SECURE DIVISION – HEALTH RECORDS PROCEDURES

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 ***Please note:*** **the ward records are currently being phased out to ensure that out of date information is not referenced and a greater reliance on the electronic record is encouraged**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 <u>important</u> that patient information is not retained at ward level beyond its purpose.

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

2 MANAGEMENT OF PRE-ADMISSION INFORMATION FOR A PATIENT <u>NOT</u> ADMITTED:

The Admission Wards will accumulate pre-admission information relating to a possible patient admission. When it is known that a patient is <u>not</u> 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 <u>important</u> 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 <u>not</u> to be retained on the Admission Ward.

- The Admission Ward will take delivery of Part 1s.

- A member of the Mental Health Law Department (MHLD) will retrieve the Part 1s when visiting the patient on admission. The MHLD 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 MHLD 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 <u>important</u> 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 <u>important</u> 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 <u>important</u> 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 <u>utmost importance</u> 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.

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 <u>all</u> 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 Foundation 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 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 Foundation 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 Foundation 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 Foundation 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 , December 2016
Next Review: December 2018
Author: Health Records Lead for HSS

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

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 (MHLD), 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 MHLD create a Patient Front Information Sheet and attach to PACIS. The MHLD 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 MHLD visit the ward at the time of a patient's admission. If the referring Agency has provided Part 1s at this time, the MHLD 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 <u>important</u> 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 <u>Judicial Reviews</u>:

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 <u>Summary of Records Storage locations</u>:

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, 1st 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 <u>Do Not</u>:

- 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 MHLD 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 form 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 <u>Patient transfer to another High Secure Hospital</u>:

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

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

- Check the 'List of Wills' spreadsheet (in the HRD shared rive) 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 <u>trust Transport</u> 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 <u>Post</u> 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.

- 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.

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.

Implemented: January 2005
Reviewed: July 2012, July 2013, December 2014, October 2015, September 2016, September 2017, May 2018,
Next Review: December 2019
Author: Gina Kelly, Information Governance Officer/Trust Health Records Manager

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:**

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

CONTENTS	MAIN FOLDER	SUB FOLDER
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	Third Party / Non-Disclosure	**TP CHILD CONTACT ONLY (Non-Disclosure)**
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**	
LUNSERS	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**	

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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-**
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**

T

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