 supervision for periods of 6 hours or more must be recorded using the tick box on the Daily Activity Note.

1.3.4 All Clinicians must ensure that relevant entries are created on the same day as the event. If this is not possible then the entry must be made as soon as possible and noted as a retrospective entry.

1.3.5 Nurses or support staff who are on duty at the time of an event are responsible for confirming the clinical notes they enter.

1.3.6 Staff leaving the Trust must ensure that all their clinical notes are confirmed.

1.3.7 It is important that the note type is chosen carefully. This should reflect the main subject of the note, for example, a service user/patient displaying a change in mental health should have a clinical note type of 'Deterioration in Mental Health'.

1.3.8 Where a number of different subjects needs to be entered into a note it is good practice to create more than one clinical note for that shift.

1.3.9 Factual information must not be removed from clinical notes. Editing a clinical note should consist of changes to grammar, spelling and adding further information where appropriate.

1.3.10 If a clinical note is entered in error and confirmed, this note should be set as **invalid** by the appropriate Clinician.

1.3.11 Users are encouraged to make full use of the inbuilt spell checker.

2. MOVEMENT AND RETRIEVAL OF CLINICAL RECORDS

This section provides an explanation of how Medical and Care Records move with the patient/service user as they move through the services across the Trust to ensure continuity of care that is supported by the Medical and Care Record (*paper and EPR*).

2.1 When a Patient/Service User Moves Between Wards or House

The Ward Manager in liaison with the Medical Records Department is responsible for ensuring the patient's/service user's Ward or House Karefile is kept on the patient's/service user's ward or in their house, and is moved with the patient/service user if he/she changes ward or house.

When transferring a service user/patient between wards it is the role of the person receiving the information on handover to ensure that the correct Clinical Team member forms are updated and accurate. The Transfer Checklist template will guide the user through the detailed requirements. Medical Records must be advised by the Ward Manager or nominated Deputy of all transfers prior to the transfer.

If work group members receive service user/patient information which is no longer relevant to them they must ensure that the information is forwarded onto the correct person. If they are unsure who to forward the information to they should return it to the sender, explaining why.

2.2 Records on Discharge or Death

Forensic and High Support Services

When a Whalley Site (*Forensic and High Support Services*) patient/service user is discharged or dies, an e-mail is sent to the Ward Manager for a member of staff to search throughout the ward, and that all documentation about the patient/service user is returned to the Medical Records Department in dated files so that it can be archived as soon as possible.

2.3 Use of Whalley Site Medical Records when Patients/Service Users Attends or is Admitted to a General Hospital

When a patient/service user attends an Out Patient Clinic or is admitted to a General Hospital for treatment, staff on the ward must refer to Procedure on Managing and Supporting Patient/Service User Attendance at Acute Hospital.

The procedure explains what information staff will need to be familiar with, what records need to be taken with the patient/service user, how events are recorded in the patient's/service user's Whalley Site Medical Records and the responsibilities of all the staff involved.

3. THE CLINICAL RECORDS TRACKING SYSTEM (ON SITE)

3.1 Patient/service user care in the NHS is a complex process and will involve many different staff in the course of a patients/service users treatment, right of access must only be available to those directly involved in the patients/service users care.

3.2 The Trust has an electronic patient record system for all inpatient services. This has an inbuilt audit trail and access is in accordance with information governance principles.

- 3.3 For all paper documentation associated with the clinical record the Trust has in place a records management tracking system to ensure that the location of records is known at all times. This system is implemented via the Medical Records Department and the Records Manager and has responsibility for the implementation of a robust medical records documentation tracking system.
- 3.4 The Medical Records Department file is kept in the Medical Records Department. If at any time a Doctor or Medical Secretary may need to remove the file, the removal and return of the file is documented by local tracking in the Medical Records Department.

4. INCORRECT DATA ENTRIES

No data can be deleted from the system. Any confirmed data entered incorrectly should be marked as invalid with the associated reason why. Users should contact the Informatics Department with Specialist LD Division in circumstances where the user cannot correct or set the data as invalid for further advice.

5. SYSTEM UNAVAILABILITY

5.1 If for any reason the CRS is not available, then written (*paper*) records must be created and entered where possible by the author of the note onto the system within 24 hours of the system working. The Nurse in Charge on the day the system recovers is responsible for ensuring notes are entered onto the system. If written records are entered by another, make it clear who is the original author. The paper record should be shredded following an entry on CareNotes

5.2 System Permissions levels

5.2.1 CareNotes access is controlled by system permissions. The system is only available to users that need access as a legitimate part of their work.

5.2.2 A single permission level is implemented across the system meaning each user can potentially see every CareNotes record. This is necessary so that the system can support bank staffing arrangements where users may be required to work in different ward areas at short notice and any inability to access the system could pose safety risks.

5.2.3 Users are not permitted to browse care records for service users without a justifiable need to do so as part of the service user's health care provision. Accessing records without a justified need contravenes the Data Protection Act and may result in disciplinary action being taken against the user.

5.3 Auditing System Usage

The CareNotes system has an inbuilt audit on all data entry, tagging user and data information to all data changes.

Reports on user activity are produced monthly and as required on an ad-hoc basis by the Informatics team in Specialist LD Division. Issues that will be investigated may include:

- Access to one or more service user records by users where there is no obvious clinical relationship
- Usage patterns indicating that user accounts may be being shared
- Unauthorised modification or access

Any unusual activity is investigated and reported to the user's line management as appropriate. Unauthorised or improper use may result in disciplinary action being taken against the user.

6. HEALTH INFORMATION CAPTURE IN CRS

When appropriate ward based staff will record physical health information in the CareNotes CRS System via the Physical Health based Intervention and Measure Forms.

7. LINKED SYSTEMS

7.1 Where it is technically achievable, service user/patient related information from other systems will be made available within CRS via the Clients Individual Summary menu option. This will initially include:-

- Client Incidents (*via Ulysses Incidents System*)
- Clients Bank Statements (*via the Clients Monies System*)
- Clients GP/Treatment Room consultations (*via EMIS System*)

7.2 It will continue to investigate integration opportunities for service user/patient based data to be made available in CRS.

