East Hampshire NHS
Primary Care Trust

Policy No: CLN/R3

HEALTH RECORDS

ALL SPECIALTIES

CORE STANDARDS AND PROCEDURES

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HEALTH RECORDS STANDARDS / PROCEDURES

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Author(s) **Matthew Thomas**

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East Hampshire NHS
Primary Care Trust

1. INTRODUCTION

These procedures have been written to support consistent good parctice in delivering the PCT's Health Record Service. They are written to support staff whose work involves them in the provision of the Health Record Service.

The procedures are intended to be used selectively, as some of the PCT's Directorates and locations work to different procedures, for example the child supprt service is supported by Portsmouth Hospitals NHS Trust, as is the case with Elderly Medicine Service provided at the Queen Alexandra Hospital and St Mary's Hospital sites.

It is intended that the procedures be used at induction or during other training.

2. WHY DO WE MAINTAIN HEALTH RECORDS

- To facilitate care and treatment to support the patient.
- The record is an integral part of the care.
- The record is as important as the direct hands-on care.

(1) Aim of the Health Record

- Aide Memoir.
- Means of communicating with colleagues.
- Records must be used.
- All directorates should use core documentation.

(2) Ways to Improve

- Try and make the records useful for the people using them.
- Integrated records must be a focus for the future.
- Must move to integrated records where all professionals "write on one sheet".
- Must change thinking processes where documentation begins and becomes a really important part and not a chore.
- How do we get the message across to staff that it is not a health mechanistic process.
- What staff write really matters.
- In litigation, the outcome is not based on truth but proof.
- Professionals see records as a tool.
- Keep it simple.
- The health record is a professional record, it is the tool of communication between staff.
- Documentation must stand professional scrutiny.
- The aide memoir must be sufficiently detailed, recognising that every that is written has the potential of a legal document.
- Cryptic comments have no place.
- If records are not professional then neither is the care (in legal terms, the first impression of the staff is gained from the notes).
- Abbreviations should not be used. If an entry is worth making, it is worth making in full. If abbreviations are to be used in notes, the words must be written in full on the first occasion of use with the abbreviation in brackets.

- Mistakes must be ruled through and initialled, not obliterated. The original words must remain legible.
- Patient notes must be credible.
- All staff should be encouraged to write the date and time on all entries. The time must reflect the time of writing the entry.
- In critical areas, staff must use a common clock or synchronise watches.
- Anything written in the health record is fully discloseable unless it is clinically considered that it is in the patient's best interest not to see the record.

3. DATA PROTECTION - PATIENT ACCESS TO PERSONAL INFORMATION REQUESTS

(1) The Data Protection Act 1998 gives patients the right of access to their own personal Health Records. Under the act this now includes both manual and computerised records and incorporates any data held about them, on video recordings or audiotape.

(2) Patients can request sight of their data at any time and are entitled to see the whole record (not just data held since November 1991 as in the Access to Health Records Act).

(3) Access to the records of deceased patients is still the subject of the Access to Health Records Act 1990 and as such should be directed to the local co-ordinator.

(4) All requests for access must be put into writing by the data subject (patient).

(5) All written requests must be sent to the local data protection co-ordinator who deals with access request (see attached list).

(6) The onus is on the patient to prove that they are the 'data subject'. If the request is directed to the reception desk or outpatient clerk, they should be given a form to complete which the patient should be directed to complete and return with the fee of £10. (form attached)

(7) As soon as a patient requests access, please inform your immediate manager and/or your local Data Protection co-ordinator.

The procedures are subject to a separate East Hampshire Primary Care Trust Policy. Please contact your local co-ordinator (Annex A) for further advice/assistance.

4. ADMISSION PROCESS

The Manager should ensure that the inpatient procedures provide satisfactory arrangements for the admission, transfer, discharge and documentation of patients using the services of any of the Trust specialties, and are in accordance with the national and local requirements.

Definition: An admission to a ward is where the health professional in charge of the patient's care (usually the Consultant or his/her medical team or the GP in the case of the community hospitals) sees fit to admit a patient to a hospital bed for the purpose of treating or observing the patient's condition. This can be either as an elective planned or booked admission or as an emergency. The hospital bed will be reserved for the patient. The Consultant or GP in charge of the patient is recorded on the system as the responsible Consultant. The admission will usually involve 1 or more overnight stays. If the admission is planned to be an overnight stay but subsequently the patient is discharged on the same day this is still an admission as the patient will have taken up the

bed for that day. Once the patient has been discharged from the Consultant this is known as a Finished Consultant Episode. If the patient is transferred to the care of another Consultant this will be known as a new Consultant Episode. Therefore patients can have 1 hospital stay but more than 1 Finished Consultant Episodes. Community episodes do not include Day admissions on wards.

(1) Referrals for Admission are made to the Ward and can be made by the Consultant, the patient's own GP or from another GP within the same practice.

- For GP Medicine - the referral will be from the GP.
- For Acute Elderly, the referral will be through the admissions office.
- For Mental Health and Community Elderly Medicine - the referral will be from the Consultant and/or their team.
- For Learning Disabilities - the referral will be from the Community Team.

(2) Referral details must include Name, DOB address and postcode and if possible brief summary of why patient is to be admitted. Be clear about taking any medical details or diagnosis and ask the referrer to spell any medical words or terms that are unfamiliar. Use the Trust Admission Form to capture all the relevant details as attached.

