Standard Operating Procedure

To be read in conjunction with the

Service User Records Management Policy

<table>
<thead>
<tr>
<th>Version Number:</th>
<th>V4.2</th>
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</thead>
<tbody>
<tr>
<td>Name of originator/author:</td>
<td>Head of Information Governance and Records</td>
</tr>
<tr>
<td>Name of responsible committee:</td>
<td>Informatics and IT Committee</td>
</tr>
<tr>
<td>Name of Executive Lead</td>
<td>Director of Strategy, Transformation and Performance</td>
</tr>
<tr>
<td>Date V1 issued:</td>
<td>October 2010</td>
</tr>
<tr>
<td>Last Reviewed:</td>
<td>March 2015</td>
</tr>
<tr>
<td>Next Review date:</td>
<td>March 2016</td>
</tr>
<tr>
<td>Scope:</td>
<td>Trust Wide</td>
</tr>
<tr>
<td>MMHSCT Document Code</td>
<td>CL13</td>
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Document Control Sheet

Document Title / Ref: Standard Operating Procedures for Service User Care Records

Lead Executive Director: Director of Strategy and Business Development

Author and Contact Number: Head of Information Governance and Records 0161 882 1081

Type of Document: Standard Operating Procedure

Broad Category: Clinical

Document Purpose: The purpose of the care records management policy and associated procedures and guidance is to ensure that all staff are aware of the standards, appropriate legislation, processes and procedures that they are required to comply with to ensure that adequate, complete and accurate service user care records are maintained and that they are controlled and managed in an effective systematic and consistent way in line with relevant professional and local standards, legislation and policy in order to ensure the provision of high quality and safe care.

Scope: Trust Wide

Version number: V4.2

Consultation: There are only minor changes from the previous version of this policy and associated procedures. Consultation limited to records management staff.

Approving Committee: Informatics and IT Committee

Approval Date: March 2014

Ratification and Date: Lead Executive Committee

Date of Ratification: March 2015

V1 Valid from Date: October 2010

Current version is valid from approval date

Date of Next Review: March 2016

Procedural Documents to be read in conjunction with this document: Service User Record Management Policy

Training Needs Analysis Impact:

- There are Training requirements for this procedural document
- Staff require regular training in records management

Financial Resource Impact:

- There are Financial resource impacts
- There is some financial impact in staff being released for training and provision of training. Document archiving and destruction

Document Change History

Changes to this document in different versions must be detailed below. Rationale for the change should also be given

<table>
<thead>
<tr>
<th>Version Number / Name of procedural document this supersedes</th>
<th>Type of Change i.e. Review / Legislation / Claim / Complaint</th>
<th>Date</th>
<th>Details of Change and approving group or Executive Lead (if done outside of the formal revision process)</th>
</tr>
</thead>
<tbody>
<tr>
<td>V4.1 Review March 2014</td>
<td></td>
<td></td>
<td>Exec Lead approval only. Reviewed to ensure meets IG toolkit requirements. Minor changes to monitoring of procedure and format due to new document control templates</td>
</tr>
</tbody>
</table>
Policy authors are asked to consider each of the nine protected characteristics under the Equality Act 2010. We expect you to demonstrate that throughout the policy process you have had regard to the aims of the Equality Duty:

1. Eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act;
2. Advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
3. Foster good relations between people who share a protected characteristic and people who do not share it.

Please provide a brief account of how you have done this, further work to be completed and any support you have had in considering the aims and working in compliance with the Equality Duty.

If you are unclear on how to do this or would like further advice and support then you may contact quality.admin@mhsc.nhs.uk.

It is the responsibility of the approving group to ensure this statement reflects the Trusts objectives and position with compliance as set out within the NHS Equality Delivery System.

The previous version of this procedure was subject to a full equality and diversity impact assessment in line with the Equality Duty which was approved by the Equality and Diversity Committee. The Equality Duty has however been considered during the review of the policy but as the policy changes are very minor they do not have any impact the policy complies with the Equality Duty.