8. REPORTING

8.1 A set of standardised reports will be created for generic use and made available in a range of formats including: Excel, SQL Reporting Services, Dedicated Web pages and the QlikView System. The Informatics Department Specialist LD Division will work closely with Clinicians to ensure effective report development.

8.2 The Informatics Department Specialist LD Division should be contacted to request additional or ad hoc reporting requirements.

8.3 A number of forms in the system will be used to capture Key Performance Indicators (KPIs). Quality Reports will be produced from this that aggregate the data based on the time taken and other parameters to show relative performance against the agreed clinical targets and requirements.

8.4 Data quality reports are produced monthly to support Mental Health Services Dataset submissions.

8.5 Reports on user access are produced monthly to enable monitoring of appropriate system use.

9. SYSTEM CHANGE REQUESTS

Changes in working practices, new requirements, data set changes, improved functionality may require the system to be upgraded.

All system change requests will be formally managed by the Informatics Department Specialist LD Division.

- Local configurable changes and new forms are subject to approval.

10. CARENOTE FORMS

10.1 Medical Record Responsibilities

The following CRS Forms are created and maintained exclusively by Medical Records:-

Information Area	Forms	National and Commissioner Data
Patient	Demographics Alias	SUS, Commissioners
MHA	Section (<i>KPI Item</i>) MHA Tribunal/Renewal Hearings MHA Consent MHA Emergency Treatment Other External MHA related Reports, Scans and Attachments	SUS, Commissioners
Episode	Inpatient Episode Ward Stay Absence	SUS, Commissioners SUS, Commissioners SUS, Commissioners
Contacts	GP Other Agencies Address Team Members (Consultant)	SUS, Commissioners SUS, Commissioners SUS, Commissioners SUS, Commissioners

The majority of data captured here will underpin our Central Returns to Secondary User Services ¹(SUS) and Local Commissioning Information, including our local Key Performance Indicators (KPI) to monitor the service quality and activity. It is therefore essential that the information and updates are added in real time verified.

10.2 Clinicians Responsibilities

— The following CRS Forms are created and maintained exclusively by the designated clinical staff groups:-

Clinical Group	Forms	Key Performance Indicators
MDT	Clinical Note	
Client Team and Ward Staff	Specialism Referral Escort and Supervision	Mandatory

¹ NHS uses SUS as the standard repository for activity for performance monitoring, reconciliation and payments – NHS in England, Operating Framework for 2008/09, December 2007, Department of Health

	HONOS Secure Diary Appointments CPA Local Health Measure Local Health Intervention Alerts Initial Treatment and Care Plan	SUS KPI in place within 24 hours
Consultants	ICD10 Psychiatric Formulation Integrated Care Plan Individual Risk Profile Medication Ward Round	SUS KPI: 12 weeks KPI: Monthly Review KPI: 12 weeks and 6 Monthly Review Monthly
PTS	Specialism Referral Intervention & Review Therapy Status Reports (e.g. Post Admission Assessments)	KPI: 18 wks to commence therapy KPI: 12 wks
BNT	Specialism Referral Intervention and Review Behavioural Management Plan	Mandatory Mandatory In place within 24 hours
Life Skills, Psycho Education, Speech & Language	Specialism Referral Intervention & Review	Mandatory
Adult Learning Services	Day Service Schedule DNA & Extra Sessions	KPI: DNA Rate
All Clinicians	Attachments Clinical Templates Templates	

Authorisation is required by the Responsible Clinician for all forms as soon as practically possible. The Responsible Clinician can delegate confirmation of documents to nominated persons, e.g. RC can nominate Associate Specialist.

All Care Team members must read and electronically sign the appropriate care documents for service users/patients in their care.

10.3 **Escort and Supervision Form (KPI Item)**

10.3.1 It is important to make sure that the information within this document is accurate and updated immediately following change to any of the criteria:-

- **Supervision Status** – records the area and its associated level, gender mix, frequency and any restrictions.
- **Escort Status** – records the areas and type of escort required.
- **Freetime Status** – free text recording of service users/patients agreed freetime.

10.3.2 The current Primary/Generic Supervision Status should be indicated as the first item for every service user/patient. Other Supervision Status can be recorded against the associated area or environment as required.

10.3.3 The Ward Round Review and Multi Disciplinary Team (MDT) meetings should review Escort and Supervision Status to ensure it is up to date, still relevant and accurate; however, the form can be updated outside these meetings as appropriate. A clinical note must be input following any changes to the escort/supervisions status outside of the MDT or Ward Round.

10.4 **Individual Risk Profile Form (KPI Item)**

This document is required to be completed within 12 weeks (*84 days*) of the service user/patient admission and is required to be reviewed at least every 6 months or if there has been a significant incident.

All service user/patient alerts should be associated with a Risk Profile entry.

10.5 **Integrated Care Plan (KPI Item)**

The Integrated Care Plan Forms are required to be completed within 12 weeks (*84 days*) of the service user/patient admission.

Each Integrated Care Plan should record all the key elements/problems of the service user/patient and include the following categorised descriptions:-

- Psychiatric and Psychological Treatment
- Nursing Care
- Physical Treatment and Care
- Other Treatment and Care Provisions

Realistic Outcome Goals/Targets should be set on the onset and an Actual Outcome recorded.

The service users/patients full Integrated Care Plan must be reviewed every month.

10.6 **Psychiatric Assessment and Formulation/HCR20v3 (KPI Item)**

This document is required to be completed within 12 weeks (*84 days*) of the service user/patient admission.

10.7 **Ward Rounds**

This document is required to be completed once a month.

10.8 **Diary Appointment**

This form is used as an invitation to the Section 117 and CPA Meetings and completed by the Clinical Admin Team.

10.9 **HoNOS**

This form is completed by Qualified Nurses.

10.10 **Specialist Referrals and Interventions**

Specialist referrals are made following agreement by the MDT. Once completed these are automatically e-mailed to the relevant specialist admin team for acceptance and a set of interventions scheduled if approved.

PTS Specialist Referral (KPI)

- Referrals should be accepted or declined by the service within 4 weeks of the request.
- PTS administration should record the *decision reason* if not accepted.
- If accepted then the service user/patient will, by default go on to the waiting list for a PTS Individual or Group Intervention/Therapy.