(3) Any patients being admitted, as a booked or planned elective episode, should be sent all the relevant documentation as meet the local and service requirements.

(4) The next stage is to arrange for the patient hospital notes to be available on the ward. If the patient is being admitted to a GP Medical or Elderly Medicine ward and is being transferred from another hospital in the Trust or from the Portsmouth Hospitals Trust (i.e. QAH, SMGH) then notes and X-rays should accompany the patient on transfer. Cheek with the referrer that this is to happen and make a note on the referral details. For AMH or EMH the notes will be sent separately to the admitting ward.

(5) To locate notes for patients coming from home, basic details - name, DOB are fed into the Patient Master Index (PMI) and the notes number checked. When the case note number is known, notes can be located and requested by telephone to the appropriate hospital/location.

(6) When the patient arrives on the ward the details are written into the admission book (if applicable to the ward but this may not be appropriate), and on to the Admission form used for data processing. Details must include:

Surname
Forename
Full address including postcode (this derives the Area of Residence)
Date of Birth
Registered GP
Referring GP
Religion
Next of kin
Ethnic Group
Method of admission

Source of admission
Ethnic Group
Overseas Visitors status
And any other mandatory requirements

(7) Patient admissions are also recorded on the bed state. Details from the bed state are manually recorded on the ward and used to validate bed state at the end of the month.

5. CLINIC PREPARATION

(1) Clinics must be prepared well in advance in order to give enough time for requesting any notes missing or test results to be requested.

(2) Obtain Pulling list for clinic either by print-out from computer or clinic list from appropriate diary

(3) Pull casenotes looking for files locally in the first instance. If Portsmouth Hospitals computer (PAS) is used book out the notes on casenote tracking function.

(4) If this is the first time in this calendar year that the notes have been pulled from file, ensure that the current year's 'Year Label' is applied at the right hand side of the notes.

(5) For new patients ensure that new casenotes are made up appropriately (see 'Making up new notes').

(6) Trace/request missing files from the site/location to where the file is last booked out to, using Fax request list.

(7) Print Clinic Lists for Reception, Consultant etc.

(8) Read last correspondence in notes to check for test results. Make sure any necessary results are filed in notes.

(9) Ensure there is sufficient stationery within the notes for the Consultant to use.

(10) Stamp or notate Clinic History sheet with date and Clinic.

(11) Stamp or notate "Routing" card (If used).

(12) Make sure there are enough Patient Labels with correct information.

(13) Put all files and Clinic List together in drawer/clinic box and store securely.

(14) Make a record of any case notes unavailable (see Appendix) for the doctor at the time of the clinic and inform him of the unavailability.

6. CLINIC RECEPTION

Always check that all appropriate signposting is in place and that the waiting room is tidy and pleasant with sufficient reading material available. Remember that under the Data Protection Act all conversations and discussions with patients should be kept as confidential as possible.

(1) Ensure client/patient notes are all available ready for the clinic. This should include any results or letters to show to the Consultant/Doctor and a Dictaphone fully equipped with batteries (if appropriate).

(2) Greet all patients politely and with a smile.

(3) As patients arrive, greet and book in (either on the Clinic Sheet or computer as appropriate to the clinic).

(4) Cheek with the patient or carer their demographic details* making any necessary changes required in the notes and on computer if appropriate. Any changes of address given to the Consultant/Doctor should be notified to admin staff for the appropriate changes to be made.

(5) Ensure that any questions asked of the patient are done in strict confidence taking the Data Protection principles into account.

(6) Show patient to waiting area.

(7) Notify Clinician of arrival.

(8) Keep patient informed of any delays or changes.

(9) After seeing the Consultant/Doctor the patient will be sent back to the Reception Desk for any follow up appointment or tests to be made if needed.

(10) Find an appropriate follow-up appointment and check with the patient that this is convenient. This will avoid a DNA situation next time.

(11) Write the appointment on the patient's card for information and record on the routing card, computer or clinic sheet that this has been done. If the department normally sends the appointment out at a later date by post make sure that is clearly conveyed to the patient.

(12) Give other information to the patient as appropriate e.g. if they require blood tests or hearing tests etc.

(13) Arrange for re-imbursement of travel expenses if appropriate and/or arrange transport.

(14) At the end of the clinic make sure that all patients have been accounted for and booked out of the clinic by perusing the clinic list. Record the outcomes of all patients on the clinic list and computer, if appropriate.

(15) Check with the Consultant/Doctor on how he wishes to deal with DNA's and send further appointments out as appropriate.

(16) Check with the Consultant/Doctor whether any patients notified them of a change of address and deal with appropriately.

(17) Retrieve the notes and all other equipment from the clinic and ensure they are returned to the appropriate destination.

(18) Record all statistics as required by the manager.

*** Demographic Details - should include name, address, date of birth, postcode, GP and NHS Number if known**

7. CLINICAL CODING PROCEDURES

Clinical Coding is carried out from Provider Spell Summary Forms (Discharge Summary forms). In all mental health units it is the responsibility of the medical staff to complete the diagnosis/investigation/recommendation section of the PSS within 48 hours of the patients discharge.

In the Small Hospitals it is the responsibility of the medical officer (usually a G.P.) or Consultant to complete the relevant parts of the PSS.

