

TITLE: MANAGEMENT OF MEDICAL RECORDS/SFH CASE NOTES AND ASSOCIATED PROCESSES PROCEDURE

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CONTENTS

	Description	Page
1	Introduction/Background	3
2	Context	3
3	Roles and Responsibilities	4
4	Procedure Details	7
5	Consultation	37
6	Equality, Diversity and Inclusivity Impact Assessments	37

1 Introduction / Background

Health records are a valuable resource because of the information they contain.

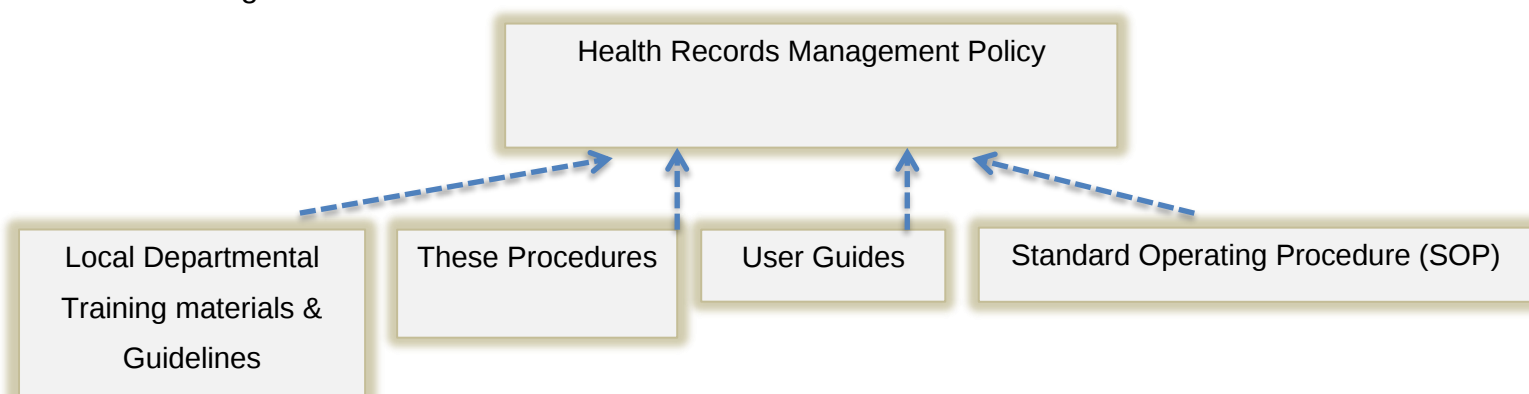
High quality information underpins the delivery of high quality evidence based health care, and many other key service deliverables. Information is of greatest value when it is accurate, up to date and accessible when needed. An effective health records management service ensures that information is properly managed and available when needed:

- To support patient care and continuity of care.
- To support day to day business which underpins the delivery of care.
- To support evidence based clinical practice.
- To meet legal requirements, including requests from patients under subject access legislation.
- To assist clinical and other audits.
- To support improvements in clinical effectiveness through research and also support archival functions by taking account of the historical importance of material and the needs of future research.
- Whenever and wherever there is a justified need for information; and in whatever media it is required.

These procedures support the Trust's Health Records Management Policy v8, and are provided to assist staff in meeting the requirements of this policy. It is important that these procedures are read in conjunction with the Health Records Management Policy. The procedures will promote a consistent approach to records management.

2 Context

As depicted below both the policy and procedures will be read and utilised in conjunction with local departmental guidelines and training materials as well as local and Medway SOPs and user guides.



Individual Responsibility of staff

All members of Trust staff are responsible for any record that they create or use. This responsibility is established at, and defined by, the law. Everyone working for the Trust and for the NHS generally who records, handles, stores or otherwise comes across information has a personal common law duty of confidence. The Data Protection Act places statutory restrictions on the use of personal information, including health information.

3.1 Who Is Responsible For Filing In Case Notes?

Every member of staff who handles case notes as part of their daily routine is responsible for maintaining accurate and tidy medical records. It should also be noted that staff who keep records in their offices, wards or departments are responsible for the safekeeping and security of the records whilst in their possession. It is also important that the records can be easily accessed by admissions staff on an emergency basis. Hence leaving records in a locked office out of office hours is not acceptable unless the admissions team also have a key/digilock number etc.

3.1.1 Ward Clerks/Receptionists

Ward clerks are responsible for filing all documentation in case notes whilst they are on the ward (investigation results, nursing documentation and any other loose documents) prior to transfer or discharge. Documentation must not be left attached to or loose within case notes.

It is entirely correct that ward clerks chase up junior doctors if hard copy results are not being signed. However, **at ward level only**, investigation results which have not been signed by the clinician can be filed in the case notes before the notes leave the ward. As results are usually acted upon by clinicians viewing the Orion system, it is not essential for test results to be signed off here. **Please note that this applies only to those received at ward level.** If results are received on the ward after the patient has been discharged, once checked by the doctor, the location of the case notes should be checked on PAS and the results sent on for filing as appropriate. Hard copies of normal test results can be disposed of in accordance with the disposal of confidential waste and do not need to be filed in case notes.

3.1.2 Clinical Diagnostic Coding Department

Notes should not be left for collection from the ward with any loose documentation or before being tidied, at KMH this is always checked by the Clinical Coding Staff (CDC) and at Newark by the patient administration clerk and filed appropriately, ensuring that documentation is in the correct patient's notes.

Any unsigned investigation results will not be filed but paper clipped to the front inside cover of the notes in order that these can be checked and signed off by the clinician after the notes have been coded. Case notes are routinely sent to the consultant's pathway co-ordinator after coding.

Staff in CDC are also responsible for filing any documentation which is sent to them whilst case notes are in their possession.

3.1.3 Pathway Co-ordinators, Audio Typists and Records Assistants

Pathway Co-ordinators are responsible for filing any documentation sent to them whilst case notes are in their possession. They are also responsible for ensuring any unsigned investigation results are checked and signed off by a doctor and then filed. However, it should not be assumed that all investigation results can be sent on to the pathway co-ordinators months after the patient has been discharged. Every effort should be made to ensure results are filed at the time they are received. It is now deemed appropriate for test results originating from an in-patient or day case episode to be filed unsigned by a clinician. **Outpatient generated results must be signed by the clinician before filing. Any loose filing not secured in case notes prior to notes leaving the department will be dealt with by the Records Assistants. If the notes are tracked to another specialty the filing can be passed to them for filing. If the case notes are in file, then the records assistants will attend case note store and complete the loose filing.**

Any letters typed about patient care are also filed by this team e.g. outpatient letters etc. Care should be taken to follow the approved colour coding scheme for typed correspondence as detailed on the dividers within the notes.

Pathway Co-ordinators are also responsible for any investigation results received in their office and ensuring they are either shown to the clinician or made available at the next OPD clinic appointment.

For any patient who “does not attend” (DNA) and is not allocated a further appointment, the referral letter should remain in the correspondence section of the case notes and returned to file.

Some patients are referred to Outpatients but subsequently may choose not to make an appointment or decide to cancel their appointment. In such cases and where PPCs manage referrals directly, they are responsible for sending the referral letter to Case Note Store for filing in the case notes. This should be done at the end of each month.

3.1.4 Clinic Prep

Staff in these areas are responsible for filing any documentation which is sent to them whilst case notes are in their possession, however, as case notes are with clinic prep for less than 3 days this will rarely happen (case notes are pulled and located for clinics 3 days in advance of the clinic date).

Some patients are referred to Outpatients but subsequently may choose not to make an appointment or decide to cancel their appointment. In such cases clinic prep staff are responsible for sending the referral letter to Case Note File for filing in the case notes. This should be done at the end of each month.

3.1.5 Waiting List Office Staff

Now that the waiting list file has been closed filing should not be sent to the Waiting List team at any point.

3.1.6 Pre-operative Assessment Unit

Staff in this department are responsible for filing any documentation which is sent to them whilst case notes are in their possession.

Any documentation completed during the pre-operative assessment should be filed before the notes leave the department. A plastic folder secured at the back of the case notes, second spine, is provided for this purpose and remains in the case notes until the patient is admitted for surgery. At this point the folder is removed and the documentation kept with the nursing notes until the patient is discharged when all documentation will then be filed as appropriate.