PTS Specialist Interventions (KPI)

- Prior to the intervention starting the *anticipated outcomes* will be recorded.
- It is important that a report from each session is recorded on the form in the *comments* field.
- The *end date* of the Intervention/Therapy sessions must be recorded and the *Actual Outcomes* achieved commented on against the previously *anticipated outcomes* stated.

Other Specialist Referrals

- Referrals should be accepted or declined within 4 weeks of the request.
- Administration should record the *decision reason* if not accepted.
- If accepted then the service user/patient will by default go onto a waiting list for that intervention.
- Creating an Intervention Form removes the service user/patient from the waiting list.

Other Specialist Interventions

- Prior to the intervention starting the *anticipated outcomes* should be recorded.
- It is important that the comments from each of the sessions is recorded on the form in the *comments* field.
- The end date of the intervention sessions should be recorded and the *actual outcomes* achieved commented on against the previously *anticipated outcomes*.

10.11 **Team Members**

The Team Members Forms for the Case Manager and Key Worker will be updated by the nursing staff when any changes occur or when a new service user/patient is admitted within 1 working day of the event.

The Team Member Form for the Consultants will be updated by Medical Records.

10.12 **Medication**

The Medication Form is not the primary method for prescribing medication; it is an electronic copy of medication prescribed by the Responsible Clinician.

This form must be confirmed by the Responsible Clinician or nominated Deputy.

APPENDIX 3

MERSEY CARE NHS TRUST

PROCEDURE FOR “MISSING” HEALTH RECORDS

- If after extensive searching health records are unable to be located it is essential that the “missing” record is reported to the Trust’s Health Records Manager.
- A full investigation should be undertaken by the senior member of the team in order to locate the records. This should include checking the Patient Information System for clues, speaking to the Healthcare professionals involved in the service users care, office searches or searches of the areas where the notes were last booked out to, speaking to the GP for further clues, library checks to eliminate whether the notes could have been misfiled.
- If after extensive searching the notes are still missing a temporary set of notes should be made up which are clearly marked “Duplicate”. Efforts should be made to retrieve as much information as possible in respect of the service user to create a duplicate set this may involve obtaining copy letters from secretarial staff, results of any investigations which may have been performed. The Healthcare professionals should be advised of the situation.
- An adverse incident form must be completed via Datix recording the fact that the health record is missing. The Datix forms are available on the trust’s website. The person completing the form should enter all relevant details and submit this. This will automatically be forward to the Datix team and a nominated reviewer for your area. The reviewer should record any additional contributing factors, actions taken/to be taken and once completed submit to Datix team.
- Details of the service user’s name, identification number and last known recorded location must recorded on the “Missing Log Template”. The locations that have been searched and individuals spoken to as part of the search should be recorded as well as time spent by Health Records Clerks attempting to locate the records.
- It is essential that these health records are still searched for on a regular basis and weekly searches should be undertaken.
- When the health records are found the Health Records Manager must be notified and an investigation undertaken into why the health records were not booked out accordingly or how they ended up at that destination.
- The duplicate set of health records must be retrieved and merged into the original set or any duplicate documentation no longer required should be shredded or put into confidential waste. Anyone involved in the original investigation process should be advised that the original health records have been located.
- The missing log templates will be reviewed on a quarterly basis by the Trust Health Records Co-ordinator and information collated will form part of the quarterly report submitted to the Information Governance Committee to underpin the Information Governance Standards.

Procedure Format

This procedure is produced in a standard format. It will be made available in appropriate languages and formats on request.

Equality & Diversity Statement

All staff have a duty to ensure that they are working within the Equality and Diversity framework of the Trust

Implemented: January 2005

Reviewed: July 2012, July 2013, December 2014, October 2015, September 2016,

Next Review: September 2017

Author: Gina Kelly, Trust Health Records Manager

APPENDIX 4 (a)

REGISTRATION

Before registering a new patient first search the PMI to ensure there is no existing patient record

If you do not have a patient reference number the easiest way to search for an existing patient is by surname, variations in spelling may hinder searches, but you can also use DOB, if part of the date is not known just enter the elements of the date of birth that are known. You can also narrow down the search by specifying sex. A list shows existing patients with that name. Check D.O.B or select '**Patient**' function button and check the address (remember patient may have changed address since last seen). Remember some Service Users have preferred names or use an alias.

You should also consider checking patient details on the Summary Care Record (SCR) before registering.

ONLY IF A PATIENT RECORD IS NOT FOUND PROCEED WITH REGISTRATION.

Certain fields in the registration screens are mandatory .i.e. you cannot leave these fields blank.

SCREEN 1

SURNAME - Entries should be standardised as far as possible, although proper consideration should be given to service user's wishes.

FIRST NAME, MIDDLES NAMES AND TITLE - When first name and title are entered, sex field will default to correct sex, (the input given is checked against existing information). The first time a name is entered the system will ask for validation to confirm spelling/usage. *Titles are also used to determine sex, but not those which could be ambiguous, i.e. Dr/Rev/Prof etc.*

POSTCODE - Always use the PAF function to check address and postcode details. Postcode field will not accept incorrect format but it will accept incorrect code (incorrect figure becomes faint). If necessary use the postcode book/telephone book.. If address N/K or NFA (No Fixed Abode), postcodes are: ZZ993VZ and ZZ993BZ respectively.

TELEPHONE NO - Should be entered in full, including area code, if none enter 'none'. Do not enter mobile numbers here these should be entered in mobile number field. Also do not enter information other than Telephone number – other information should be recorded in the notes field as appropriate.

MOBILE NO - Should be entered in full

E-MAIL – Should not be used at present

DOB/AGE - When D.O.B is entered, age is automatically calculated. If only a year of birth is known enter as 01/01/ccyy. If D.O.B is not known but an approximate age is, calculate the year of birth and enter as 01/01/ccyy. If no judgement can be made on either the D.O.B or approximate age enter a 1year and amend as soon as possible. (If age is more than 115 system will ask you to confirm.)