In some units the PSS is also being used as the prescription form for TTO's. It is generally accepted that some nursing staff complete some of the forms and, although this is not considered to be desirable, it has become acceptable because of the difficulties encountered when requesting some medical staff to complete this task.

It is not acceptable under any circumstances for clerical staff (e.g. ward clerks) or for untrained nursing staff to complete the forms.

Queries raised by the clinical coders are returned to the appropriate medical staff, often via a medical secretary or ward clerk. The help that they give in ensuring that medical staff complete the forms punctually, making case notes available etc, is invaluable.

There is a separate policy for Clinical Coding, which is available from your Clinical Coding Clerk.

8. DISCHARGE PROCEDURE

(1) When a patient's details are input to the Patient Administration System, on admission, a Discharge Summary Form is generated.

(2) This is then kept on the ward until the patient is ready for discharge. The Discharge Summary is most important as it is used for several purposes:

- To inform the GP of discharge and details of procedures undertaken etc.
- It provides Patient with copy of details sent to GP
- It is used for validation and coding purposes
- Gives a Summary for inclusion in hospital records, which can subsequently used to provide the Clinical Codes.
- In some wards this is now being used to send to pharmacy for 'TTO's'.

(3) When patient is ready for discharge the Discharge Summary Form is completed fully and adequately by the medical staff and distributed as follows:

- Copy to GP
- Copy to patient
- Copy to SJH for coding
- Copy in patient record

- A photocopy may be kept on the ward if required

(4) In cases where the Discharge Summary Form is being used to order TTO's, the whole copy should be sent to the pharmacy with the medication listed clearly. Pharmacy will dispense the medication, return to the ward and will take a copy of the form for their own records.

(5) If a Discharge Summary Form is not available on discharge then a discharge letter is completed and given to the patient - a copy is sent to GP. However, in wards where the form is being used to order TTO's, a fresh copy of the form should be requested prior to the patient discharge,

(6) If appropriate, Nursing Staff complete a Discharge Audit form whilst discharge is being planned. This is also photocopied - with a copy in notes and a copy in Audit File.

(7) A note of date of filing is made in admission book and notes booked back to file.

(8) Ensure appropriate arrangements to return any patient property has been made before discharge takes place.

(9) Issue any medical certificate as appropriate.

9. DISPOSAL OF RECORDS

(1) All records must be kept for the minimum retention period as stated in the Disposal Schedule.

(2) Any records that are not to be disposed of after the minimum retention period must be clearly marked to this effect, in red ink on the front of the folder. It is the responsibility of the Consultant in charge to designate any record as 'not to be destroyed'.

(3) All records confidentially destroyed must be logged on PAS in Case Note Location before destruction.

(4) All records must only be destroyed using the confidential destruction procedures in place within the PCT.

(5) All documents weeded from records must also be confidentially destroyed.

(6) All papers and documents detailed as confidential must be confidentially destroyed and not placed in ordinary waste bins. This includes handwritten notes that have been used to record telephone messages with patient or staff names on them.

10. DESTRUCTION OF CASE-NOTES

(1) Case-notes should be identified for destruction in accordance with the retention schedule contained in HSC 1999/053 "For the Record". Particular attention should be given to the extended retention periods for children, obstetrics and mental health

(2) It is recommended that some visible means of identifying the last year of attendance should be used on the outside of the case-notes (e.g. year of last attendance sticker affixed to the spine) to speed up the weeding process from the secondary filing area.

(3) The content of the case-note should then be checked to ensure that the date of last attendance is correct.

(4) Where case-notes for destruction have been weeded from a secondary filing area the current (active) filing area should be checked to ensure that there are no active duplicate or temporary case-notes in circulation. If these are found they should be merged with the old case-notes and the merged set of case-notes filed in the current filing area.

(5) Case-notes that should not be destroyed should be clearly marked and not destroyed. Clinicians will usually have identified these case-notes.

(6) The case-notes for destruction should be checked against PAS by another member of staff to ensure that there are no current episodes in progress and that the year of last attendance is correct. Where it is incorrect the year of last attendance on the case-notes (see 2. above) should be amended.

(7) The names or user identifications of the two staff members who have checked the date of last attendance from the case-notes and against PAS should be clearly recorded on PAS using the comments field if there is no defined field available.

(8) When the case-notes have been crosschecked against PAS and thereby verified for destruction, the Master Patient Index on PAS should be updated to indicate that the case-notes have been destroyed.

(9) If PAS has a case-note tracking module installed and implemented this should also be updated.

(10) Once PAS has been fully updated the case-notes should be placed in confidential waste containers or bags to await destruction.

(11) The Health Records Manager should then authorise destruction of the case-notes by an approved contractor who will ensure that this is done under secure conditions and will provide a certificate of destruction to the Trust.

(12) The certificate of destruction should be filed.

*** See Annex D for NHS Retention and Disposal Schedule**

11. ETHNIC GROUP DATA COLLECTION

(1) Ethnic Group Data has to be collected for all Inpatient Admissions.

(2) This is the responsibility of the designated person on the ward.

(3) All patients must only be asked once during any admission so, ward procedures must be in place to cover this.

(4) The designated person must not assume the Ethnic Group of the patient. This has to be the patient's own conception of their own Ethnic Group.

(5) The data should be entered on the admission form before forwarding to the Data Processing Clerk.

(6) The data should then be entered onto the patients' records on PAS by the designated Data Processing Clerk.