In line with the Trust values we may publish this document on our External Website. Is there any

Can be published
reason you would prefer this is not done?

It is the Authors responsibility to ensure all procedural documents comply with the Trust values

If you are unclear on any of the requirements in the document control sheet then please email quality.admin@mhsc.nhs.uk before proceeding
### Monitoring and Compliance Requirements Sheet

(This section **MUST** be completed by the Author without exception). This section demonstrates the Trust’s commitment to Continuous Improvement and Lessons Learned from Incidents, Reports from the Coroner or other External Agencies and will be submitted as evidence as required.

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<tr>
<th>Minimum Requirement/Standard/Indicator to be monitored and Section of Document it appears</th>
<th>Process for monitoring</th>
<th>Responsible Individual</th>
<th>Frequency of Monitoring</th>
<th>Responsible Committee/Group/meeting for review of results / action plan approval / implementation</th>
<th>Comments</th>
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<td>Level 1 .1.7a. The documented process includes duties.</td>
<td>Review</td>
<td>Head of IG &amp; Records TIGG</td>
<td>Yearly</td>
<td>Informatics and IT Committee</td>
<td>Policy section 6 And in procedural guide section 7</td>
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<tr>
<td>Level 1 .1.7b. The documented process include legal obligations</td>
<td>Review</td>
<td>Head of IG &amp; Records TIGG</td>
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<td>Informatics and IT Committee</td>
<td>Policy section 7. And in procedural guide section 3 and Appendix A</td>
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<td>Level 1 .1.7c. The documented process include Record Creation</td>
<td>Review</td>
<td>Head of IG &amp; Records TIGG</td>
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<td>Informatics and IT Committee</td>
<td>Procedural guide section 9 And procedural guide section 10</td>
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<tr>
<td>Level 1 .1.7d The documented process include Record Tracking</td>
<td>Review</td>
<td>Head of IG &amp; Records TIGG</td>
<td>Yearly</td>
<td>Informatics and IT Committee</td>
<td>Procedural guide Section 14 Plus Appendix H</td>
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<tr>
<td>Level 1 .1.7e The documented process include Records Retrieval</td>
<td>Review</td>
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<td>Informatics and IT Committee</td>
<td>Procedural guide section 14 Plus Appendix G</td>
</tr>
<tr>
<td>Level 1 .1.7f The documented process include Records Retention and Disposal</td>
<td>Review</td>
<td>Head of IG &amp; Records TIGG</td>
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<td>Informatics and IT Committee</td>
<td>Procedural guide section 16 And procedural guide section 17</td>
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<td>Level 1 1.7g</td>
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<td>The documented process include Implementation evidence – Tracking records</td>
<td>Survey</td>
<td>Head of IG &amp; Records TIGG</td>
<td>Yearly</td>
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<tr>
<td>Level 3 1.7</td>
<td>The documented process include Monitoring evidence – tracking records</td>
<td>Survey and review of action plans</td>
<td>Head of IG &amp; Records TIGG</td>
<td>Yearly</td>
<td>Informatics and IT Committee</td>
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### 1.8 - Health Record Keeping Standards