BIRTH NAME– If a maiden name is known enter only the surname as the system will automatically populate the forename of the service user.

BIRTH PLACE – Enter place if known e.g. Liverpool, London.

GP CODE – Search and select code for current GP. If unknown or unregistered you should check on SCR before registering as Unknown or Unregistered.

RELIGION – Record the patient’s religious belief in this field

OCCUPATION – The patient’s occupational group is to be entered here

MARITAL STATUS – The patient’s current marital status is to be recorded here

SCREEN 2– Others Involved

Automatically defaults to **N.O.K** - if no N.O.K still create record and enter none. NB. If N.O.K details are not known at this point, the screen should be left blank; in this case the system will automatically copy the patient’s details over to the second screen. NOK details can be entered at a later date by returning to the patient registration screens and using the ‘Insert’ command button. **DO NOT** type over the patient details on screen 2

CATEGORY – Select the type of record that is being recorded (.i.e. Carer, N.O.K, Mental Health Act Nearest Relative)

SURNAME - Enter the surname of the person involved. At this point, the pop-up button on the end of the field should be used to check whether this person is already registered as an ‘Other Involved’. If the person appears in the list they should be selected. The screen will then auto-populate with the remaining fields.

FIRST NAME, MIDDLE NAMES AND TITLE – Enter appropriate information in these fields.

ADDRESS – If the address of this person is different to the service user, the correct usage of P.A.F should be adhered to, in order for the correct address details to be recorded. If the address is the same as the service user, the ‘**HOME**’ keyboard key should be pressed to copy over the patients address details.

TELEPHONE NO - Should be entered in full, including area code, if none enter ‘none’. Do not use this field for other than telephone number.

MOBILE NO - Should be entered in full

E-MAIL – Should not be used at present

RELATIONSHIP - Select the relationship of the ‘other involved’ person to the patient e.g. wife, son.

END DATE – If the person recorded changes address or stops’ being involved as the stated category to the patient, the end date is entered here. A new ‘others involved’ record should be inserted, if appropriate, by using the ‘**Insert**’ command button and entering the relevant details.

D.O.B - The date of birth of the person is to be entered here.

ETHNICITY – Record the ethnicity as reported by the person, or leave blank if unknown.

SCREEN 3

DIRECTORATE – The service area the patient is currently being seen in is to be recorded here. A pop-up button will bring up a coded list of options

PATIENT STATUS – This field is to be left blank. The system will, as part of its nightly maintenance checks, automatically enter the patient’s current status

PREVIOUS IN-PAT - This field is to be left blank. This is checked as part of the clinical coding process.

WARD/BOROUGH – The system will automatically populate this field with the correct Electoral Ward their address is located in. If the incorrect use of P.A.F has been carried out or P.A.F has not been used to insert the patient’s address, the system may not be able to enter the correct information.

OLD C/S – An associated reference number for the patient can be recorded here. If more than one number is to be recorded, the other references should be inserted via the '**Alias**' function screen.

M.HEALTH C/S NO - This is auto generated by the system when registration is complete. Always check this has been done. The field is not editable. This is the patients X Number.

TEAM REFERENCE – The predominant team under which the service user is being cared for is to be entered here e.g. team with CPA responsibility.

NHS NO – Enter if known. If access to SCR is available a trace of SCR can be made and the NHS number then entered in to ePEX. The field will not accept an inappropriate number as a check algorithm takes place to ensure the number entered is a legitimate NHS Number.

DHA of RESIDENCE - The system will default to the correct code based on the postcode recorded.

ETHNIC GROUP – The ethnic group the patient feels they belong to is to be recorded in this field

SSD - An associated Social Services Department number for the patient can be recorded here. If more than one number is to be recorded, the other references should be inserted via the '**Alias**' function screen

CAUSE OF DEATH - This field is to be left blank.

DATE OF DEATH - Should be entered if known.

N.I – The patient's National Insurance number can be entered here, if known.

1st MENTAL HEALTH PRESENTATION (WITH ANY PROVIDER) – The date of the patient's 1st treatment/attendance with any Mental Health provider is recorded here. If only a year of treatment/attendance is known, the date should be recorded as '01/01/ccyy.

PRIMARY CLIENT TYPE – The primary client type field is to capture what type of services this service user needs. The pop-up list available is a 'Social Services defined list' not a specific 'Mental Health/Learning Disabilities' list. Further guidance should be obtained from a Social Work colleague.

MILITARY VETERAN – Record here if the patient is a Military Veteran.

NOTES - This field is very useful for expanding/clarifying information, it is very important though that the information included in the notes field is relevant to the screens being accessed e.g. address or access information but no clinical information should be recorded here.

SCREEN 4

LANGUAGE – If the patient is unable to communicate in spoken English, the Language field is used to record the language they prefer to communicate in.

DISABILITY – Record here if the patient has indicated they have a disability or not.

INTERPRETER REQUIRED – Record here if the patient requires an interpreter.

NATIONALITY – The patient's nationality is to be recorded here

SEXUAL ORIENTATION – Record here the patient's self reported sexual orientation

PHARMACY – Record here the patient's preferred pharmacy/chemist

ADVANCE DECISION – Record here when known that the patient has an advance decision in place

ADVANCE STATEMENT – Record here when known that the patient has an advance statement in place

CARE PLAN COPY – Record here when known that the patient has requested to receive copies of their care plans

LETTERS COPY – Record here when known that the patient has requested to receive copies of their clinical letters etc.

RAPID ACCESS – as appropriate record here if patient on 'Rapid Access' status.

Please only enter required/appropriate information into each field. Notes or instructions etc. should only be entered into notes field.

Please ensure that this document is accessible to all trained ePEX users.

Please do not hesitate to contact the ePEX Team or Data Quality Team as appropriate on (0151) 472 4014 should you require any assistance.

APPENDIX 4 (b)

Registering a Patient on RiO

Any new Patient to Local Services in Mersey Care must be registered on the RiO system.

1. Click on Client Record button on the toolbar.
2. Click on Registration from the drop down options
3. Type in the details of the Patient in the search boxes
4. Click on the Magnifying Glass to start the search.
5. Click on the Search National Records option at the bottom of the window.