(7) If the data is not available from the patient at the time of admission then the designated person should interview the patient at another time. The appropriate

field should be marked with 'to be collected later'. This must not however, interfere with the normal administration process of entering the patient's record on to PAS.

(8) Should the Ethnic Group data item be blank then the Data Processing Clerk should return the admission form to the appropriate ward asking for completion and a note kept for chasing should the data not be forthcoming.

12. FILING DOCUMENTS IN HEALTH RECORDS

Health Records are a vital record of a patient's Inpatient, Outpatient and any Community episode and it is therefore absolutely vital that every person who deals with the record takes responsibility for ensuring that all documents are-filed safely and securely.

The Trust has several types of records and all of them should be dealt with according to specialty / service requirements but there must be an overall uniformity and standard which must be implemented.

(1) All documents should have the Case Note number recorded on it (on the right hand side) in the event of it becoming detached from the Health Record at any time in the future.

(2) Sort documents/results into casenote number order. If there is no casenote number, look up patient on computerised Patient Master Index if appropriate and if the patient record is found with a Case Note number add to document.

(3) Some records are filed alphabetically without use of casenote number or identifier; ensure that the patient's name is on each document to avoid loss of document. (This may be the vital document in the case of a complaint or problem).

(4) Pull appropriate case notes. Double check that you are filing in the correct patient's notes. File document into correct section, and file according to instructions for the service.

(5) File results on to appropriate mount sheets as follows:

Pink	Haematology	}
Green	Biochemistry	} The latest result on top
Blue	X-ray, CT, Ultrasound	}
Yellow	Microbiology, Cytology, Histology	}

(6) All correspondence should be filed according to instructions for the service.

(7) All Clinical history sheets should be filed at the back of the section so that it reads in chronological order as in a book.

(8) Ensure notes are tidy and any loose filing that has not been filed correctly filed as above.

(9) NB: The timely and correct filing of results and documents into patients notes is vital for quality patient care.

(10) Mark notes if there is a second volume (see separate instructions).

(11) If it is known that there are 2 patients with the same name, either mark the notes carefully with an appropriate warning or use the 'Same Name' warning stickers.

(12) The Discharge summary should be filed in the clinical history section of the notes.

13. FILING OF HEALTH RECORDS

The storage area should be maintained in a tidy condition at all times. It should be all members of staff responsibility to ensure that this happens and any problems reported to the manager. A tracer system should always be in place whether computerised or manual.

(1) Notes are returned to filing area within the Health Records Departments, from various sources i.e. outpatients clinics, ward stays, etc, and should be sorted according to local requirements.

(2) Each Health Record should have a corresponding tracer card which should be updated when casenotes are removed.

(3) Check that no other request for use is indicated. i.e. for another clinic. If not then place tracer card within the notes and return to shelf.

(4) If the notes are needed for another purpose, update tracer indicating date and destination, place a destination label on notes and place appropriately, i.e. in postbag for return to clinic, to Clinic Prep etc NB: Always check that the name and number on the notes matches the details on the tracer.

(5) Check that no loose documents are visible within the record. Ensure that these are secured in the correct place within the file. If necessary return the file to the originating location with a polite note to file and organise the file.

(6) If a duplicate file for the same person is found to exist then the documents should be merged together into the original and the duplicate destroyed.

14. VOLUMISING PROCEDURE
(SPLITTING AND CROSS-REFERENCING OVERSIZE CASE NOTES)

(1) Case notes that are in excess of 7 cm are unmanageable in the operational clinical arena and should therefore be split into volumes.

(2) The case notes should be split on a chronological basis, with the most recent documentation in the latest volume. The notes should be checked meticulously for current episodes of care as both inpatient and out patient.

(3) The newly created volume must contain the notes from at least one outpatient attendance plus any associated diagnostic tests and correspondence and all documentation relating to the last inpatient episode for each consultant that the patient is currently under the care of.

(4) The 'old' case notes should be checked for loose filing and all documentation secured to the body of the folder in the appropriate location.

(5) The volumes should then be clearly marked 'Volume 1', 'Volume 2' on the outside cover. The start and end date of Volume 1 and the start date of Volume 2 should be clearly marked on the inside of the front cover.

(6) Older volumes should be crossed through and "Volume Closed" should be clearly written across the front cover. No further documentation should be inserted into closed volumes.

(7) The closed volume should have the year of last attendance sticker affixed, corresponding to the year of the last documented attendance in that volume.

(8) PAS should be updated to indicate that there are multiple volumes of the case notes.

(9) The most recent volume should always be used and tracked on PAS, in the normal way.

(10) When a consultant specifically requests an older volume of case notes, the volume number, the requesting consultant and the date of the request should be entered into the comments field on PAS. Both current and requested older volumes should be kept together at all times whilst the older volume is in circulation.

(11) On return to the library, PAS should be updated by removal of the consultant request from the comments field. The older volume should be checked for erroneous, new material and then returned to its storage area. The current volume should be filed in the current / active filing area.

15. HEALTH AND SAFETY IN HEALTH RECORDS

(1) Ensure that staff are aware of Non-patient manual handling and fire procedures and attend relevant training.

(2) Ensure adequate lighting and heat.

(3) Supply step stool or equivalent to enable the retrieval of notes from top shelves and to avoid over-reaching.

(4) Do not store any items on top of high cabinets.