3.1.7 Case Note File/Admissions

Staff in this department are responsible for filing any documentation which is sent to them whilst case notes are in their possession. However, Records Assistants from clinical specialties are expected to attend case note store for the filing of their loose documentation if the notes are currently stored there.

As with the pathway co-ordinators, just because this is where the majority of case notes are kept it should not be assumed that all filing should be sent here.

Remember! It is not acceptable to transfer case notes from one department to another with loose papers inside. The risk of these falling out and getting lost or finding their way into the wrong set of notes is too great. Anyone who finds loose papers inside case notes should be able to file them. Failure to do so is clearly a significant clinical risk.

3.1.8 Doctors, Nurses and Professions Allied to Medicine

It is appreciated that these persons have clinical responsibilities and that filing in the case notes may not be the most appropriate use of their time. However, using the adage 'A test is not done until the result is in the notes' it may be faster and more reliable for important test results to be filed away, as the result is reviewed, by the person doing the review.

It is certainly the responsibility of medical staff to sign off results as they are available, to indicate that the result has been assessed, acted upon if necessary, and that the report can be filed.

It should also be noted that the clinical professions have a duty to label clearly any new or loose pieces of paper in order that support staff can file them easily.

4	Procedure Details
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4.1	Where Should Each Document Be Filed In The Case Notes?
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This guidance essentially repeats the instructions, which are pre-printed on the lilac/green case notes themselves. For case notes which predate these (buff or grey sets) there is no formal case note structure, but ideally they should be filed in a similar way. There are of course much fewer of these in circulation now. There is a separate Maternity Filing Policy which should be used when filing maternity records. This too can be accessed via the Trust's intranet.

4.1.1 First Spine

1. Identification Sheet
2. Alert Notification or divider
3. Specialty Dividers
4. Safeguarding Divider – this is only added for the recording of information on the following:
 - Safeguarding Children
 - Safeguarding vulnerable adults
 - MAPPA information– Multi-Agency Public Protection Arrangements.
5. Correspondence

4.1.2 Second Spine

1. Clinical Coding sheet
2. Investigations 1
3. Investigations 2
4. Investigations 3
5. Operation Records
6. Allied Health Professional Records
7. Nursing/Therapy records

4.1.3 First Spine Dividers

Identification Sheet

This is a white sheet at the front of all case notes, which contains basic demographic data, which duplicates that held on the Medway PAS system (Patient Administration Computer system) and a list of recent attendances and alerts.

If **at any time** you interact with the patient please ensure that name, date of birth, address, telephone numbers, and GP details are all accurate. Then ensure that any changes are recorded on Medway PAS and a new ID sheet printed and filed in the case notes. Be aware that it is not advisable to make notes on this sheet if they need to be retained as this sheet does not remain in the case notes. An updated version showing all recent attendances is provided for each attendance, or when patient demographics are updated on Medway PAS.

Sometimes we have patients who have been adopted or have undergone or going through gender reassignment. As a result many of these patients require their details to be updated on Medway and on their case notes. Please do not make these changes without taking advice from either the Patient Services Manager or the Medway PAS Manager.

Please note that only Admissions staff will make changes to the date of birth, at the same time ensuring that new bar code labels for tracking purposes, identification labels and front sheets etc. are placed in the case notes.

This is particularly important as at SFH the patient's date of birth is the basis used to file and locate case notes. Failure to replace the bar code labels on the patient's case notes could result in clinical risk, as it would be difficult to then locate the case notes, with the numbers no longer matching.

4.1.4 Alert Divider

The process followed in relation to Alert Dividers is in line with the Trust's Alert Policy.

An alert divider will be found in the front of all case notes. This should be used if indicated by the individual patient circumstances. There are 6 alert groups as follows:

- 1. Security – Blue**
- 2. Allergy/Anaesthetic – Red**
- 3. Infection Control – Yellow**
- 4. Disability Alerts – Aqua**
- 5. Clinical Alerts – Orange**
- 6. Administration Alerts – Purple**

There are multiple alert types within each group. Further details can be found in the Alert Policy and the associated document; Adding Alerts in Medway and in the main SFH NHSFT Case Notes.

The Alert Policy intends for the alerts within the case notes to match the alerts on Medway. They are colour coded and the alert divider reflects this.

Very important documents may also be filed immediately behind the red divider. This would include 'Allow Natural Death' forms, or notification of Advance Directives to Refuse Treatment ('Living wills') and copies of documented power of attorney.

Please highlight to the doctor responsible if you ever suspect that important information is missing from this.

When a new volume of case notes is created, the old Alert Divider will be removed from the most recent volume and placed in the new one if it has alert information written/stickers on it. Before placing the divider in the new volume a photocopy will be taken and placed in the previous volume. Case Note File standing operating procedures provide full details of how this is to be done.

4.1.5 Specialty Dividers

This is the section that doctors will write in. It should have one or more dividers to stop different specialties' notes from becoming mixed together:

Medical = Green divider
Orthopaedic = Yellow divider
Gynaecology/Paediatrics = Pink divider
Surgical = White divider
Maternity = Blue divider (set of 5)
Oncology = Lilac divider
Pain = Cream divider
Breast = Orange Divider

History and continuation sheets that are written on by clinicians should be filed in chronological (date) order within each of these dividers, from earliest at the front to latest towards the back. Each sheet should be clearly marked with the consultant and patient's names and the patients ID number. A patient addressograph label can be stuck to the page to ensure the latter. Anyone preparing case notes should ensure this.

Inpatient and outpatient notes are not filed separately within each Divider – if a patient has been admitted to hospital then the next outpatient clinic should follow on a new page after the last inpatient page. Similarly any inpatient written records should follow on from the last outpatient episode.

The hospital prints flashes of colour on the corners of the history sheets to allow specialties within each section to keep their note taking together e.g. urology separate from general surgery within the surgery divider, respiratory separate from cardiology within the medicine divider. If you don't have the correct colour flashes for the corresponding doctor, then more can be obtained via forms management from Procurement, or the generic white 'continuation sheet' can be used as long as the consultant details are written at the top.

Letters – especially hospital clinic letters – should not be filed in this section at all. Originals should be filed in the correspondence section. The Obstetric department also files an additional copy of their referral letter with the maternity booklet in the obstetric section.

Operation records should be filed in the Operation Records divider in the second spine. but if they have been hand written in this section (section A3) they should be written in red ink to highlight major episodes in the patient's treatment. The red ink rule also applies to scope procedures e.g. cystoscopy, endoscopy, colonoscopy, etc which are otherwise filed in divider B8, as are intrauterine procedures. Similarly positive microbiology and cervical smear tests in GU medicine.

Maternity hand-held records should be filed in the Obstetric section of the notes once the pregnancy has completed. Foetal monitoring or CardioTocoGraphs (CTG) should also be filed within the maternity divider and not within "Investigations 2" as previously.

4.1.6 Safeguarding (RED with "Safeguarding" written on the tab)

All safeguarding information is filed within this divider e.g. confirmation of referral to Children's social services, child protection reports, case conference minutes and reports, chronology of attendances. The divider is not restricted to paediatric records; it is also used for safeguarding issues relating to the safeguarding of vulnerable adults and any information relating to Multi-Agency Public Protection Arrangements (MAPPA).

If this divider is placed in the record a sticker is also placed on the red alert divider to indicate that sensitive third party information is contained within the record. If a patient with a safeguarding divider is allocated a new volume of case notes, then the safeguarding divider should be taken from the current volume and photocopied. The photocopy should be placed in the current volume and the safeguarding divider and all documents store behind it should be transferred into the new, latest volume.

4.1.7 A5. Correspondence

All letters should be filed within this section. This includes GP referral letters, outpatient clinic letters and ward discharge letters.