<p>| Level 1.8a. | The documented process include Basic Record Keeping Standards to be used by all staff | Review | Head of IG &amp; Records TIGG | Yearly | Informatics and IT Committee | Procedural Guide Section ...11. And procedural guide section 12 |</p>
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<th>Yearly</th>
<th>Informatics and IT Committee</th>
<th>See above Procedural guide Section 12</th>
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<td>The documented processes include process forming surea contemporaneous record of care is completed</td>
<td>Head of IG &amp; Records TIGG</td>
<td>Yearly</td>
<td>Operational Management Team</td>
<td>Under review in line with TNA. Move to two yearly. With training on induction for all new staff. Monitoring will be via L&amp;D Department training records produced monthly to ensure all appropriate staff remain current. Procedural guide section 19</td>
<td></td>
</tr>
<tr>
<td>Level 1.8c..</td>
<td>Review</td>
<td>Head of IG &amp; Records TIGG</td>
<td>Yearly</td>
<td>Operational Management Team</td>
<td>Under review in line with TNA. Move to two yearly. With training on induction for all new staff. Monitoring will be via L&amp;D Department training records produced monthly to ensure all appropriate staff remain current. Procedural guide section 19</td>
</tr>
<tr>
<td>The documented processes include how the organisation trains staff, in line with the training needs analysis</td>
<td>Head of IG &amp; Records TIGG</td>
<td>Yearly</td>
<td>Operational Management Team</td>
<td>Under review in line with TNA. Move to two yearly. With training on induction for all new staff. Monitoring will be via L&amp;D Department training records produced monthly to ensure all appropriate staff remain current. Procedural guide section 19</td>
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<tr>
<td>Level 1.8d</td>
<td>Review</td>
<td>Head of IG &amp; Records TIGG</td>
<td>Yearly</td>
<td>Informatics and IT Committee</td>
<td>Policy section 9 Procedural guide section 13 and 20 and 21</td>
</tr>
<tr>
<td>The documented processes include how the organisation monitors compliance with all of the above</td>
<td>Head of IG &amp; Records TIGG</td>
<td>Yearly</td>
<td>Informatics and IT Committee</td>
<td>Policy section 9 Procedural guide section 13 and 20 and 21</td>
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<td>Yearly</td>
<td>Informatics and IT Committee</td>
<td>Policy section 9 Procedural guide section 13 and 20 and 21</td>
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<tr>
<td>The documented processes include implementation evidence – Basic record keeping standards</td>
<td>Head of IG &amp; Records TIGG</td>
<td>Yearly</td>
<td>Informatics and IT Committee</td>
<td>Policy section 9 Procedural guide section 13 and 20 and 21</td>
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<td>Head of IG &amp; Records TIGG</td>
<td>Yearly</td>
<td>Informatics and IT Committee</td>
<td>Policy section 9 Procedural guide section 13 and 20 and 21</td>
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<tr>
<td>The documented processes include monitoring evidence – basic record keeping standards</td>
<td>Head of IG &amp; Records TIGG</td>
<td>Yearly</td>
<td>Informatics and IT Committee</td>
<td>Policy section 9 Procedural guide section 13 and 20 and 21</td>
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<td>with Continuous improvement.</td>
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<td></td>
<td>See above. Trust Information Governance Group will approve and monitor action plans generated by the Trust Records Management Group. Final approval and progress will be reported to I&amp;IT committee. Multidisciplinary audit of records annually.</td>
<td></td>
</tr>
</tbody>
</table>

NB: If you have selected audit you should complete the required audit registration form and standards document and submit these with your expected timescales for completing the audit to quality.admin@mhsc.nhs.uk as soon as possible and no later than 4 weeks prior to the audit commencing.

The Group / Committee should also ensure the monitoring work is added to their yearly schedule of monitoring and action logs as appropriate.
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Have you considered using a flowchart in your document to provide easy reference for staff? If you need support in developing a flowchart contact quality.admin@mhsc.nhs.uk
1 Introduction

Information is the lifeblood of any NHS organisation and is essential to the delivery of high quality evidence-based health care on a day-to-day basis. It is therefore essential that the records generated in the course of care provision are created, used and managed in an effective systematic way using common standards.

Manchester Mental Health and Social Care Trust Board are committed to ensuring that there is a culture within the organisation which ensures that the safety of service users, staff and members of the public is central to the organisation’s objectives and practice.

As such the Trust Board are therefore committed to ensuring that an appropriate structure and framework is in place to ensure that care records are created, maintained, managed and controlled in an effective systematic way, in line with the relevant legislation, government policy and professional and regulatory bodies codes and standards in order to provide care that is safe and of the highest possible quality.

