Fareham and Gosport NHS
Primary Care Trust

FAX

Please telephone 01329 233447 if any page is missing or indistinct

To **Strategic Health Authority** Date **20 September 2002**

For the Attention Of: **Eileen Spiller** Fax No: **023 8072 5457**

From **Margaret Smith**
Primary Care Lead Pages (include this sheet) **49**

Gosport War Memorial Hospital

Please find attached the following documents:

1. Accessing your Medical Health Records (5 pages)
2. Trust Dissolution Project (13 pages)
3. Access to Personal Records (30 pages)

A further document entitled Health Records – Standards and Procedures will be e-mailed to you as soon as possible. (40 pages).

Regards

Caroline Harrington
Risk & Litigation Manager on behalf of Margaret Smith

FAREHAM & GOSPORT PRIMARY CARE TRUST

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1. 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 audio tape.

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 are 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 Portsmouth HealthCare Trust Policy. Please contact your local co-ordinator for further advice/assistance.

2. 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 a 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 patient's own GP or from another GP within the same practice. This GP becomes the referring GP. Or the referral can be made by the Consultant.
   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 who are 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. Check 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. Patients admission is also recorded on 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.

3. 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 (HIS) 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.

4. 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. Check 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

5. 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 GP) 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. Kathryn Bowes SJH ext. 4296 or Judy Woodley SJH ext. 4303.

6. Discharge Procedure

1. When a patient's details are input to the Community Information 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.

Discharge Summary form attached for information

7. 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 CIS in Case Note Location before destruction.

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

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 hand-written notes which have been used to record the telephone messages with patient's or staff names on them.

7. Contact Health Records Project Manger for confidential destruction procedures if in any doubt.

*** See attached for NHS Retention and Disposal Schedule**

8. 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 CIS 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 CIS.

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.

9. 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 patients 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**
Blue	-	x-ray, CT, Ultrasound	)**on top**
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

10. 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.

11. 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 exists within storage area

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

4. Ensure that the step stool is of an adequate height to reach the top shelf and has 'grab handles' for steadying should the user overbalance.

5. Do not store any items on top of high cabinets.

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

7. Ensure that full knowledge of the recommended weight is known and is displayed within the filing area.

8. Ensure that files do not get too large and are split up into an adequate number of volumes.

9. 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.

10. Keep aisles and filing bays clear at all times.

11. Do not overfill cabinets and shelves.

12. Do not use staples on records files.

13. Ensure that there are no trailing electrical or other leads.

14. Ensure that risk assessment is carried out as per Risk Policy.

15. Ensure that all VDU Users comply with European guidelines and that seating, lighting and positioning are compliant.

16. 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

12. 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.

13. 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 (see 7 Disposal 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. 'N' 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 imaging must be catalogued and sorted according to the department/specialty requirements.

6. The location of the notes must be changed in CIS.

14. 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 check 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 Numbers 9 and 10 for Filing procedures

15. 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 found to be already known to the service, then 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 be used 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 co-incidentally 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.
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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.

16. Minor Injuries

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).

17. 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 CIS 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 Trust policy on Out of Area Treatments

18. 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.

19. Patient Registration

1. When a patient is admitted/referred - check if patient is registered on HIS/CIS using PMI-LIS. Use all methods of checking - surname, initial , sex, then if not found proceed to further searches i.e. with DOB etc.

2. If already on system check that all details are present and accurate update if necessary using PMI-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 checks. 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 CIS at all times and that if they are not known every effort must be made to get the correct details.

20. 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.**

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.

   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 keyworker appointed.

21. 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.

22. 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.

4. Same Name Labels are available for this procedure.

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

23. 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.

24. 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.

25. Tracing notes through the Trust

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 CIS the patient record must be accessed and the case note location changed on the record.

If the user has access to HIS the patient record must be accessed and the function Case Note Tracking (CNT) must be used to record the new location.

26. 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.

Internal (Sites within Portsmouth Health Authority)

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 (sites outside Portsmouth Health Authority)

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.

4. PATIENT RECORDS MUST NEVER BE TRANSPORTED USING BLACK BIN BAGS.

27. 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:
   The numbers of weeks waiting for routine appointments for each Consultant and each site at which they work.
   The numbers of patients waiting for each Consultant for 0-4 weeks, 4-13 weeks, 13-26 weeks, 26+ weeks.
   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

28. 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.

29. Missing Health Records

Missing health records are a serious risk to the Trust and it is therefore vital that the Tracing procedures are undertaken at all times, as detailed in number 25. However, should a set of notes go 'missing' the following procedures should be undertaken.

1. Highlight the fact that a record is 'missing' to your line manager and work colleagues as soon as this becomes apparent.

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. Post the name of the record missing in a recognised but safe place for all staff to be aware of the incident.

4. Check on CIS or HIS to try to establish the last location or look to see which service the patient last attended as this may provide clues.

5. Make a clear list of all the places that have already been searched.

6. Maintain the list of places searched as this progresses.

7. Ask a colleague to search for the record in case this has been missed by you. Easy done!

8. Check what the Tracer says and follow this through.

9. 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.