Secretaries typing clinic or ward discharge letters should follow the colour coding scheme as above in section 3.6 and print out case note copy letters on coloured paper – this ensures that whilst different specialties letters are filed together in date order, anyone looking through this section can quickly pick out letters by type of medical problem. Electronically generated discharge letters should also be filed here

4.1.8 Second Spine Dividers

Clinical Coding Sheet

This is a white printout for clinical diagnostic coding. This enables the doctor responsible for the patient's care to note what problems the hospital has recorded the patient as having experienced during any recent in patient/day case episode of care. Incorrect coding can mean the Trust is not paid appropriately for the work it has done. Doctors should therefore review the details and sign their agreement with the diagnosis or contact clinical coding if there is an error.

When a patient is admitted either from the waiting list or as an emergency, a "re-peelable" CDC sticker will be stuck to the front of their case notes to indicate that diagnostic coding will be necessary. This is very important to ensure that coding can take place as soon as possible in order to support the Trust's income flows.

4.1.9 Investigations 1

This section should contain printed reports of all the patients' investigations. The reports are mounted on the appropriate mount sheet. Colour coding is also used for the mount sheets:

Pink = Haematology

Green = Biochemistry

Blue = Microbiology (Bacteriology/Virology/Serology)

Yellow = Histopathology/Cytology/Immunology/Blood Bank

Black = Radiology – which now has full A4 size reports and are therefore filed immediately behind this sheet rather than mounted on to it. As previously.

These can be ordered from procurement via the “forms management “ordering process. If you are in doubt ask your manager or procurement about this.

There are 11 sticky strips to each mount sheet – **do not stick more than this number of reports to one mount sheet using sellotape** as the mount sheet is then too heavy and tears out of the notes. If you finish one mount sheet please obtain a fresh one as needed. Sellotape will also perish over time and the results may then fall out of the case notes.

Care may be needed in filing blood bank, radiology or immunology reports, as these are all printed on white paper, but are filed on different mount sheets. A quick scan of the report should tell you on which mount sheet to file it.

Use common sense – if histopathology has produced such a long report that they have printed it on an A4 sheet then hole punch it and file this next to the histopathology mount sheet – don't fold it up to stick it on the mount sheet. It is important that different types of test results do not get mixed up.

Results should only be filed once the doctor who has requested the test has reviewed the result and signed the result. There are two exceptions to this rule: hard copy results received at ward level and normal test results. This ensures that vital or dangerous results are not missed. In areas with rapid doctor turnover then the doctor currently on duty should be asked to scan them quickly for dangerous results which may need immediate action. It is one of the key responsibilities of junior doctors to review test results and act upon those needing intervention (even if that action is only to alert the team who were looking after the patient previously). Test results requested on the Emergency Assessment Unit (EAU) will not be sent to EAU as it is likely that the doctor requesting the test will no longer be on call. Such results will be sent to the consultant's office for checking, action, signing and filing.

Hard copies of computer results reporting screens will print off with “DO NOT FILE, COPY ONLY”. It is not necessary to file these unless it is obvious that the original has not been filed.

4.1.10 Investigations 2

This is the section for all 'full page' results reports (except if they fall into the categories above). This might include:

Inpatient cumulative results charts
Audiology reports
Bladder cancer cystoscopy reports
Bronchoscopy
Gastroscopy or Enteroscopy reports
Colonoscopy or Sigmoidoscopy reports
Nerve conduction studies
Developmental screening
Growth charts
Oncology treatment records
Respiratory function tests
PUVA/UVB charts from dermatology
Echocardiograms
Cardiac Angiography Reports

CardioTocoGraphs (CTG) should now be filed within the maternity section in the first spine in an envelope that has been hole punched and then sealed with a treasury tag at the opening flap to stop the trace escaping.

Some of the older buff dividers have two errors on this divider:

- Photographs should no longer be stored in notes, but a note kept of their existence on the trusts digital image database (accessible through the Orion computer system).
- ECG, exercise ECG and 24 hour tape reports should all be filed in the next divider (Investigations 3).

This error has been updated on the later prints of case notes and all lilac copies

4.1.11 B9. Investigations 3

This divider is for any result with an ECG tracing on it. They should be filed in strict date order so that changes can be compared over time. **ECG pages should all be hole punched at the bottom of the page** so that the patients name and the date of the recording are furthest from the margin.

4.1.12 B10. Operation Records

This divider should contain all documentation relating to operations. This will include the operation note (unless it was written in red ink within the specialty divider, A3); yellow consent forms, anaesthetic records and other theatre related paperwork.

4.1.13 Allied Health Professionals

This divider is provided for all professions allied to medicine to file, and/or record activities relating to their service. The staff groups involved are as follows:

Physiotherapy
Occupational Therapy
Orthotics
Speech and Language Therapy
Dietetics
Chaplaincy
Clinical Psychology

Now that Sherwood Forest Hospitals has responsibility for some Psychology services, arrangements have been made for record keeping for Psychology patients as follows:

Out patients – patients attending the psychology service as an outpatient will have a separate set of SFH Psychology notes. These have a blue folder to differentiate them from the main green sets. They too can be tracked from one location to another so that they can be located easily when required.

In patients Stroke Unit – Psychology records will be filed in the main green/lilac SFH notes behind the Allied Health Professionals divider. Running records and psychometric records are to be kept in a 'sealed envelope' in the SFH notes. This will be an opaque/solid plastic folder with a press stud opener whilst the psychologist is seeing the patient. After the episode of care is completed, notes will be placed in a paper envelope which is then sealed up. In both cases, the envelopes will have a pre-printed Information Governance sticker warning that these notes are to be accessed by Clinical Psychology only.

4.1.14 Nursing records

This section is usually fairly bulky, as it will include all the paperwork generated by nursing staff during a patient's admission. This will include:

Admission nursing assessment
Care plans
Evaluation sheets
Patient handling plans
Waterlow scores
Nutritional assessments
Nursing transfer letters
Observations (Temp Pulse BP) charts
Fluid balance
Peak flow charts
Food records
Stool charts
Urinalysis records
Glasgow coma scale charts
NEWS/Early Warning Score charts
Barthel charts
MRSA Screening & De-colonisation checklist.

This divider should also be used to file charts which are filled in by doctors, but used by nursing staff such as:

Drug charts
Fluid prescription charts

4.1.15 The Sticker Pocket

Newer sets of case notes incorporate a plastic pocket inside the back cover. This is to be used for patient sticky labels only. If you see other documents filed in this then please remove them and file them correctly.

Older case notes may have a larger cardboard pocket built into the back cover. Whilst strictly speaking this should only be used for sticky labels, it has historically been used to loose file letters and other papers. These should be filed correctly. Where time permits case note stores on both sites will convert old brown/grey sets to new lilac ones when pulled from file for appointments or admissions.

If the case note covers are falling to pieces and the notes need to be re-housed, then the Case Note Store team will be asked to repair or replace with a new SFH lilac set, but can otherwise be left alone.

4.1.16 Aligning Sheets Before Hole Punching

All sheets to be filed in the case notes should already be appropriately hole punched. If not they should be punched “centred”, either by using the device which may be on the hole punch, or by folding the sheet and making a small crease on the edge and then lining this up with the guide on the hole punch. If this is not done and sheets are not aligned the case notes begin to look very untidy and quite often sheets will hang outside the cover, become damaged and torn and may fall out of the case notes all together, thus resulting in clinical and information governance risk.

4.2	Principles Of Records Management
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4.2.1 What are the principles to follow?

Records are valuable because of the information they contain, but the information is only usable if it is correctly and legibly recorded when the record is created, and is then kept up to date, is only accessible to those with a legitimate need and is closed and disposed of when appropriate.

4.2.2 Good record keeping ensures that:-

- Staff can work with maximum efficiency without having to waste time hunting for information.
- There is an audit trail which enables any record entry to be traced to a named individual at a given date/time with the secure knowledge that all alterations can be similarly traced.
- Those coming after can see what has been done, or not done, and why.
- Any decisions made can be justified or recognised at a later date.

4.2.3 This is essential for the following reasons:-

Providing effective patient care.
 Clinical liability.
 Parliamentary accountability.
 Purchasing and contract or service agreement management.
 Decisions on service delivery.
 Financial accountability.
 Disputes or legal action.