The Personal Demographics Service search window will be displayed:

RiO will automatically search to see if that patient/client is already registered on the system; if they are not already registered a notification will pop up to say No Records Found that Match the Search Criteria

6. Ensure that the Family Name, Date of Birth and Gender sections are completed.
7. Click on the Search button at the bottom of the window.
8. The result will be displayed.
9. Click on the Patients Name.
10. An Access Reason window may be displayed:
11. If the above window is displayed enter a Reason and Comment in the relevant sections.
12. Click on the Save button.

The Demographic Details window will be displayed with Local data displayed on the Left and NCRS National data on the right.

13. In the NCRS National data section, put ticks next to the correct information
14. Once this is complete click on the Save to local only button.

If the information does not match it is highlighted in yellow. If there are differences you will need to Edit the Clients record to make the information match

When entering information into any window in RiO, the text boxes with a dotted outline do not allow data input. The Text boxes shaded pink are all mandatory fields and need completing.

Registering a Patient Locally

Registering a Patient should only be done once you have searched the National Care Records system using various search criteria. Searching the RiO system should also be done thoroughly before registering to ensure there are not duplicate records.

Searching for the Patient

1. Click on the Client Record button on the toolbar.
2. Click on the Registration option
3. In the Family Name section, enter the Patient's Surname.
4. In the Given Name section, enter the Patient's Forename.
5. Click on the Magnifying Glass on the right of the window.

Registering the Patient

At least two sections must be completed before the system will perform the search. If the patient is not found try a few different scenarios or a wild card (*) can be used in case of different spellings. For example Smith could be spelt as Smyth, entering Sm* will return all versions of entries with Sm in the surname.

1. At the bottom of the window, click on the Create New Client Registration option.
The Demographic Details window will open.

Entering Current Address

To enter the Patient's Current Address

1. Click on the magnifying glass on the right of Client Current Address to input the details.
2. The address can either be entered manually or searched for using the Postcode.
3. Click in the Postcode section and enter the postcode.
4. Click on the Search button. The address will be displayed on the right of the window.
5. If this is the correct address, click on the Accept Address button. The window will close and the details will be added to the relevant sections.
6. If address is not correct and to enter the details manually, click on the Enter Manually button at the bottom of the window.

When entering information into any screen in RiO, the text boxes with a dotted outline do not allow data input. The Text boxes shaded pink are all mandatory fields must be completed.

7. Enter the Patient's address in the required sections.
8. Click on the OK button to accept and return to the Address Search window.
9. Click on the Accept Address button.
10. A date must now be entered in the Address from Date section. If not known enter 01/01/1970 as a Default.

Entering the Patient's GP details

1. Click on the magnifying glass on the right of the GP section to open the GP Search window.
2. Enter as much of the GP details as possible or enter a postcode.
3. Click on the Search button. A list of possible GPs will be listed.
4. Click on the correct GP in the list
5. Click on the Accept GP button to return to the registration window.
6. Complete any remaining Mandatory sections.
7. Click on Save at the bottom of the window.

If the Patient details match any details already registered on the system a Warning message will be displayed.

8. Select the appropriate option of Yes or No

Viewing/Editing Patient Demographics

Patient demographics are visible in the Client Record view.

1. Click on Client Record button in the toolbar.
2. Click on Case Record option.
3. Search for the Patient.

Editing Demographics

To add or edit the Demographics in the Clinical Portal window,

1. Click on the Demographics heading on the left of the window.

A new window will now open with several links along the bottom. The links will give you access to various sections of the Patient demographics. You can now add or edit any of the Patient Information from this window i.e. change of address or change of GP.

When any new demographic details are added to the Patient record, RiO keeps a history of all the previous information.

Viewing Demographic History

To view history of Addresses or to add a new Address.

1. Click the Addresses option at the bottom of the window.
The window shows the Patient current address
2. Click on the History button to view previous Addresses.

Adding an Address

1. Click on the Add Address option at the bottom of the window.
 2. Complete the Mandatory Fields highlighted in pink.
 3. Click on the Save option
- To return to the previous window,
4. Click on the Registration Details option.
- The same process is used for each of the links shown below.
5. If any information has been added click on the Save option.

Adding a Temporary Address

A Temporary Address should be entered when the patient is temporarily living somewhere away from their home address i.e. a patient moving from home to a rehabilitation unit.

1. Click on Client Record button on the toolbar.
2. Click on Case Record from the drop down options
3. Search for the Patient
4. Click on the Demographics heading on the left of the window
5. Click on the Addresses link at the bottom of the window

The following window will be displayed:

6. In the Address Type section, click on the down pointing arrow button and click on the Temporary Address option.
7. Click on the Magnifying glass and complete the remaining mandatory fields for the Temporary Address.
8. Click on the Save button.

If a Temporary Address is added with an end date the Show Closed option (bottom right of the window) will have a tick in it. This has been ticked to make this address visible.

If an end date is not added, it will show in this window without clicking that option.

A temporary address will not be visible on the patient home demographics page. To view you would have to go to Demographics/ Addresses/History.

RiO QRG V0.1 Date of Approval: October 2015 Next Review Date: October 2016

APPENDIX 5

PROCEDURE FOR MERGING DUPLICATIONS ON CLINICAL INFORMATION SYSTEM (EPEX)

To ensure the robustness of the patient electronic health records on the Patient Clinical Information System (ePex), merging of duplications must be performed on a regular basis. These duties should be carried out only by those authorised to do so who are part of the Data Quality Team.

Once the Data Quality Team are alerted of duplications by users of the Patient Clinical Information System or by analysing a downloaded file of the Master Patient Index, using the NHS Number to match duplicate records, the potential duplications must first be validated to ensure they are the same patient.

Data Quality Staff must compare the patient's demographic details on the duplicate electronic health records i.e. name, date of birth, addresses (current and previous), General Practitioners, NHS number, religion, next of kin details and ethnicity. If they are exactly the same then the duplicate records can be merged. The Summary Care Record or Open Exeter can be used for confirmation as well as contacting clinical staff patient is currently under the care of.