(5) Do not carry any more than the recommended weight of health records. Assess the weight before attempting to pick the package up.

(6) Always tell someone if you are going to work in a unmanned records library and tell them how long you expect to be, in case you have an accident.

(7) Keep aisles and filing bays clear at all times.

(8) Do not overfill cabinets and shelves.

(9) Do not use staples on records files.

(10) Ensure that there are no trailing electrical or other leads.

(11) Ensure that risk assessment is carried out as per Risk Policy.

(12) Ensure that all VDU users comply with European guidelines and that seating, lighting and positioning are compliant.

(13) Ensure that all users are aware of the scheme to refund eye tests and that it is their own responsibility to arrange an eye test at an approved optician.

It is everyone's responsibility to inform their manager of any perceived hazards

16. HEALTH RECORDS MANAGEMENT

(1) There should be data collected and updated regularly by each Health Records / Admin Manager for each area / specialty managed by the Trust.

These must cover the following:

(a) Current storage requirements, linear footage and number of records

(b) Annual growth rate

(c) Recall rates

(d) Record density (average number of documents per record)

(e) Average number of records in and out of the library each day

(f) Average number of records stored off site on a temporary basis.

(2) This information will be made available to support business cases for any new development and for rationalisation of Records Libraries or stores.

17. HOUSEKEEPING OF HEALTH RECORDS

(1) All individual records should be weeded on a regular basis.

(2) Any duplicate documents and correspondence should be removed and confidentially destroyed (Section 9 Destruction of Records) by whoever finds them.

(3) All live records must be kept updated with the patient's current details.

(4) All Health Records Libraries should have a regular programme of culling of expired records (i.e. W number of years after the last contact according to the NHS Retention and Disposal Schedule.)

(5) All notes removed from the shelves for archiving, destruction or optical amassing must be catalogued and sorted according to the department / specialty requirements.

(6) The location of the notes must be changed in PAS.

18. MEDICAL SECRETARY'S PROCESS

(1) Usually, Consultants or doctors dictate their clinical letters on to mini cassette tapes during their Clinics. So prior to Clinic, Medical Secretary ensures tape and Dictaphone are given to appropriate Clinic Receptionist or made available to the Consultant.

(2) Once Clinic has finished, the notes and/or cassette tape are delivered to the Medical Secretary's Office. The secretary should cheek that all notes have been returned from the clinic and that are none missing.

(3) If any notes are missing or have been removed by the Consultant or doctor an appropriate record should be made on the tracer card.

(4) The secretary then types the clinical letters as per Consultant's dictation on the tape, using transcriber and headset.

(5) Take the appropriate number of copies of each letter as per specialty procedures and send as soon as possible e.g. GP, patient's notes, and copy for office if appropriate.

(6) When all letters are typed, they are sent or given to the Consultant for signature.

(7) Some Consultants also dictate their clinical findings on the tape, to be typed in patients' notes, e.g. orthopaedic.

(8) Finally, on completion of the clinic typing, Medical Secretary sorts through and returns patients' notes as appropriate.

(9) All notes must be checked that documents are filed in the notes and that the notes do not require repair.

See Sections 10 and 11 for Filing procedures

19. MAKING UP HEALTH RECORDS (PATIENT NOTES)

(1) Always check on the Patient Master Index to see if patient is already known to the service.

(2) Always search the index properly using as many different search criteria as possible.

(3) If the patient is already known to the service, the casenotes should be requested or obtained from the Health Records Library and used for this episode.

(4) If the patient is not known, a new folder should be raised to record the episode.

(5) Allocate a new index number and ensure that the patient is added immediately to the Patient Master Index using the new casenote number. This will avoid the problem of the patient coincidentally being referred to another service and yet another new number being allocated thus creating a duplicate.

(6) Ensure that the details are put on the front of the folder and are correct, if necessary amending any old details to the updated ones.

(7) Ensure that a current Year Label is affixed to the notes on the right hand side.

(8) Ensure that all the correct documentation is added to the folder and that all documents are filed in the appropriate divider.

(9) Complete the details on the Tracer card including the destination of the patient record and file in the records library to indicate that a new file has been raised.

20. MINOR INJURIES UNITS

(1) A count of the number of daily attenders is taken at midnight by night nursing staff, which covers the 24 hour period up to midnight.

(2) This is broken down into waiting times for assessment.

(3) A running total is kept daily, and recorded on the appropriate statistics form.

(4) On the first working day of the month following the month end, the monthly totals are calculated and balanced. Any problems of reconciliation are sorted out in liaison with appropriate nursing staff.

(5) Appropriate monthly forms are sent to Information Services for inclusion in Service Agreement monthly reporting to Health Authorities.

(6) Patient Charter monitoring is completed as requested by the Service Manager and to the laid down procedures for Quality Standards.

(7) File a copy of the Casualty card in patients notes if becomes inpatient (Acute or Community).

21. OUT OF AREA TREATMENTS

(1) Ensure that the correct postcode and GP of the patient is ascertained when all patients are admitted or referred to the service.

(2) When the details of the patient are input to PAS the area of residence and the responsible organisation will be identified on the system.

(3) Ensure that the service manager or line manager are aware that an 'Out of Area' patient has commenced an episode.

See separate PCT policy on Out of Area Treatments

22. OUTPATIENTS APPOINTMENTS

(1) When a referral is received from a GP or another Consultant, all patients should be registered on the Patient Master Index and allocated a casenote number.