4.2.4 It is therefore important that you always:-

Record all relevant information, making sure that it is complete.
 Ensure that it is legible so that it can be read easily and reproduced when required.
 Keep it filed where it can be found when needed.
 Keep it up to date.
 Explore alternative methods to share information rather than copying it in order to reduce risks to confidentiality.
 Suitably dispose of records as soon as possible (subject to national and local retention periods, see Retention and Destruction Policy).
 Remember that the originator is the person who has the ultimate responsibility to retain control over the original document and subsequent amendments.

4.2.5 What needs to be done to achieve the best standards?-

Managers in all areas need to ensure that staff are aware of legislative requirements such as the Data Protection Act and the Freedom of Information Act. They should also be aware of the vital role that records play in delivering health care.

4.3	Information Asset Owners Responsibilities
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4.3.1 Each Divisional Information Asset Owner will:-

- Assess the current standard of record keeping.
- Develop professional standards and co-ordinate and liaise with colleagues within the health sector to develop best practice.
- Conduct a records audit (to identify what records collections already exist and why).
- Establish access controls.
- Performance manage the records management process.
- Liaise with appropriate IAAs to ensure that any risks to medical information are documented and escalated to the appropriate IAO.

4.3.2 Rationalise records collections by:-

- Encouraging users to share records and the information they contain (subject to Data Protection and agreed confidentiality guidelines).
- Ensuring effective cross-referencing or merging.

4.3.3 Put the proper controls in place by:-

- Producing local standards.
- Communicating the standards by issuing the policy as a reference point for staff.
- Using the policy as a basis for audit activity.

4.3.4 Publicise and promote the local guidelines by:-

- Implementing a formal training programme to launch and support the records management policy.
- Including records management in induction training and staff handbooks.
- Staging awareness raising sessions using real examples to demonstrate the benefits and place articles in the Trust's newsletter; speaking at team briefings and other meetings.

4.3.5 And finally, maintain standards by:-

- Promoting quality through the professional skills and qualifications of key personnel.
- Monitoring performance through quality control and internal audits.
- Identifying areas where improvements can be made.
- Reporting breaches through incident reporting, investigating and improvement.
- Reporting performance standards to the Information Governance Manager, Information Governance Group and Risk Committee.
- Undertaking records review at appropriate times to identify records for destruction, permanent preservation or archiving in accordance with the Records Retention and Destruction of Records Policy.

4.4	Standards For Patients Records
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4.4.1 Records will include the following core patient/client information:-

- Full name.
- NHS Number whenever possible.
- Address, including post code.
- Telephone numbers, ideally home, work and mobile.
- Date of birth.
- Sex.
- First language (if not English).
- For in-patients, the contact name and number for person to notify in an emergency (next of kin/personal representative).
- General medical or dental practitioner including name, address and practice number where known.
- If a patient has been adopted it is imperative that their birth details and name are NOT recorded anywhere in their records.

Physical Aspects Of Record

- 4.4.2** The record will contain clear instructions regarding the filing of documents within it.
- 4.4.3** All patient documentation, including machine produced records, must be securely filed within the record, in the specified order and behind the appropriate divider. Inside pockets or flaps should not be used. Only patient labels should be stored in the back pocket of the record.
- 4.4.4** All staff who use and are responsible for storing notes have responsibility for filing within case notes whilst they are in their custody. Detailed guidance and responsibilities regarding filing is found in Appendix 3 of this policy.
- 4.4.5** CTG Recordings are securely stored in re-sealable, hole punched, manila envelopes and stored in the main body of the notes .
- 4.4.6** A designated place in the record is to be used for operation notes, invasive diagnostic notes and other key procedures. A divider is found in the second spine of the case notes for this purpose.
- 4.4.7** The record should make reference to any other sets of records held for the patient within the Trust (see 'Multiple Sets of Case Notes' below). If a patient has been adopted and has a new identity and we have been made aware a sticker will be placed on the alert divider to indicate that the patient has other notes. Access to these notes can be made by SFH employees by contacting the Patient Services Manager or Team Leader, Case Note Store.
- 4.4.8** All professionals' health records for a patient will be filed together on discharge or death wherever possible.
- 4.4.9** There will be a standard format for the outside cover of health records created within the Trust. This cover will have core information only and the folder will be clearly marked as follows:

SHERWOOD FOREST HOSPITALS (NHS FOUNDATION TRUST) CONFIDENTIAL NOT TO BE REMOVED FROM THE HOSPITAL

A sticker will then be attached to indicate whether the record will normally be held at the King's Mill or Newark records store when not in active use.

- 4.4.10** Records not for destruction within normal timescales will be clearly identified. This may include records where there is litigation pending or where the records are being retained for research purposes. These records will be prominently identified on the front or inside cover marked "request for permanent retention by".
- 4.4.11** The clinical records from all professional groups i.e. medical, nursing, physiotherapy etc are all a vital part of the client's record. These records shall be filed together in the same record wherever possible and to ensure that the client/patient's clinical information is kept together and that vital pieces of clinical information are not missing when decisions are made.

Multiple Sets Of Casenotes

- 4.4.12** The Trust will continue to work towards a reduction in multiple case notes for one patient but in the short term records will highlight the cross references to one another both manually on records and via access to computer linkages between services.
- 4.4.13** Where the patient has more than one set of current records within the Trust, each set of records will highlight the existence of the other set/s of records including the registration number wherever possible e.g. where a patient has two sets of records this will be identified prominently at the front of each record.
- 4.4.14** Where it is appropriate to have separate records e.g. physiotherapy, there needs to be a link to the combined case notes to ensure that all parties are aware of the other's involvement in the care of that particular patient.

4.5	Developing And Updating Clinical Documentation/ Forms To Be Filed Within Case Notes
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Initial Guidance and Advice

4.5.1 Is the documentation/ form required?

- what are the indications for use/purpose of it.
- which staff will be completing it.
- which patients will it be used for.
- does it complement a specific clinical policy/guideline.
- has agreement been sought and gained for the development/revision of the documentation/form.

4.5.2 Is the documentation/ form new or being revised?

- Scope requirement to ensure no duplications.
- Potentially undertake joint working if a document/form is already in production.
- For more complex, lengthy or detailed projects, consider if a small working group/'task and finish' group is required.

4.5.3 Which staff groups will be using the documentation including any training issues?

- Aim for it being used by an inexperienced member of staff.
- Ask junior staff to review the draft document during the development/revision process – can they understand it/would they know how to use it.
- If the documentation is new or has undergone a major revision, consider if training is required (e.g. rolling programme by the author/specialist; link staff; general dissemination of supporting written information etc).

4.5.4 Printing documentation/forms

- Prior to undertaking the project/early in the process identify funding for the printing of the documentation/form.
- If the documentation/form is being externally printed, where possible, ensure it is produced 'pre hole punched' in preparation for filing. (There may be an extra charge for this).
- Where possible develop/revise documentation/ forms in black and white/greyscale (including the Trust logo). Only use colour if it is of significance to the documentation/form.

4.5.5 Template – portrait/landscape

- Standard blank templates have been produced in both portrait and landscape – the standard 'sticky label'/ID box; Trust logo; and minimum document control details have already been applied. The margins have been initially set at 2cm all round. Select the most appropriate template.
- for the printing of the documentation/form.
- If the documentation/form is being externally printed, where possible, ensure it is produced 'pre hole punched' in preparation for filing. (There may be an extra charge for this).
- Where possible develop/revise documentation/forms in black and white/greyscale (including the Trust logo). Only use colour if it is of significance to the documentation/form.

Essential Elements

4.5.6 Obtain the relevant template (portrait or landscape)

- Request from the Patient Services Manager or Deputy Director of Nursing & Quality. (At the same time you may also wish to request examples of some completed documentation/forms to help with your project).

4.5.7 Standard 'sticky label'/ID box

- For single page documentation/forms, ensure the standard 'sticky label'/ID box is evident (already applied to template). This ensures that all patient details can be hand written if an ID label is not available for use.
- When printed the box should be approximately 7cm x 3.5cm.
- The size/details required within the standard 'sticky label'/ID box may be changed if the documentation/forms are for use within specific clinical areas where the ID labels are produced in a different format/size (i.e. Emergency Department, Radiology). Forms will be considered on a 'case by case' basis.