Usually it is the first/oldest of the health record numbers to be merged which has the most information recorded against it therefore this must be kept as current health record number once they are merged. A record must be kept of the other health record number(s) issued under Alias Reference numbers on the system.

Before merging on the Patient clinical Information System the correct address history must be ascertained to ensure the current address is correctly showing. The addresses in the history must be in chronological order and there must only be one record for each address at each time with the correct start and end date. If required the current patient's address can be checked by contacting the staff involved in the patient's care.

An electronic health record can contain quite a lot of activity e.g. appointments, contacts, referral, ward stays, episodes, mental health acts, Assessments, Crisis, Day Care, warning, help plan, electroconvulsive therapy, letters, CPA documentation, addiction service pathways and pathology reports. It is important to ensure all activity is merged correctly therefore screen printouts of all summary screens must be taken and a small sample of full records of each type must be printed out for validating after merging.

First step of the merging process is to make a note of the ePEX system numbers for all duplicate records e.g. 12/1123, these are used to search and confirm the records to be merged. Please note you can only merge two records at one time.

To merge in ePEX select the health record that does not have current address, if both have the same address it does not matter, this enables the correct current address to appear correctly on registration once merged.

In the records Registration screen click on the 'Delete' button, then click on the underlined word 'Merge'. In the second surname box click on the pop up box (3 dots), click on 'Search' and type the surname and click ok. Scroll through the names until you find the second record confirm using ePEX system number and click 'Select'. Press the return key and answer message 'Process with merge', do a final check on the ePEX system numbers and then select 'Yes'. It may take a few minutes to thirty minutes to merge the records depending on the size of each record, you will be taken back to the registration screen once the merge has completed.

Firstly ensure that the correct health record number is showing in the field District Reference on page 3 of registration, if not amend accordingly.

Now check the current address details are correct and for any inconsistencies in the address history i.e. are they in chronological order, duplicate address histories (both records may have same address and when merged both appear but only require one), start and end dates ensure no gaps in dates.

Next check all the activity has successfully merged using your screen printouts delete any duplicate episodes, alias names and alias references numbers.

If during the merging process there are any problems the Senior Data Quality Analyst must be notified, who will investigate and liaise with the system suppliers through the System Development Team for a resolution.

Network problems may result in a partial merge and only part of both records are merged. If this occurs then a validation check must be done against both records to ensure data has not been lost, a further merge must be done with a final validation check.

Once the merge process has been completed a list of all the merged records must be sent routinely to the Electronic Management Team to ensure the scanned manual records are merged on the WinDip system. In addition all users of duplicate numbers will be notified by telephone (followed up by an email) of newly merged records.

Any ePEX screen printouts must be shredded afterwards.

For information purposes the Data Quality Officers must record the details of each merge in the Excel spreadsheet provided. The spreadsheet is located as follows: <S:\Mental\Data Quality Team\Arundel DQ team\AJK DUPS\Duplicates resolved3.xls>. The information collected allows the Data Quality Team to ascertain if there is a training issue and to provide figures for reports e.g. Data Quality Report and Performance Report.

Even though every effort is done to confirm duplications there is always a possibility of an error. In such cases the Senior Data Quality Analyst must be informed and a manual unmerging of the records must be done as soon as possible. For this all manual health records must be obtained by the Data Quality Officer prior to unmerging to ascertain the correct activity for each patient. The Data Quality Officer may need to speak with the patient's current clinical staff.

A new record must be created on ePEX for the health record with the least data as it will have to be manually re-entered. Once the activity has been re-entered the new record's number must be replaced with the original health record number, the Senior Data Quality Analyst will liaise with the system suppliers as they must delete the health record number from the merged record first.

Then manual health records are separated and returned to the appropriate health records department with a covering letter.

In exceptional circumstances a note is typed against a patient's name 'Not to be confused with ***) to stop these types of errors occurring.

Implemented: January 2008
Review Date: October 2016
Next Review Date: October 2017

APPENDIX 6

Local Division - Addictions Service

Management Office
William House
Rathbone Hospital
Mill Lane
Liverpool L13 4AW
Tel: 0151 471 7896

Local Division - Liverpool Services

Admin Manager
Management Offices
Broadoak Unit
Thomas Drive
Liverpool L14
0151-250 5009

Local Division – Sefton, North Liverpool & Kirkby

Admin Manager
Switch House
Northern Perimeter Road
Bootle
L30 7PT
0151-527 3116

Local Division – Learning Disability Services

Service Manager
Hesketh Centre
51-55 Albert Drive
Southport
PR9 0LT
01704 383600

Secure Division – Medium Secure Services

Business Manager
Scott Clinic
Rainhill Road
St Helens
WA9 5BD
0151-430 0300

Secure Division - High Secure Services

Health Records Lead
Ashworth Hospital
Maghull
L31 1HW
0151471 2629

APPENDIX 7

Guidance on countersigning in ePEX/PACIS

There are times when staff members who record in ePEX/PACIS will need their entry to be countersigned. This sheet is for guidance purposes. If you have any further questions then please speak to your line manager/supervisor.

What am I doing by countersigning?

You are confirming that the entry is an accurate account of any communication to, from or about a service user. That any intervention documented or outcome stated occurred. All entries on ePEX/PACIS must adhere to the required standards of the health records policy.

Who needs to have their entries countersigned?

The following groups of staff need to have their entries countersigned

STUDENTS: all students should have their entries countersigned; they should ensure that their entries comply with MCT standards for recording in health records along with the standards set out by their registering body

Who can countersign?

For students the record needs to be countersigned by the person who has direct supervisory responsibility for the student or by the person who has been delegated the task if they are different.

NON-REGISTERED STAFF: all non-registered staff must have their entries countersigned unless they have been deemed to be competent in record keeping by their manager. This competency can be demonstrated by the person having a recognised health/social care qualification (NVQ or equivalent) or having sufficient experience in their role.

This competency will be decided by the person's manager and will be monitored through supervision.

Who can countersign?

For non-registered staff the record needs to be countersigned by the person who has direct supervisory responsibility for the staff member or by the person who has been delegated the task if they are different.

