LOCAL DIVISION – HEALTH RECORDS PROCEDURES

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 ☒ 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 temporally 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
6. Add address
The following window will be displayed:
7. In the Address Type section, click on the down pointing arrow button and click on the Temporary Address option.
8. Click on the Magnifying glass and complete the remaining mandatory fields for the Temporary Address.
9. Click on the Save button.

If a Temporary Address is added with an end date the Show Closed option (bottom right of the window) must be 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.

REGISTRATION on EPEX

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 in not unknown 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.

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 quiet 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 use 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: May 2018
Next Review Date: December 2019

MERSEY CARE NHS FOUNDATION 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 where 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 where 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.

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