Please note: For multiple page documentation/forms subsequent pages must have space for at least the patient's name and date of birth (usually across the top of the page). However, this is not needed if the form is going to be printed double-sided or pre-printed.

4.5.8 SFH logo

- The logo ensures the documentation clearly originates from and is in use by our Trust. This is particularly useful if medical notes need to be transferred to external organisations e.g. other Trusts, or are required for legal purposes.
- The logo is set at a specific size for displaying on A4 paper (applied to template). If required the logo can be reduced in size to accommodate other information. Please ensure it is reduced from the corner to ensure it is not 'squashed'/becomes disproportionate.

Please note: For multi-page documentation/forms, the Trust logo is only required on the first page.

4.5.9 Margins

- For single sheet documentation/forms – leave a sufficiently wide margin (approximately 2cm) on one side to ensure once hole punched it can still be read when filed within the case notes.
- For multiple page documentation/forms – ensure the above principles apply to all sides being hole punched.

4.5.10 Document control

- **Job title/role** – include the author's job title/role responsible for the form. This will help ensure the correct person is approached to review and update the form when it is next due for review.
- **Issue date (month year)** – this identifies when the form is implemented and also indicates the dates of subsequent revisions of the form. (Please note this is not the month of approval unless they are the same.
- **Review date (month year)** – this identifies when the form is due for review. This is usually a maximum of 3 years from approval unless a shorter period is necessary. The review date may also be shortened if the form is for pilot use. Further advice can be obtained from the chairman of the MRAG or NDG.
- **Version number** – it may be appropriate to include a version number as well as the issue date. Further advice on this can be obtained by the chairman of the MRAG and NDG.
- **To be filed in** – this information is required to highlight where in the medical notes the documentation/form should be filed. This ensures consistency and ease of finding the relevant documentation/form at a later date should it need referring to. Further advice can be obtained from the chairman of the MRAG.
- **Documentation/forms which are appendices to clinical policies/guidelines** – Occasionally documents which are to be filed in case notes are appendices of policies, it is however, still necessary for this information to be on the form although it may be more relevant to display the information within a text box in an appropriate place on the form instead.

4.5.11 Number of pages

- For efficiency try and use an even amount of pages to reduce unnecessary waste of space.

4.5.12 Title

- Ensure the documentation/form has an appropriate short title. This will help to easily identify what the form is to be used for.
- If the form is published to the intranet, (usually those which are not available through forms management, the title will be used to help search for it.

4.5.13 Appropriate space to record date and time

- Ensure space is provided to record the date and time the documentation/form is completed.
- Consider if this needs to be once to indicate completion of the whole form or if multiple spaces need to be included to record information weekly, daily, hourly etc.

4.5.14 Appropriate space to record signature, print name and where relevant include job title/role

- Ensure space is provided to record the signature of the person completing the form.
- If multiple spaces are used it may be more appropriate to include space for initials only.
- Where possible include space for the person completing the form to print their name (and if required their job title/role).

4.5.15 Type font and size

- Trust standard is Arial 12pt.
- Where possible stick to the above standard.
- Depending on the documentation/form and its use it may be appropriate to increase or decrease the font size.
- Any variations will be discussed and considered during the consultation and approval process.
- Where possible, use **bold type for emphasis**; rather than underlining; *or italics*.

4.5.16 Mental capacity

- Where applicable, ensure information is included to prompt the user to assess a patient's capacity (if it is in doubt) using the two stage test. If the patient lacks capacity then a best interest's checklist should be completed and care planned in the patient's best interests.

Desirable Elements/Further Considerations

4.5.17 Displaying the information/layout

- Consider using flowcharts, text boxes, arrows and bullet points etc. to help ease comprehension when reading and the usability of the documentation/form.
- Ensure the information 'flows' within the document i.e. follows the patient journey.

4.5.18 Pictures/images

- Ensure any pictures/images are big enough to be clear and legible.

4.5.19 Instructions/guidance for using the documentation/form

- If the documentation/form complements a specific clinical policy/guideline the instructions for use may be included within that document. However, it may be useful to include some basic instructions/guidance on the documentation/form to help the relevant staff complete it correctly and gain appropriate compliance.
- This may include the appropriate timeframe/timescales for recording the relevant information (e.g. the start/ end time of the form, 00:00 – 24:00).
- Consider using one page of the documentation/form to give guidance and instructions on how to use it and the other for recording purposes.

4.5.20 Additional information if required

- Consider if space is required for “additional information” to allow for the recording of any further details either not covered within the documentation/form or for recording the individualised requirements of the patient (i.e. to personalise it).

4.5.21 Page numbers

- For multiple page documentation/forms, consider using page numbers. Where possible use the format “X of Y”.

4.5.22 Consultant/clinical area

- Consider if it is necessary to record the patient’s consultant and what ward/clinical area they are being nursed in.

4.6	Other Health Records
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4.6.1 Accident and Emergency/Emergency Department Records

The Accident and Emergency record will be contained in the main SFH record for patients who are subsequently admitted, with a copy being kept in the A&E department.

There is a system for ensuring that the GP is sent details of the Accident and Emergency attendance.

Accident and Emergency records are stored separately to the main SFH case notes. They are stored in slip files, beige coloured for adults and blue for paediatrics. Key details to be noted:

- The storage and management of A&E notes is the responsibility of the A&E department.
- The current year’s notes are stored within the department whilst previous years notes are archived to other storage areas on the KMH site. The records are filed according to the A&E attendance number.

- A&E notes for children under the age of 8 are always merged to ensure multiple attendances are noted to support safeguarding of children processes.
- A&E notes are not permitted out of the department. Anyone requiring access to them are required to attend the department and where appropriate take copies.
- New records are prepared by the A&E receptionists at the time of patient attendance.

4.6.2 Therapy Notes

The Therapy Department also keep a separate record for their patients, although some documentation will be recorded in the main SFH notes, in particular those relating to in patients. Key details to be noted:

- The current year and previous 2 years records are kept within the Therapy Department in alphabetical order by patient name. Previous years notes are archived in secure storage areas also on the KMH site but away from the department.
- Access to Therapy notes can be arranged via the Therapy secretarial team on extension 4265 or 4267.
- Notes for current patients who are still attending are stored securely in the relevant treatment area, being pulled from file and returned after use by the relevant therapist.
- New records are prepared by the Therapy Admin team prior to the patient's attendance.

4.6.3 Psychology Notes

Patients attending the outpatient Psychology service will be provided with a separate Psychology record folder. Key details to be noted:

- Records of current patients are kept securely in Clinic 9 where the Psychology service is provided.
- Archived records are also kept on the KMH site in an archive storage area.
- Access to Psychology records can be arranged via the Psychology team secretaries on ext 6692.
- In patient Psychology records are made in the main SFH folders and are filed behind the Allied Health Professionals divider.

4.6.4 Sexual Health Records

Sexual Health Records are now kept electronically with no new registrations being allocated paper records. Archive records are stored with an off-site storage company. The Sexual Health Team regularly call back paper records which have reached the point at which they can be destroyed.

HIV patient records are recorded in the main SFH records in accordance with national guidelines.

Access to Sexual Health Records is limited but can be arranged via the admin team in the sexual health department.

4.6.5 Adopted Persons Records

The records of adopted persons will need to be altered to reflect their new name and identity and any previous records will be archived. This process will be completed/organised by the Patient Services Manager and or Case Note Store Team Leader. No other staff members should make any changes to records in order to ensure legal requirements are complied with and to reduce clinical risk.

More detailed information about records of adopted patients can be found in the Trust's Adoption Policy.

4.6.6 Records Of Transgender Patients

Records of transgender persons will be altered in line with the wishes of individual patients. Again this will be carried out by the Patient Services Manager who will ensure that the process is completed in line with the patient's wishes and in accordance with associated legal requirements. Any staff member who is aware of a transgender patient or who is asked to make changes to either Medway or the case notes to reflect a new identity should consult the Patient Services Manager/PAS Manager

4.6.7 Diaries

It is the Policy of the Trust that diaries should not be used to record clinical information except in circumstances where the healthcare professional does not have access to the patient healthcare record. In the exceptional circumstance of clinical information being added to a diary then this information should be transferred to the patient's record as soon as possible.