NB It should be remembered that designated authority may change with shifts

OTHER IDENTIFIED STAFF: there are times when any staff member of any grade or discipline can have their ePEX/PACIS entries countersigned if it is identified that they have failed to maintain their records to the expected standard of the Trust or in line with the standards set out by their own registering body for their profession. The timescale for records to be countersigned will be set out by their line manager or senior manager.

Who can countersign?

Either the direct line manager/supervisor of the person or a senior manager as agreed.

Where supervisors delegate the responsibility for countersigning they must be assured that it will be competently carried out and recorded appropriately.

Helena McCourt
Deputy Director of Nursing

Version 0.1

Senior Nurse Forum

September 2012, December 2014, September 2015, September 2016

Review Date: September 2017

APPENDIX 8

RETENTION PERIODS FOR CLINICAL RECORDS

RECORD TYPE	Minimum Retention Period (years)	Notes
A.W.O.L. forms	See Service User (Patient Record)	
Admission Book	8	
Accident Register (RIDDOR)	8	
Assessment & Review reports	See Service User (Patient Record)	See Service User (Patient Record)
Audit Records – original documents	5	From completion of the audit
Client Observation Record	See Service User (Patient Record)	See Service User (Patient Record)
Clinical reports	See Service User (Patient Record)	See Service User (Patient Record)
Clinical reports – Legal	10	To be filed separately from Service User record.
Computerised records	The recommended retention periods apply to both paper and computerised records.	
CPA Documents	See Service User (Patient Record)	See Service User (Patient Record)
Delayed Discharges	See Service User (Patient Record)	See Service User (Patient Record)
ECT	See Service User (Patient Record)	See Service User (Patient Record)

Medication administration record	See Service User (Patient Record)	See Service User (Patient Record)
MHA appeals/renewals	See Service User (Patient Record)	See Service User (Patient Record)
MHA claim forms	See Service User (Patient Record)	See Service User (Patient Record)
MHA commission visits	See Service User (Patient Record)	See Service User (Patient Record)
MHA monitoring forms (MHA1)	See Service User (Patient Record)	See Service User (Patient Record)
MHA record of treatment Forms	See Service User (Patient Record)	See Service User (Patient Record)
Observation Checklists	See Service User (Patient Record)	See Service User (Patient Record)
Service User/ Patient Record – ADULT	<p>For all Local Services Divisions 20yrs for Mental Health Records after no further treatment considered necessary Except HSS who will retain no longer than 30 yrs For both Local & HSS or 8 yrs after Service Users death</p> <p>Prior to the destruction of records held the Trust's Health Records Manager must be notified - details of all records identified for destruction must be recorded on the electronic logs</p>	<p>For further advice on which records should be Preserved, contact the Health Records & Information Quality Manager. In exceptional circumstances a lead clinician may wish to retain a record permanently. The lead clinician should discuss this with the Caldicott Guardian and if agreed, a "Permanent Preservation" label must be affixed to the front of the Health Record and a reason for retaining the record clearly documented inside the notes.</p>
Service User/ Patient Record – CHILD	<p>Until the service user's 26th birthday, or 10yrs after no further treatment considered necessary, whichever, is the longer: or 8 yrs after service user's death.</p>	<p>For further advice on which records should be preserved, contact the Health Records & Information Quality Manager. In exceptional circumstances a lead clinician may wish to retain a record permanently. The lead clinician should discuss this with the Caldicott Guardian and if agreed a "Permanent Preservation" label must be</p>

		affixed to the front of the Health Record and a reason for retaining the record clearly documented inside the notes.
Psychology Records	See Service User (Patient Record)	See Service User (Patient Record)
Prescription Pad (In-patients)	See Service User (Patient Record)	See Service User (Patient Record)
Research & Development	Minimum 30 years – allowed to retain longer in certain circumstances	For further advice contact the Research & Development Dept.
Serious Incident Files	Permanent	
Ward Registers	2 years	

GUIDANCE 'A'

GOOD NOTEKEEPING GUIDANCE FOR JUNIOR DOCTORS

Please read this in conjunction with the Trust Guide to Good Record Keeping which is available on the Trust website.

Abbreviations should be kept to a minimum and only common, well known ones should be used. Records of all contacts should be entered on to Epex contemporaneously or as soon as possible after the event.

Documents on Epex should be locked once they have been signed off by you and are complete. As Epex only identifies trainees by their job roles it is important that trainees write their name at the bottom of any entries they have made into Epex.

Timescales for letters and CPA documents

All letters (including discharge summaries) and CPA documents should be dictated as soon as possible so that they are sent to the GP within 10 working days. Normally these documents will be typed by the team secretary and will need to be locked after you have checked and signed them.

CPA documentation

You should be familiar with CPA policy and documents which you use regularly. The policy, information and CPA guides are accessible in Epex via the tab 'CPA Guides and Information'. There is a simple CPA documentation flow chart which you can print off from Epex.

Initial Assessment Part 1 and Initial/Care Assessment Part 2

Junior doctors should complete the Initial Assessment Part 1 and the Initial/Care Assessment Part 2 for every patient they see who is new to our service, or who they are assessing urgently, for example, if they present to A&E.

Make sure Care Cluster is documented as well as diagnosis. Mention any specific medication monitoring requirements eg lithium monitoring and metabolic monitoring and record any specific actions required from primary care. If on CPA include name of care coordinator.

Statement of care

You will need to complete a statement of care as a record of any ongoing reviews of out-patients who are not subject to CPA.

The Statement of Care should contain the following information:

- The date when the patient was seen.
- Who was present during the interview?
- Recent update on problems, symptoms and events.
- Review of the patient's mental state.
- Summary of current risk.
- Review of medication and side effects.
- Care Cluster
- The sections for diagnosis, medication and plan must be completed.

- There should be a clear indication of further follow-up arrangements.

Discharge from Service to Primary Care Letters

These should be done on the ordinary Statement of Care and should contain as a minimum:

- Original reason for referral or reason why the service user was under the Trust's care.
- Summary of risks and their management
- Care coordinator (if was on CPA in past)
- Diagnosis and Care Cluster
- In 'Current Medication' any specific medication monitoring requirements eg metabolic monitoring, lithium monitoring.
- In 'Care Plan Details' a discharge management plan including signs of relapse, details of actions for GP and service user if relapse occurs. Ensure 'care plan developed with my lead professional' box is ticked.