2 Purpose

The purpose of the care records management policy and associated procedures and guidance is to ensure that all staff are aware of the standards, appropriate legislation, processes and procedures that they are required to comply with to ensure that adequate, complete and accurate service user care records are maintained and that they are controlled and managed in an effective systematic and consistent way in line with relevant professional and local standards, legislation and policy in order to ensure the provision of high quality and safe care.

3 Legal Framework

All NHS records are Public Records under the Public Records Acts and must be kept in accordance with the following statutory, Government policy and NHS guidelines

- The Freedom of Information Act 2000
- Data Protection Act 1998,
- Public Records Act 1958 and 1967,
- Access to Health Records Act 1990
- The Caldicott Report,
- Records Management: NHS Code of Practice 2006 (Parts 1 and 2),
- Care Quality Commission (CQC) regulations
- Information Governance Assurance,
- NHS Confidentiality Code of Practice,
- The common law duty of confidentiality,
- NHS Litigation Authority (NHSLA) standards
- Connecting for Health record keeping standards
- Relevant professional standards
4. **Objectives**

The objectives of the care records management policy and this associated procedures and guidance are:

- To ensure that care records are created and managed in a systematic and safe way to ensure service user safety and provision of high quality care.
- To define the standards for good record keeping.
- To ensure the establishment of a regular cycle of audit to monitor and measure the application of care records management and practice against agreed indicators and standards, and to implement any action that arises as a result of the audits.
- To provide a clear system of accountability and responsibility for record keeping and use. Ensuring all member of staff including bank, locum and agency staff are clear about their roles and responsibilities.
- To ensure staff create and keep records which are adequate, consistent, and necessary for statutory, legal and business requirements in order to provide quality care, facilitate audit, fulfil the Trust’s responsibilities, and protect its legal and other rights.
- To ensure systematic, orderly and consistent creation, retention, appraisal and disposal procedures for care records throughout their life cycle.
- To ensure systems are such that care records can be efficiently retrieved by those who have a legitimate right to do so when and wherever needed.
- To ensure records keeping systems are managed to maintain appropriate confidentiality, security, authenticity and integrity for records in their storage and use.
- To ensure targeted training and guidance on legal and ethical responsibilities and operational good practice for all staff involved in care records management so they understand what information should be recorded, how it should be recorded, why it should be recorded, how to validate it, how to correct errors and how to use the information.
- To identify links with other relevant Trust Policies, Procedures and Guidelines.
- To ensure that record keeping procedures are fully compliant with the relevant legislation and Government policy.

5. **Scope of the Policy and Procedural Guidance**

It is recognised that at this point in time the Trust has both electronic and manual records. The care records management policy endorses the main service user record to be used in the Trust as that which is recorded and held electronically.

Where the electronic system cannot provide the necessary level of functionality required paper records will continue to be used until such time as an electronic alternative becomes available. The scope of this document therefore relates to all clinical and social care records held in any format by the Trust, electronically or in physical/manual form.

The Trust records management duty also includes responsibility for the legacy records of predecessor organisations and any obsolete service that was previously under Trust management.
It is recognised that the Trust works with many partner organisations in the provision of care for its service users. The scope of this document extends to all those working under such arrangements who contribute to the care records for which the Trust is responsible.

6. Associated Policies

This document should be read in conjunction with the following Trust policies:

- Data Quality Policy
- Information Governance Policy
- Information Sharing Policy
- Information Security Policy
- Email and Internet Use Policies
- Safe Haven Policy
- Access Control Policy
- Access to Records Policy
- Confidentiality Code of Conduct
- Admission, Discharge and Transfer Policy
- Freedom of Information Policy
- Policy for the Management of Incidents including SUI’s
- Policy on Procedural documents
- Mental Health Act Policies
- CPA policy
- Relevant Governance policies
- Relevant Human Resources Policies

7. Duties and Responsibility

7.1 Managerial Accountability, Duties and Responsibility

The Chief Executive and Executive Directors carry corporate level responsibility, however anyone treating service users and who create, receive, input to and use care records have a personal and professional responsibility to ensure they keep appropriate records of their work in the Trust and manage those records in keeping with the care records management policy and subsequent guidance.