4.7	Storage, Security and Tracking of Case Notes
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4.7.1 All health records must be traceable at all times. When not in use all health records must be held in a designated secure records store. For the Mansfield locality this is at King's Mill Hospital and Newark Hospital also has a secure records facility.

4.7.2 Records will be filed in accordance with local service procedures and will be done in such a way to ensure quick and easy retrieval out of hours.

4.7.3 There will be an effective and compulsory tracking system for records so that the whereabouts of a particular set of records is known at any one time. This is currently provided on Medway PAS.

4.7.4 **Everyone** responsible for using patients' case notes will ensure that they are promptly tracked in and out of the appropriate location on the Medway PAS system (Patient Administration computer system). Support in the tracking of notes is always available from the Admissions staff who provide a 24 hour service. However, it is expected that all staff will be trained in this process and are responsible for tracking of notes as a general rule. Nottinghamshire Health Informatics Service provide the training in this aspect of Medway, and staff will not be allocated individual Medway access until they have been trained in this important role.

- 4.7.5** Movement of other types of clinical record e.g. Physiotherapy records should be recorded either on a tracer card or book.
- 4.7.6** Except in specific and exceptional circumstances original records may not be sent outside of the Trust. Where required, photocopies of relevant sections must be made by the person sending the notes. See Appendix 11 below for details regarding the transfer of information. If it is necessary to send the original notes then they must be tracked using the Medway tracking module.
- 4.7.7** An incident form must be completed in accordance with the Incident Reporting Policy and Procedure and the local Information Asset Owner informed of any instances of missing records. Such forms will be directed to the Team Leader in Case Note Store so that extensive searches can be instigated and in exceptional circumstances when they cannot be located they will be marked as lost.
- 4.7.8** Records must be stored securely, away from observation by the public and in locked storage units or rooms or within the secure records stores.
- 4.7.8** All staff are responsible for the safe custody of records in their use. Where records are in clinical use outside of the records store they must be held securely. Rooms containing health records must be locked if left unattended. Arrangements for access out of hours must be made with the Patient Services Manager or Team Leader Case Note Store. Notes will be filed in such a way that they can be quickly and easily retrieved out of hours. Consideration should be given to having a labelled location in the relevant office/store for each tracking location for that area. This will ensure availability of records for emergency admissions 24 hours per day.
- 4.7.9** The obligation to retain the confidentiality of all information, particularly that about patients or clients, rests with the Trust that manages the service concerned ('Data Controller') as well as with individual employees.
- 4.7.10** At all times, the security and confidentiality of records will be observed. Staff will only take records home as a result of a specific healthcare or operational need (e.g. evening home visit, or meeting next day). Records must not be left in staff cars overnight and never left visible in an unattended car. Security and confidentiality must be observed when moving records between sites. Where this exceptional arrangement is required it must be agreed formally and involve a risk assessment which will be shared with the Information Governance Team.

Access to records

- 4.7.11** Current case note files requested by clinical and other staff from case note stores will be provided the same working day or within 24 hours as a maximum wherever possible. In an emergency records will be obtained for clinicians within two hours.

Organisation Of Stores

- 4.7.12** All health record stores will be lockable.
- 4.7.13** All record storage units will conform to the Health and Safety at Work Act and Fire Regulations.

- 4.6.14** Racking for storage of live case notes will consist of a strong construction, not more than 7 feet high from the floor.
- 4.7.15** There must be a written protocol in each area stating the procedure for obtaining records from the records store.
- 4.7.16** There must be a suitable archive storage area and Trust wide agreement regarding archiving records and arrangements of archive stores to allow easy retrieval of records. Retention of records and archiving is in accordance with the Retention and Destruction Policy.
- 4.7.17** The disposal of all information (manually recorded and computer based) must be carefully controlled to maintain confidentiality. Destruction orders will be provided and clear written contracts with the carrier used to confirm the nature of the destruction. Disposal of records is in accordance with the Records Retention and Destruction of Records Policy. It should be noted however, that at present no medical records will be destroyed as per the requirements of the Goddard Enquiry. Any queries regarding this should be directed to the Information Governance Manager and/or the Patient Services Manager.
- 4.7.18** Any waste paper containing patient information can be shredded or secured in a confidential waste bag and disposal arranged separate to the general waste in accordance with the Trusts waste management procedures.

Computer Security

- 4.7.19** Each Division must implement and adhere to the Trust's Information Security Policy, which will address the following areas: -
- Physical security/equipment security.
 - User password management.
 - Computer virus control.
 - Data back-up.
 - Computer network management.
 - Data and software exchange.

4.8	Standards for Computer Records
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- 4.8.1** Information technology is being used increasingly within the NHS. The trend is for the majority of information to be transmitted electronically. If electronic documents are to be used in courts, evidence must be produced to show that the computer has not been misused or was operating properly when the document was produced. It is therefore essential that all staff follow the Information Security policy and the Use of Internet and E mail Policy. These policies address the following areas: -
- Physical security/equipment security.
 - User password management.
 - Computer virus control.
 - Data back-up.

- Computer network management.
- Data and software exchange.

- 4.8.2** As increasingly information is transferred electronically Divisional Directors//Information Asset Owners/Information Asset Administrators will need to ensure records are stored securely, access is controlled and staff receive adequate training.
- 4.8.3** The principles of data quality, accuracy and controls of written records apply equally to electronic records.
- 4.8.4** Associated computer and paper systems must contain the same information.
- 4.8.5** Computerised patient information systems will contain the national and regional minimum data sets (MDS).
- 4.8.6** Computer records are subject to the same information security measures as paper records including limited access, confidentiality and accessibility.

4.9	Transfer of Records/Sharing of Information
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4.9.1 Before passing on information to another person or organisation you must:-

- Consult the Information Sharing Protocol and be satisfied that the recipient person or organisation has a legitimate case for holding the information, and that their intended purpose is compatible with the purpose for which the information was collected.
- Ensure that you are passing the information on to the correct person or organisation.
- Ensure that information will be managed appropriately after it has been passed on.
- Assess how much information needs to be passed on, and pass on no more than is necessary and agree information with the Caldicott Guardian where necessary.
- Ensure adequate arrangements for the safe transfer of the information and ensure that safe haven procedures are followed however you are transferring the information.
- Take special care when transferring information by email (see Internet and Email Policy). If patient identifiable information is being transferred by email, it must be sent from NHS.net to NHS.net email accounts and be password protected as per the safe haven procedure.

4.9.2 Be satisfied that the recipient has a legitimate case for holding the information:-

Since all personal information was originally collected for one or more specific purposes (Section 8 of the Data Protection Act) it cannot be passed on unless the proposed use is also compatible with that original purpose. As stated in Section 10, if there is no explicitly documented consent for the use of a patient's personal data then it may be reasonable to assume implied consent to use the data in the course of the care and treatment of the patient, but for no other purpose.

If you are not sure whether the subject has given consent for their information to be passed on to another person or agency then the safest course of action is to check consent with the subject or, as second best, with the original collector of the information. Guidance should be sought from the Patient Services Manager/Information Governance Manager/Caldicott Guardian if there is any doubt.

4.9.3 Ensure that you are passing the information on to the right person or organisation:-

- Always check the address of the recipient organisation carefully.
- Information given in telephone calls must be in accordance with the Safe Haven procedure.
- It is important to confirm the identity of the recipient. Dial back arrangements based on published telephone numbers and caller's name must be used, especially for uncommon requests; as per Safe Haven policy.
- In the case of clinical information it is essential to ensure that the correct patient has been identified using at least two pieces of information, such as name and date of birth.

4.9.4 Ensure that information will be managed appropriately after it has been passed on.

Before passing personal information on to another person or organisation you must be satisfied that the recipient will treat it with the same care as is afforded by the Trust, and that they understand their responsibilities with regard to storage, management, and onward transmission of the information. Contact the Information Governance Team for advice.

4.9.5 Assess how much information needs to be passed on, and pass on no more than is necessary.

In the same way that, when collecting information, no more detail should be collected than is necessary for the intended purpose, when passing on information to another person or organisation no more information should be passed on than is necessary for their purpose. Personal identifiers should be removed if they are not required for the recipient's purposes.