(Child and Family Therapy allocate family casenotes and file alphabetically)

(2) For Mental Health Services and CFTS the referral should be noted in the referral book ensuring that all local specialty information is made.

(3) Patient should be sent appointment letter stating time, date, venue, who seeing, enclosing map of venue and other helpful information as appropriate to the site and location.

(4) Letters to be sent out within required Quality standard deadlines.

(5) Information of appointment entered on client record (if appropriate to service / specialty.

(6) Ensure that all patients are aware of the Data Protection responsibilities of the service and make the standard patient letter available.

23. PATIENT REGISTRATION

(1) When a patient is admitted/referred - cheek if patient is registered on PAS using PM 1 -LIS. Use all methods of checking - surname, initial , sex, then if not found proceed to further searches i.e. with D.O.B. etc.

(2) If already on system check that all details are present and accurate update if necessary using PM 1 -ADD/Revise.

N.B. All patients may not be on the system.

(3) If patient is not on system, check with Central Registration Department they will run further cheeks. Registration will enter all details on the system and allocate a new casenote number. The folder is then sent to the relevant department.

(4) If the casenote folders have not been used for a period of time the number may have been withdrawn i.e.. microfilmed (this will be indicated on screen). If so the Registration Department must be informed and they will check details, allocate a new casenote number and send folder as above.

It is important that the NHS No., the correct Date of Birth and the GP of the patient is captured on PAS at all times and that if they are not known every effort must be made to get the correct details.

24. REFERRAL LETTERS

Consultant Referral

(1) All referrals received into the office, date stamped and logged, appropriate to service.

(2) Check to see if patients are known to the service either on the computer or in manual Patient Master Index.

(3) Check also the patient's area of residence. If from outside the area, refer to Out of Area Treatments procedures (**Section 19**).

(4) Passed to Consultant for prioritisation or to go to referral meeting for discussion of urgency. (Clinical staff to decide for Substance Misuse).

(5) If known to service look for case notes of patient - attach referrals. For self-referral services e.g. Substance Misuse, the patient would be seen before finding case notes. - See self-referral notes, below.

If referral is accepted refer to Appointments procedure.

(6) Record on referral system for statistical purposes.

Self referral (for some services)

(1) If a patient self presents, they are seen on the day by clinician.

(2) Information passed to Admin Staff and particulars entered in referral book.

(3) Checks to be made through central registration to see if patients have been known to service.

Any referrals to be prescribed should be discussed at review meeting, then process to see Consultant/Doctor if necessary and key-worker appointed.

25. REQUESTS FOR INFORMATION OVER THE TELEPHONE

All staff should be aware that they may, at any time, receive requests for personal information about patients to which the requester may not be entitled. Information given to those who do not have a need to know may constitute a breach of both the Data Protection Act and Caldicott Guidelines.

(1) If there is any doubt at all as to the identity of the caller then they should be informed that we do not release patient information over the telephone and that they should submit their request in writing.

(2) Where the caller is known to you, and proper identification is made the information requested can be given to the requester.

(3) Staff should be particularly wary of callers claiming that they need the information because their computer is 'out of order'.

(4) If the caller is genuinely from inside the premises make sure that their full identity is established at the outset of the conversation. If there are any doubts as to the identity of the caller politely ask for an extension number to return the call.

(5) Even if the caller is well known there might still be doubts whether the caller is entitled to the information they are seeking.

(6) If the caller is calling from outside the site/locality, it is essential that staff take a careful note of their full identity (name, position, organisation they represent) at the outset of the conversation.

(7) Caller from Government Departments, such as the Benefits Agency, Disability Living Allowance Agency, Social Services etc should be asked to submit their request for information in writing on the appropriate documentation. If the enquiry is urgent the request can be faxed through. (It is possible to set up a password system for regular enquiries).

(8) Offer to call the requester back but use the main organisation number via the switchboard and not a direct dial number.

(9) Do not be pressurised into giving information to the caller by them claiming to be in an emergency situation.

(10) If the caller becomes verbally aggressive politely decline to give any information and put the phone down.

(11) Refer any incidents to your manager who should raise a Risk Event form.

26. SAME NAME LABELS

(1) It is not uncommon to have a patient in the same specialty with the same name or same details.

(2) In any instance the records should be clearly marked with the information that another patient exists with the same name or details.

(3) Same Name Labels are available for this procedure.

(4) The PMI should be updated on both records, using the free text, with the details of other patient.

27. SECURITY OF HEALTH RECORDS

Remember that all Health Records are now subject to the Data Protection Act and Caldicott Guidelines should be applied when sending them to another locality or service.

(1) Notes should not be sent outside of the organisation in the event of a complaint or litigation they will be required for reference.

(2) Notes sent 'proof of posting' with a compliment slip to show where they are being returned to and the following written on the back of the envelope "If undelivered return to ....."

(3) Notes are kept in lockable filing cabinets or secure and locked areas.

(4) Offices should always be locked when no-one is in the room.

(5) Notes are never left where public or patients can have access to them.

(6) Medical Records Library is always kept locked and there is restricted access to authorised personnel only.

(7) Casenotes sent internally are always put in a sealed envelope or opaque bag.