10. Check again after a few days as sometimes the notes reappear.

11. Check all the other health record locations throughout the Trust.

12. **If the notes have not been traced within 1 month then a 'risk event' form should be completed and sent to the Trust Central Office at St. James Hospital for recording on the Carekey system.**

13. In the event of a complete failure to locate the records then 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.

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'

30. 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 CIS.

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 CIS contact the CIS training department for training and access to the function.

31. Central Mental Health Records Library

SECURITY

1. Access:

- The library is located in the corridor near to the Estates Department.
- Each department will have a designated person(s) responsible for accessing the library.
- A list will be kept and maintained at the Front Hall of St. James Hospital.
- Each dept is responsible for notifying Von Dixon of change of personnel.
- Changes of personnel will be notified to the Front Hall and the list will be amended accordingly.
- Access to the library will be via a key and swipe card which will be drawn and signed out to the named personnel.
- The key and swipe card must be returned to the reception desk at Front Hall at the end of the session and must not be retained for any period of time as this will cause inconvenience to other staff.
- **Please do not leave the library unlocked when unattended.**

2. Alarm:

- The library is alarmed between the hours of 5pm - 7.30 am by St. James Security.
- The alarm panel is located on the right hand side of the entrance to the reception area.
- The code will be managed by Admin Support in Elderly Mental Health Division
- The alarm system will be managed by St. James Security as with other systems.

- Please see no 5 for access out of hours.

3. Fire Exit:

- In the event of a fire the fire exit is located in the rear of the library on the right hand side.
- The exit is through the Estates Department.
- The fire assembly point will be in the yard outside Estates Department.
- Follow the usual fire routines.
- **Keep the aisles clear at all times.**

4. Fault Reporting:

- Please ensure that if any faults i.e. leaks, faulty locks, etc are noticed you report them to the Faults Dept in Estates & notify Front Hall immediately.

5. Incidents:

- All accidents and incidents occurring in the library must be reported in the usual way to the User's manager and a risk event form completed as appropriate.
- All accidents and incidents must be noted in the accident book located on the notice board for monitoring by Admin Support in Elderly Mental Health Division.

FILING HEALTH RECORDS

PLEASE NOTE THAT ALL RECORDS ARE FILED BY CASENOTE NUMBER

1. Current Filing:

- The central library will hold 0 -10 yrs for current records and 10 - 20 yrs for Archived records.
- Outlying areas will hold 0 - 5 years current records at the units.
- Colour coding will be used to separate records which will be clearly marked in the library.
- Red - Current: Blue - Archived: Yellow - Deceased.
- When pulling records from archives **please ensure the tracer card is filed in the current notes section** (unless pulled for reference only) then the tracer card is filed in the archives.

2. Deceased Filing:

- Deaths will be filed separately
- **Deceased records are to be clearly stamped with the date of death (dd/mm/yyyy) of the patient.**
- **It is the responsibility of each speciality/unit to ensure that the date of death is recorded within the notes. (mm/yyyy if not otherwise known)**
- There is a standard 'deceased' stamp which every area should use.
- Deceased records are to be filed with the tracer card.

3. Sending Records to Central Library:

- Each area will be given a specific time during the working calendar for records to be sent in for integration in the central library. This will avoid the problem of overstaffing in the library at any one time.
- All areas to sort Health Records sent for central filing into Current/Archive/Deaths to allow for easy integration of records.
- **Any records that are not sent in the agreed format will be returned.**
- All records are to be filed numerically in sequential numbering sequence.

4. Destruction of Records:

- Health Records will be regularly weeded and sent for confidential destruction as per HSC 1999/053.
- If the record is not to be destroyed they should be clearly marked - **'NOT TO BE DESTROYED'.**

5. Access out of Hours:

- 752/night co-ordinator will need to contact security to gain access to the records library.

- The 752/Night Co-ordinator is the named person to contact for drawing of notes out of hours.
- The period of time covered is after 17.00 hrs - 8.30 hrs.

6. Telephone:

The telephone will be in situ within the Library for security purposes in the event of any untoward incident. (please see item 5 in section 5)

7. Fax

The fax will be in situ within the reception area to be used for faxing out in emergencies.

8. Tracer Cards:

- Tracer card must be completed when removing a set of casenotes from the library
- Please ensure that the date is recorded **dd/mm/yy**
- The patients name and casenote number is recorded on the card and filed in correct place.
- All records of patients who are **DECEASED** must have a tracer card completed.
- **REMEMBER** a tracer card must be completed for every set of casenotes removed from the library.
- Tracer card should be filed back in the notes when the casenotes are returned to the library.

2. Electronic Case Note Location

When the casenotes are drawn from the library, the location they are required to go to should be changed in Case Note Location on CIS. This will ensure that the accurate location of the casenote is always known to all users.

- When casenotes are returned to the library the Case Note Location must be changed on the patient's record.

- **TRACER CARDS MUST ALWAYS BE COMPLETED IF CIS/CASENOTE LOCATION IS NOT ACTIVATED.**

TRACER CARDS SHOULD ALWAYS BE COMPLETED. REMEMBER YOU MAY BE THE NEXT PERSON WHO REQUIRES THE RECORD OF THE PATIENT WHOSE RECORD HAS BEEN REMOVED WITHOUT A TRACER CARD.

See H.R. Standards & Procedures