4.9.6 Ensure adequate arrangements for the safe transfer of the information.

You must select a mode of transfer that maintains the security and confidentiality of the information. All documents must be packaged so that personal information is not revealed during transportation. The courier or carriage agency must have appropriate standards of security and assurances of confidentiality.

4.9.7 Take special care when transferring information by E Mail.

Standard email is insecure. Please refer to the Trusts email and internet use policy for advice on the use of email. If patient identifiable information is being transferred by email, it must be sent from an NHS.net email account and to an NHS.net email account, and be password protected as per the safe haven procedure.

4.9.8 Follow safe haven procedures for the despatch and receipt of health records.

The term “safe haven” refers to an agreed set of administrative arrangements for ensuring the safety and secure handling of confidential patient information. All services should use safe haven procedure principles when dispatching and receiving confidential personal data.

4.9.9 Location.

If confidential personal data is stored or held until transferred this must be in a safe and secure environment that is locked when not attended.

4.10	Consent, Confidentiality and Access
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Keeping Patients Informed

4.10.1 Patients, parents/carers should be kept informed from the outset of how information regarding their care will be used. This will be done by routinely providing patients with the necessary information as a part of care planning and notices for patients. Where applicable arrangements will be made for the leaflets and/or posters to be available for clients whose first language is not English.

4.10.2 Children under 16 who have the capacity and understanding to make decisions about their own treatment are entitled to decide whether personal information may be passed on and generally to have their confidence respected. (see Working Together for Safeguarding Children).

This Trust has, however, agreed to routinely share information with GPs, School Nurses and Health Visitors following discharge from A&E, and the Paediatric wards. Consent would be sought if this was related to particularly sensitive information, unless it was clearly a child protection issue.

4.10.3 It is neither practicable nor necessary to seek a patient’s consent every time information needs to be passed on for a specific purpose, but the following guidelines should be used.

- Letters will be copied to patients in accordance with Department of Health guidance.
- Information may be passed on to someone else:-
 - a) For the purposes which were explained to the patient at their initial contact, but only on a need to know basis, if the following circumstances apply:
 - b) The recipient **needs** the information to comply with their duty of care, because s/he is directly involved with the patient’s care and treatment as a member of an NHS or multi-disciplinary team.

c) The use of minimal information is **justified** for one of the following wider purposes: for co-ordinating NHS care with other agencies, monitoring and protecting public health.

d) The information is required by statute or court order.

- 4.10.4** The clinician decides upon the extent to which information may be shared with other professionals concerned with the patient's health. The Trust expects clinicians to carry out scrutiny/redaction of any such records before releasing information to other health professionals and a checklist and further guidance is available to aid this process. It is the clinician's duty to ensure that those with whom information is shared are aware of their obligations under the Data Protection Act and Caldicott2 recommendations, and that they also appreciate the professional rules of confidentiality. Clinicians will also be working within their own established code of ethics.
- 4.10.5** The patient's wishes regarding use and disclosure of information should be respected, unless there are overriding legally acceptable considerations to the contrary.
- 4.10.6** In child and vulnerable adult protection cases the overriding principle is to secure the best interests of the child/vulnerable adult. Therefore if a health professional (or other member of staff) has knowledge about abuse or neglect it may be necessary to share this with others on a strictly controlled basis so that decisions relating to the child/vulnerable adults welfare can be taken in the light of all relevant information. In child protection cases, Nottingham City and Nottinghamshire Safeguarding Children Boards child protection procedures must be followed. Further advice can be obtained from the Trust's Safeguarding team.
- 4.10.7** In the event of any breaches in confidentiality the member of staff who becomes aware of the incident will be responsible for informing their line manager immediately and completing an Incident Reporting Form on the Datix system.
- 4.10.8** Disclosures can be made without consent to prevent serious crime or violence. Difficult decisions may require legal advice prior to disclosure. In the case of crime the information released must be limited to what is strictly relevant to a specific investigation and must occur in consultation with the senior clinician/senior manager/Caldicott Guardian. The Trust's Police Procedure will be followed in such instances.
- 4.10.9** Any disclosures to the Police or other agency must be undertaken in conjunction with the consultant or delegated other senior clinician involved in the patient's care and referred to the Caldicott Guardian, again following the Trust's Police Procedure.
- 4.10.10** Confidential information will not be discussed on the telephone unless the member of staff is clear about the identity of the caller and that the caller is entitled to receive that information. This will be checked when necessary e.g. with call back prior to release of any information.

4.10.11 Relatives and friends can be kept up to date with the progress of a patient's treatment if the consent of the patient has been obtained prior to information being released. Care should always be observed that any disclosure is appropriate and in accordance with the patient's wishes.

4.10.12 Any video or photographs of patients must also be treated with confidentiality and consent obtained.

Disclosure For Litigation

4.10.13 The High Court has statutory powers to order:-

- a) The disclosure of documents before and during proceedings for personal injury or death.
- b) The production of information to an applicant and his/her legal, professional advisors. Such orders should clearly specify what information is required and by whom. The health professionals' responsibility for a patient's care will be consulted about the disclosure in case there is a risk to the patient's (or someone else's) health. A written agreement/signature from the professional is ideal. Where staff cannot be traced and have left the Trusts the new consultant/lead clinician should be consulted.

4.10.14 At the patient's request, information relevant to legal proceedings may be released, usually to the patient's legal or medical advisor. This information is passed to the lawyers acting on behalf of the Trust where the action involves the Trust or a member of staff. The patient/client's written request and signed consent is required (not a photocopy).

4.10.15 Any requests relating to litigation disclosure must be highlighted to the Legal Services Manager who will ensure that the correct procedures are followed and assist staff in any case where legal advice is required.

Access to Health Records

4.10.16 Access to Health Records requests are dealt with:

At King's Mill Hospital by the Access to Health Records Team which is managed by the Information Governance Manager. This team also deals with requests for Mansfield and Ashfield Community Hospitals.

At Newark, requests are carried out by the administration team which is managed by the Hospital Manager.

There are specific Trust wide procedures to be followed in dealing with such requests which conform to the requirements of the Data Protection Act and the Access to Health Records Act.

4.11 Data Protection Act Principles

The Data Protection Act is based on 8 principles.

4.11.1 First Principle. Personal data must be processed fairly and legally.

The data subject must give their permission or the processing is necessary for legal or contractual reasons.

The data subject should know who the data controller is, why the data is being processed.

The processing of the data must not lead to any discrimination of any kind.

4.11.2 Second Principle. Personal data must only be obtained for specified and legal purposes and must only be processed in a way that is consistent with the specified purpose.

Data controllers and data users must not collect and use data unless there is a specific and valid reason for doing so.

The data subject must be told what the information will be used for.

Personal data collected for one reason must not be used for any other unrelated purpose.

4.11.3 Third Principle. Personal data must be adequate, relevant and not excessive for the purpose it is processed for.

Only data needed for the specific purpose should be asked for or recorded. Information that is not relevant for the purpose must not be collected simply because it might be useful in the future.

4.11.4 Fourth Principle. Personal data must be accurate and, where necessary, kept up to date.

Data users should record data accurately and take reasonable steps to check the accuracy of the information they receive from the data subjects or anyone else.

Data controllers should scrutinise all storage systems to destroy inaccurate and out-of-date information and correct inaccurate records.

4.11.5 Fifth Principle. Personal data processed for any purpose must not be kept longer than is necessary to fulfil that purpose.

Organisations will need to keep some data on current and past employees to respond to enquiries from new employers or from the Inland Revenue.

Other types of data may not be relevant for future purposes and should not be kept for longer than is necessary.

4.11.6 Sixth Principle. Personal data must be processed in line with data subject's rights.

The right of subject access lets an individual find out what information is held about them.

Data subjects have rights to prevent processing that is likely to cause damage or distress to themselves or anyone else. They also have the right to claim compensation for damage and distress caused by someone breaking the conditions of the Act.

Data controllers must not use personal data for direct marketing purposes.

Individuals have the right to take action to correct, block, erase or destroy data that is inaccurate or contains opinions that are based on inaccurate data.