28. TELEPHONE CALLS - PROCESSING

(1) The telephone is the window on to the service and should always be answered promptly and efficiently. To delay is to give a very poor view of the service and not just the department.

(2) Smile! Identify office, name and say how can I help you (If it's internal, just say the office name).

(3) Listen and take down notes (Always have paper and pen by the phone).

(4) Deal with the query or pass on call to someone else who can help (after telling the caller that you are transferring them.

(5) Assess urgency of call - prioritise.

(6) Write down message and make sure you leave it or give it to relevant person.

(7) If you have any doubts that the person to whom you have taken the message will not be returning to the office quickly enough to deal with the problem then bring to the attention of another person within the office/department.

29. TRACING AND TRACKING NOTES

All casenotes have a recognised 'home' and when removed from that location it is vital that a clear audit trail is in place.

(1) All notes should be filed in the filing rack at the recognised 'home' when they are not in use.

(2) All notes should be filed with a yellow tracer card clearly marked with the patients name and case note number.

(3) When the notes are required to be removed from the racks, the tracer card must be marked with the date of removal (dd/mm/yyyy), reason for removal and the name of the person removing them.

(4) The notes should then be transferred to the new location.

(5) When the notes are received into the location they should be logged in to the department to ensure that knowledge of the receipt of the notes is noted.

(6) When the notes are then sent back to the records store they should be logged out again.

If the user has access to PAS, the patient record must be accessed and the case note location changed on the record and the function Case Note Tracking (CNT) must be used to record the new location.

30. TRANSPORTATION OF NOTES

The Data Protection principles and Caldicott guidelines must always be observed when patient records are being sent throughout the localities. Never, ever record the patient's name on the outside of the envelope, for all to see, or record on the envelope the fact that it contains patient records.

Patient records must never be transported using black bin bags.

Internal

(1) Notes must always be placed in a sealed robust envelope or opaque bag.

(2) Destinations must be clearly identifiable.

(3) Once notes have been booked or tracered out, an adhesive label (which is removable at the end of the activity) is attached with the clear destination, requester and date required.

External

(1) Permission must be given to send the notes out of the Trust as this is not a usual thing to do and there must be extenuating circumstances.

(2) Notes must be booked/tracered out.

(3) Notes must always be sent in a robust envelope or opaque bag.

31. WAITING LIST STATISTICS

(1) Waiting List data is a one-off snapshot in time of the current situation for waiting lists.

(2) Waiting List data should be calculated on the last working day of the month or the first working day of the next month and should always be done at these times to be consistent.

(3) It is vital that waiting list data is provided to Information Services on a regular monthly basis by the 7th day of the following month.

(4) The following data items are required:

(a) The numbers of weeks waiting for routine appointments for each Consultant and each site at which they work.

(b) The numbers of patients waiting for each Consultant for 0-4 weeks, 4-13 weeks, 13-26 weeks, 26+ weeks.

(c) The numbers of referrals received during the previous month, split by GP other.

(5) It is vital that all patients are counted as these form part of the Performance Indicators required by South West Region and the Department of Health.

For further information on how to calculate the waiting list contact Information Services at St. James Hospital on Tel.no. 023 9289 4355

32. YEAR LABELS

(1) Year Labels are an excellent way of ensuring that all Health Records can be extracted from the filing system quickly and archived according to the Trust Preservation, Disposal and Retention Policy, and to comply with the Department of Health Guidelines.

(2) Each department should have a supply of coloured Year Labels according to the year in which the Health Record is raised and used. (Each year is a different colour and there is a national system for issuing these.

(3) Place the Year Label on the front of the record (on the right hand side) where it is going to be most easily visible at a quick glance from the filing system.

(4) Each year that the patient is seen the label should be updated with the most current label. i.e. If the patient is seen in 1999 the colour will be pink. If the patient then returns in the Year 2000 as part of an ongoing episode the colour will be different.

(5) When the episode is closed and the folder remains on the shelf, the record will be retrieved easily for archiving by pulling out all the same coloured label.

33. MISSING HEALTH RECORDS

Missing health records are a serious risk and it is therefore vital that the Tracing procedures are undertaken at all times (Section 26). However, the following procedures should be undertaken if a set of notes go 'missing'.

(1) Highlight the fact that a record is 'missing' to your line manager and work colleagues as soon as this becomes apparent. Complete the Search Log for Missing Case-Notes (**Appendix B**) and place the form in a recognised but safe place for all staff to be aware of the incident.

(2) Search in the place you would normally expect to see the record but look either side and above and below where it should be filed.

(3) Check on PAS to try to establish the last location or look to see which service the patient last attended as this may provide clues.

(4) Make a clear list of all the places that have already been searched.

(5) Maintain the list of places searched as this progresses.

(6) Ask a colleague to search for the record in case this has been missed by you. Easily done!

(7) Check what the Tracer says and follow this through.

(8) Mark the Tracer with a coloured pen that the notes are required elsewhere should they be returned to file, with the name of the person who requires them.

(9) Check again after a few days as sometimes the notes reappear.

(10) Check all the other health record locations throughout the Trust.

(11) In the event of a complete failure to locate the records, a temporary folder should be raised marking it clearly as a temporary folder and indicating who the original should be referred to (the member of staff who has been searching for the record) should it be located.

(12) Inform the Health Records Manager by means of a phone call/fax/email etc should the notes be returned to file and are no longer 'lost'.

