SPECIALIST LEARNING DISABILITY DIVISION – HEALTH RECORDS PROCEDURES

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

The Creation of Care Records

CARENOTES Care Records System

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

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

1. Access to Care Records

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

1.2 Pre Admission

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

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

1.2.1 **Ward Manager**

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

1.2.2 **Professional Clinical Staff**

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

1.3 Clinical Notes and Activity Notes

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

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

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

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

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

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

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

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

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

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

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

2. MOVEMENT AND RETRIEVAL OF CLINICAL RECORDS

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

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

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

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

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

2.2 Records on Discharge or Death

Forensic and High Support Services

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

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

When a patient/service user attends an Out Patient Clinic or is admitted to a General Hospital for treatment, staff on the ward must refer to

Procedure on Managing and Supporting Patient/Service User Attendance at Acute Hospital.

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

3. THE CLINICAL RECORDS TRACKING SYSTEM (ON SITE)

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

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

3.3 For all paper documentation associated with the clinical record the trust has in place a records management tracking system to ensure that the location of records is known at all times. This system is implemented via the Medical Records Department and the Records Manager and has responsibility for the implementation of a robust medical records documentation tracking system.

3.4 The Medical Records Department file is kept in the Medical Records Department. If at any time a Doctor or Medical Secretary may need to remove the file, the removal and return of the file is documented by local tracking in the Medical Records Department.

4. INCORRECT DATA ENTRIES

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

5. SYSTEM UNAVAILABILITY

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

5.2 System Permissions levels

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

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

5.2.3 Users are not permitted to browse care records for service users without a justifiable need to do so as part of the service user's health care provision. Accessing records without a justified need contravenes the Data Protection Act *(from May 2018 this will change to the General Data Protection Regulation)* and may result in disciplinary action being taken against the user.

5.3 Auditing System Usage

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

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

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

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

6. HEALTH INFORMATION CAPTURE IN CRS

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

7. LINKED SYSTEMS

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

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

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

8. REPORTING

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

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

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

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

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

9. SYSTEM CHANGE REQUESTS

Changes in working practices, new requirements, data set changes, improved functionality may require the system to be upgraded.
All system change requests will be formally managed by the Informatics Department Specialist LD Division.

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

10. CARENOTE FORMS

10.1 Medical Record Responsibilities

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

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

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

10.2 **Clinicians Responsibilities**

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

Clinical Group	Forms	Key Performance Indicators
MDT Client Team and Ward Staff	Clinical Note Specialism Referral Escort and Supervision HONOS Secure Diary Appointments CPA Local Health Measure Local Health Intervention Alerts Initial Treatment and Care Plan	 Mandatory SUS KPI in place within 24 hours
Consultants	ICD10 Psychiatric Formulation Integrated Care Plan	SUS KPI: 12 weeks KPI: Monthly Review

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

	Individual Risk Profile Medication Ward Round	KPI: 12 weeks and 6 Monthly Review Monthly
PTS	Specialism Referral Intervention & Review Therapy Status Reports (e.g. Post Admission Assessments)	KPI: 18 wks to commence therapy KPI: 12 wks
BNT	Specialism Referral Intervention and Review Behavioural Management Plan	Mandatory Mandatory In place within 24 hours
Life Skills, Psycho Education, Speech & Language	Specialism Referral Intervention & Review	Mandatory
Adult Learning Services	Day Service Schedule DNA & Extra Sessions	 KPI: DNA Rate
All Clinicians	Attachments Clinical Templates Templates	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.7 **Ward Rounds**

This document is required to be completed once a month on all wards, apart from the Medium Secure Unit, where it is every two weeks.

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

10.9 **HoNOS**
This form is completed by Qualified Nurses.

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

PTS Specialist Referral (KPI)

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

PTS Specialist Interventions (KPI)

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

Other Specialist Referrals

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

Other Specialist Interventions

- Prior to the intervention starting the *anticipated outcomes* should be recorded.

- It is important that the comments from each of the sessions is recorded on the form in the *comments* field.

- The end date of the intervention sessions should be recorded and the *actual outcomes* achieved commented on against the previously *anticipated outcomes.*

10.11 **Team Members**

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

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

10.12 **Medication**

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

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

MERSEY CARE NHS FOUNDATION TRUST

PROCEDURE FOR "MISSING" HEALTH RECORDS

- If after extensive searching health records are unable to be located it is essential that the "missing" record is reported to the trust's Health Records Manager.

- A full investigation should be undertaken by the senior member of the team in order to locate the records. This should include checking the Patient Information System for clues, speaking to the Healthcare professionals involved in the service users care, office searches or searches of the areas where the notes where last booked out to, speaking to the GP for further clues, library checks to eliminate whether the notes could have been misfiled.

- If after extensive searching the notes are still missing a temporary set of notes should be made up which are clearly marked "Duplicate". Efforts should be made to retrieve as much information as possible in respect of the service user to create a duplicate set this may involve obtaining copy letters from secretarial staff, results of any investigations which may have been performed. The Healthcare professionals should be advised of the situation.

- An adverse incident form must be completed via Datix recording the fact that the health record is missing. The Datix forms are available on the trust's website. The person completing the form should enter all relevant details and submit this. This will automatically be forward to the Datix team and a nominated reviewer for your area. The reviewer should record any additional contributing factors, actions taken/to be taken and once completed submit to Datix team.

- Details of the service user's name, identification number and last known recorded location must recorded on the "Missing Log Template". The locations that have been searched and individuals spoken to as part of the search should be recorded as well as time spent by Health Records Clerks attempting to locate the records.

- It is essential that these health records are still searched for on a regular basis and weekly searches should be undertaken.

- When the health records are found the Health Records Manager must be notified and an investigation undertaken into why the health records where not booked out accordingly or how they ended up at that destination.

- The duplicate set of health records must be retrieved and merged into the original set or any duplicate documentation no longer required should be shredded or put into confidential waste. Anyone involved in the original investigation process should be advised that the original health records have been located.

- The missing log templates will be reviewed on a quarterly basis by the trust Health Records Co-ordinator and information collated will form part of the quarterly report submitted to the Information Governance Committee to underpin the Information Governance Standards.

Procedure Format

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

Equality & Diversity Statement

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

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