4.11.7 Seventh Principle. Appropriate security measures must be taken to protect against unauthorised or illegal data processing.

Data controllers must make sure that security controls are in place and are followed.

Only employees who need to use personal data to carry out their work should have access to the data.

Measures to prevent unauthorised access should be implemented.

4.11.8 Eighth Principle. Transferring personal data outside the European Economic Area (EEA) is restricted unless the rights and freedom of data subjects are protected.

Some countries, outside Europe, do not have the same legal requirements to protect information.

4.12	Advice re Multi Volume Sets Of Case Notes
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What Happens When The Case Notes Become Very Bulky?

As soon as the case notes exceed 6cm (about 2 inches) deep they become unwieldy. At this point a new volume of notes is required. Case Note store staff will arrange for an additional volume of case notes to be created. The red Alert divider is transferred into the most recent/new volume and any details associated with Infection control are copied onto another divider and placed in the previous volume. Any red safeguarding dividers will also be transferred into the new volume. A sticker on the front of the notes will indicate a **multi-volume set of notes**.

Similarly case note folders can sometimes become damaged or worn. A new folder should be provided in such cases, and this can be arranged by contacting the case note store staff. Any pulled from file in a poor state will be replaced before being sent out.

4.13	Tracking Of Case Notes
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Tracking Of Case Notes

- 4.13.1** Not only is it essential that details are accurately and tidily recorded in case notes, it is equally important that they can be swiftly and easily located when required. SFH NHS FT has a case note tracking module as part of its Medway PAS computer system. This means that case notes can be electronically tracked from one location to another as they move around the Trust sites, as well as being able to record when they are sent off site.
- 4.13.2** It is therefore important that key staff are trained in the case note tracking system in order that case notes can be located when required. This can be organised by contacting the Medway PAS trainers who are based in the Nottinghamshire Health Informatics Service Department. Individual Medway PAS log on credentials will not be provided until this has taken place.
- 4.13.3** We may need to locate notes for routine purposes, such as clinic appointments, but may also apply to emergency situations such as Emergency Department attendances, or admissions etc. Regular and sustained use of the tracking system contributes to the Trust's avoidance of clinical risk, by ensuring the location of case notes at any given time.
- 4.13.4** Staff will take responsibility for tracking case notes in and out of their office, department etc. ("Send" and "Receive" in Medway Pas terminology). Remember, if you have tracked a set of case notes into your office, ward or department, they are then your responsibility. They should be stored safely and securely and in a manner in which another member of staff can find them if required out of hours etc.
- 4.13.5** If the case notes are requested from your office and your doctors have not yet finished with them a re-peelable tracking sticker is available from supplies to denote that you need them sending back afterwards.
- 4.13.6** Staples should NEVER be used to affix notes onto the covers of case notes – they can tear the covers when caught awkwardly, and have also been reported to cause hand injuries to Case Note Store staff when retrieving tightly packed case notes from shelving.

4.14	Obtaining/Retrieving Case Notes
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4.14.1 Notes required for forthcoming outpatient clinics

Notes for outpatient clinics do not need to be requested from the Case Note Store as clinic lists are printed by Case Note Store staff 4 days in advance of clinic and pulled from file and sent to the appropriate case note prep area. Those notes required for clinic but not in file will be requested by Case Note Store staff with the requirement that the recipient will forward the notes for immediate prep.

4.14.2 Ad Hoc requests for obtaining/retrieval case notes

If a set of case notes is required on an ad hoc basis the following process will be followed:

- Requester will access the Medway PAS case note tracking module and identify where notes are currently tracked (if they do not have access then contact Case Note Store as described below).
- Requester will call the person, to whom notes are tracked and request them, giving their name, tracking code and telephone number. Current process for tracking requires staff to include their extension number on the Medway PAS comments screen to aid such requests.
- Person to whom notes are currently tracked will locate the notes, track/send them to the requester with the details provided and envelope them and address them accordingly. Depending on the urgency, the notes will either be placed in the internal mail system for non-urgent requirements, but for urgent requests, the Case Note Store will be contacted and a request will be made for the Case Note Porter to collect and deliver.
- If the case notes are found to be tracked to case note file, then users of the electronic requesting system should use this for obtaining the notes (see below). Other staff should contact the Case Note Store Supervisor on 3098 or Case Note Team Leader on 2517.

4.14.3 Requesting system for Case Notes currently filed in Case Note Store

- There is an in house requesting system within the Trust which is made available to Pathway Co-ordinators and other patient administration staff for routine requesting of case notes.
- Staff can gain access to this system, if appropriate, by contacting their Supervisor, who will ensure access is provided and details on how to use the system.
- Records requested routinely will be pulled within 24 hours and sent to the requester. Those requested urgently will be pulled during the morning or afternoon session when the request was received. The notes will then be sent to the requester via the Case Note Porter.
- Please note if records are required immediately i.e. requested by the Emergency Department, and are in the case note file, then please contact Case Note Store staff by vocera (ask for Admissions) or telephone Case Note Store on 3098. These requests will be dealt with immediately.
- In all instances staff are required to use the case note tracking system to record the case note movements resulting from these requests. Staff will also remember to track/receive them in to the new location, thus supporting patient safety and avoiding clinical risk.

4.15	Destruction of Case Notes
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4.15.1 The destruction of case notes within the Trust is carried out in accordance with the Trust's Retention and Destruction Policy. This process will only be carried out by staff that have been trained in its requirements.

4.15.2 The following guidelines are to be followed and checks made when identifying files to be considered for destruction:

- Has patient attended in last 8 years or have 8 years passed since patient died?
- If the above applies it is possible that the case notes can be destroyed but the following checks also need to be made:
- Are there any maternity records? – if so to be kept for 25 years after the birth of the last child.
- Are there any notes relating to the patient when a child? If so to be kept until the patient's 25th birthday or 26th birthday if patient was 17 when treatment concluded.
- Has the patient had a joint replacement? If so to be kept for 10 years.
- Has the patient any oncology notes? – if so to be kept for 30 years.
- Is there any indication that the patient's notes are linked to any litigation or complaint against the Trust? – if so check with Improving Patient Experience Department and or Legal services Department.
- Does the patient have Crohns disease or colorectal cancer? – if so the notes should be kept for 30 years.
- Has the patient undergone PUVA treatment in Dermatology? If so the notes must be checked by the Dermatology Department before notes can be destroyed.
- Does the patient have any Psychology records? If so the records need to be retained for 20 years after last attendance or for 8 years after death.
- After carrying out the above checks the notes will be marked with a review sticker which will indicate that this check has been made and the date which they can be reviewed again for destruction. The sticker will also indicate the reason why the notes are to be retained.
- Once the above process is complete and it is clear that the case notes can be destroyed then the following will be carried out:
- A record will be made that the destruction has been carried out in the site specific record (King's Mill or Newark).

- The following data will be recorded:

Patient Surname and Forename

Hospital ID number

Which volumes of case notes have been destroyed

Date they were destroyed

Name of person who has carried out the checks and destroyed the notes.

- When a set of case notes has been destroyed a record will be made on Medway PAS by tracking the case notes to a destination of “DEST” which will read as destroyed on the tracking system and therefore make it clear to other users around the site that this has taken place. The records will also be marked as destroyed. If the patient should attend the Trust again in the future a new set of notes can be made up and tracked using the same number, again, making it clear that a new set is now in circulation.
- Once the notes are ready to be destroyed they will be placed in a confidential waste bag and disposed of in line with Trust policy for the disposal of confidential waste. Such waste will be stored securely until collected by the Portering staff.

5	Consultation
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The consultation for this procedure has been distributed and commented on by:

Medical Records Advisory Group

Patient Services Governance Committee

D&O Governance Committee

Information Governance Committee

Nursing and Midwifery Committee

Clinical Lead for ICT

Clinical Coding Manager

Safeguarding Lead

Deputy Divisional General Managers in other Divisions

6	Equality, Diversity and Inclusivity and Impact Assessments
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- **Privacy Impact Assessment** – not applicable
- **Environmental Assessment** – not applicable
- **Equality Impact Assessment** – not applicable as undertaken on overarching policy