Risk Assessment

This should be completed when there are significant risks identified or at the point of referral to Stepped up Care or in-patient services.

In-Patient Documentation

Admission Clerking

Please use the format suggested in the In-patient Medical Clerking Form for recording your clerking assessment. Check you are not duplicating information already gathered by A&E staff.

Physical examination should be documented on the relevant forms in clinical pathways on epex.

Admission Summaries

These should be dictated and typed up shortly after admission. They should include:

- Date dictated
- Date typed
- Date seen
- Name
- Date of birth
- Address
- Diagnosis
- Mental Health Act status
- Date of admission
- Medication on admission
- Care co-ordinator
- CPA level
- Circumstances leading to admission
- Past psychiatric history
- Past medical history
- Family history including details of any children
- Social history
- Forensic history
- Personal history
- Premorbid Personality
- Summary of risk issues
- Mental state on admission

- If the past psychiatric history, past medical history, family history, forensic history, social history, personal history, and premorbid personality are fully documented in recent previous letters or CPA documents they do not need to be repeated in full, but the date of the relevant document should be stated.

The admission summary then forms the basis of the discharge summary.

(in some units, the team PA will be preparing these and you will use these as a basis to complete the discharge summary)

In- Patient Discharge summaries

These should include all the information on the admission summary plus:

- Date dictated.
- Date typed.
- Date of discharge.
- Diagnosis and Care Cluster on discharge.
- Medication on discharge.
- Care Co-ordinator.
- CPA level at time of discharge.
- Progress on the ward.
- Investigations and results.
- Any referral made or pending.
- Update of risk issues.
- Plan for follow-up.

Review of Patients

During their in-patient admission all reviews should be documented on Epex in the Ward Stay section.

Inpatient admissions also require medicines reconciliation, following which the relevant box on the kardex must be signed.

All medication kardexes should be filled out correctly with no omissions, in black ink using capital letters.

MDT reviews

Review records must include;

- The names and designations of all present.
- A summary of the discussion about the patient's progress and relevant events since the last MDT review.
- A summary of any interview with patients or relatives. Third party information should be clearly marked.
- A summary of any interview with the patient.
- A summary of current mental state.
- Current medication should be recorded and reasons for any medication changes should be documented.
- Any changes to risk should be recorded.
- There should be a clear plan recorded.
- The Minutes should be agreed by all present.

For All Patients

Telephone contacts or meetings regarding patients

Any telephone contact with the patient, their GP or third parties need to be recorded as soon as possible after the event on Epex.

Third party information should be clearly labelled.

Paper Records

Any paper correspondence received about or from patients should be signed and scanned into the Documents section of Epex as soon as possible.

There may be instances when junior doctors need to make handwritten records, for example when assessing someone in A&E or in the out-patient clinic etc.

These records should be

- Clearly labelled with the patient's name and X number at the top of each page.
- Made in black ink only.
- The date and venue of the review should be recorded.
- The names and designations of all persons present should be recorded.
- All entries should be signed and dated with name and designation printed legibly.
- The written records should be scanned on to Epex as soon as possible and the original document destroyed. If the written document is not going to be followed by a Statement of Care or Initial Assessment document on Epex, it is good practice to put a contact on to Epex signalling the existence of the document within the documents section.

June 2015 R McCutcheon

Equality and Human Rights Analysis

Title: IT06 Health Records Policy & Procedure
Area covered: Trustwide

What are the intended outcomes of this work? <i>Include outline of objectives and function aims</i> This policy is issued as guidance to everyone working with Health Records who records, handles, stores or otherwise comes across Service User information within the Health Record
Who will be affected? <i>e.g. staff, patients, service users etc</i> Staff, Service Users, Carers

Evidence
What evidence have you considered? At review the policy was read be reviewing analysts
Disability (including learning disability) At review no change was noted
Sex At review no change was noted
Race At review no change was noted
Age At review no change was noted
Gender reassignment (including transgender) There are specific requirements within Health Record process in relation to Gender Reassignment.
Sexual orientation At review no change was noted
Religion or belief At review no change was noted
Pregnancy and maternity At review no change was noted
Carers At review no change was noted
Other identified groups At review no change was noted
Cross Cutting At review no change was noted

Human Rights	Is there an impact? How this right could be protected?
Right to life (Article 2)	<i>Use not engaged if Not applicable</i>
Right of freedom from inhuman and degrading treatment (Article 3)	<i>Use supportive of a HRBA if applicable</i>
Right to liberty (Article 5)	
Right to a fair trial (Article 6)	
Right to private and family life (Article 8)	
Right of freedom of religion or belief (Article 9)	
Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)	
Right freedom from discrimination (Article 14)	

Engagement and Involvement <i>detail any engagement and involvement that was completed inputting this together.</i>

Summary of Analysis <i>This highlights specific areas which indicate whether the whole of the document supports the trust to meet general duties of the Equality Act 2010</i>
Eliminate discrimination, harassment and victimisation
Advance equality of opportunity
Promote good relations between groups

What is the overall impact?

Addressing the impact on equalities

There needs to be greater consideration re health inequalities and the impact of each individual development /change in relation to the protected characteristics and vulnerable groups

Action planning for improvement

Detail in the action plan below the challenges and opportunities you have identified. *Include here any or all of the following, based on your assessment*

- Plans already under way or in development to address the **challenges** and **priorities** identified.
- Arrangements for continued engagement of stakeholders.
- Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)
- Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service providers and regulatory bodies
- Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results
- Arrangements for making information accessible to staff, patients, service users and the public
- Arrangements to make sure the assessment contributes to reviews of DH strategic equality objectives.

For the record

Name of persons who carried out this assessment:

Gina Kelly

Reviewed Gina Kelly – no changes required

Kate Greenwood

Reviewed by Gina Kelly and Meryl Cuzack – no changes required

Lee Ellison

Date assessment completed:

19/02/2012

4th December 2015

10th & 23rd October 2016

Name of responsible Director:

Jim Hughes

Date assessment was signed:

19/02/2012