34. DECEASED RECORDS

When a notification of a death of a patient is received the following steps should be taken:

(1) Always ask the person notifying you to confirm the date of the death of the patient.

(2) If the date of death is not known then the person notifying should be requested to ascertain this.

(3) Pull the Health Records from file or retrieve from the latest location.

(4) Stamp the records on the right hand side, with the 'Deceased' stamp.

(5) Record by hand the date of death within the appropriate place on the deceased stamp.

(6) Check the records for any future appointments or patient transport arranged, and cancel accordingly.

(7) Inform anyone within the team/department who needs to know.

(8) Record the death on the patient's record on PAS.

(9) Send the records to the deceased file within the Health Records Library.

(10) If you do not have access to the 'Record Patient Death' <RPD> on PAS, contact the PAS training department for training and access to the function.

East Hampshire NHS
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Appendix A. DATA PROTECTION TEAM

Name	Position	Area of Responsibility
East Hampshire Primary Care Trust DP Team		
Dr Ian Reid	East Hampshire PCT Raebarn House 3rd Floor Hulbert Road, Waterlooville, PO7 7GP 023 9224 8800	Caldicott Guardian
Matthew Thomas	East Hampshire PCT Raebarn House 3rd Floor Hulbert Road, Waterlooville, PO7 7GP 023 9224 8800 matthew.thomas@ports.nhs.uk	PCT Coordinator
DP Local Co-ordinators		
Code A	Waterlooville Health Centre Dryden Close Waterlooville PO7 6AJ 023 9224 0340	Child Health
Code A	East Hampshire PCT Raebarn House Code A	Trust HQ
Code A	Battenburg Avenue Clinic Battenburg Avenue North End Portsmouth PO2 0TA Code A	Podiatry Teams
Code A	Senior Dental Administrator Dental Department Battenburg Avenue Code A	District wide Dental Services + Access to Health Records
Code A	Information Co-ordinator Data Information Elderly Mental Health Division St James' Hospital 023 9289 4460	Elderly Mental Health + Access to Health Records
Carol Farmiloe	Office Manager Divisional Office (Elderly Medicine) South Block Queen Alexandra Hospital 023 9228 6893	Elderly Medicine
Alison Grout	Admin and Support Manager Waterlooville Health Centre 023 9245 5111	Health Centres and District Nursing + Access to Health Records
Code A	Secretary OT Department Petersfield Hospital 01730 26322 Code A	Occupational Therapy
Code A	Resources Centre St. James Hospital 023 9282 2444 Code A	Media and Communications
Code A	Administrator Palliative Care Department Rowans Hospice 023 9225 0001 Code A	Palliative Care Service
Code A	Office Administrator Occupational Health St. James Hospital 023 9282 2444 ext. Code A	Occupational Health

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Name	Position	Area of Responsibility
Caroline Man	Personnel Manager Personnel Department St James' Hospital 023 9289 4308	Personnel Services
Lin Pearce	Admin & Support Services Manager Petersfield Community Hospital 01730 263221 ext 111	Health Centres/Small Hospitals
Code A	*Admin Secretary* *Petersfield Community Hospital* *01730 263221*	*Access to Health Records only* *(Lin Pearce for other DP issues)*
Jo Snaith	Manager Sharland House Fareham 01329 233521	Dental Access Centre
Ian Waterhouse	Office Supervisor Havant Health Centre 023 9245 5111	Child and Family Therapy (DP +Access to Health Records)
Fran Williams	District Nursing Havant Health Centre Civic Centre Road Havant PO9 2AX 023 9245 5111 x325	District Nursing
District-wide PCT Support DP/Caldicott		
Code A	Data Protection Co-ordinator St. James Hospital 023 9282 2444	ICT Data Protection
Support Services		
Jean Kennedy	CIS Applications Manager St James' Hospital 023 92 822444 x 4195	ICT Services (Access to Records for Child Health Immunisation / Vaccination Data)
Judy Woodley	Information Services Finchdean House 023 9282 2444 x5128	ICT Services (PCT Information)
Portsmouth City Primary Care Trust		
Pam Hobbs	Portsmouth City PCT Trust Central Office St. James Hospital	Caldicott Guardian and PCT Co-ordinator
Code A	Portsmouth City PCT	Trust HQ coordinator
Fareham and Gosport Primary Care Group		
Vacant	Fareham/Gosport Fareham Reach Gosport Rd Fareham 01329 229411	PCT Coordinator
Hampshire Partnership NHS Trust		
Alison Thompson	Admin & Support Manager Park Way Centre 023 9247 1661	Adult Mental Health
Fran Buxey	Administration Co-ordinator The Meadows 01489 581540 x202	Adult Mental Health

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Appendix B. SEARCH LOG FOR MISSING CASE NOTES

DATE	PATIENT NAME	CASE NOTE NUMBER	LAST TRACED / TRACKED TO	DATE TEMPORARY FOLDER CREATED	REASON FOR CREATION OF TEMPORARY FOLDER	DETAILS OF FURTHER SEARCHES	DATE FOUND	LOCATION OF NOTES WHEN FOUND

a. This log must be completed as soon as it is confirmed that a case notes folder is missing.
b. Searches for missing notes must be undertaken on a regular, weekly basis. The person undertaking the search must complete the Further Searches column, signing and dating the entry.
c. The reasons why case notes were missing or unavailable should be fully documented.