Specific responsibilities and duties of staff are outlined below however it is the responsibility of all Trust staff including those on temporary or honorary contracts and students to comply with the care records management policy and this associated procedural guidance.

Compliance with Trust policies is a condition of employment and breach of a policy may result in disciplinary action.

7.2 Specific Responsibility

7.2.1 Chief Executive - as the accountable officer has overall responsibility for ensuring service user records are managed responsibly within the Trust.
7.2.2 **The Trust Caldicott Guardian** - has a particular responsibility for reflecting service user interests regarding the use of their personal identifiable information and ensuring such data is shared in an appropriate and secure manner. The Trust Medical Director is the Caldicott Guardian and is also the nominated lead for all care records and responsible for the professional standards in care record keeping.

7.2.3 **Trust Records Manager** — this role has been delegated to the Head of Information Governance and Records is responsible for overall development and maintenance and monitoring of records management practice and policy. They are responsible for drawing up guidance for good record management practice and for the implementation of and promoting compliance with this policy to ensure good quality record keeping and the easy, appropriate, timely availability of service user information. They will also set an annual work programme to ensure care records are managed and regularly audited in accordance with this policy and relevant professional standards. They must have an up-to-date knowledge of the laws and guidelines concerning good record keeping confidentiality, data protection and access to service user information in particular.

7.2.4 **Clinical Systems Managers** - are responsible for the day to day management of the Trust Electronic service user record systems and as such are responsible for ensuring that staff are trained to create electronic records in line with the requirements and standards laid down within this policy and associated procedures.

7.2.5 **Heads of Department/Senior Managers** - have overall responsibility for the management and handling of care records in their area in that they should ensure records are controlled and managed in a way which meets this policy and associated procedures.

7.2.6 **Line managers/supervisors** - must ensure that all their staff, who have cause to create, input to or use care records are adequately trained in this area and apply the appropriate guidelines. They must ensure that standards of record keeping by staff under their management or supervision are routinely monitored and audited. They must have an up-to-date knowledge of the laws and guidelines concerning good record keeping confidentiality, data protection and access to service user information in particular. Line managers will where they identify poor recording practice, must take appropriate management action to improve standards.

7.2.7 **Professional Leads**— are responsible for advising the various professions in relation to good practice and assisting in ensuring that professional standards are maintained.

7.2.8 **Local Records Managers** - there are currently local “care records managers” in each locality of the Trust. It is anticipated in the foreseeable future that a centralised records team will be established and will be responsible for supporting the Heads of Department in the management of care records Trust wide. However in the meantime this will remain the responsibility of the locally designated records managers who will work closely with the Trust Records Manager in ensuring compliance with the standards, legislation, policies and procedures relating to the management of care records in their locality/service area.
7.2.9 Clinical Audit – will be responsible for ensuring that within the audit programme regular audits of record keeping are undertaken in line with the requirements of NHSLA, CQC, the various professional body standards.

7.2.10 Internal Audit – may as part of the annual audit programme audit/monitor care records management processes and procedures in operation and compliance with this policy.

7.3 Individual Duties & Responsibility

Individual members of staff whether permanent, temporary, contracted or a volunteer are responsible for any records, which they create or use. As such they are responsible for ensuring the records are created and managed following the appropriate standards as laid down in this document and also in line with their professional codes of practice and the legal framework for management of records.

In addition everyone working for or with the NHS who records, handles, stores, or otherwise comes across service user information has a personal common law duty of confidence to both service users and their employer. This duty of confidence continues even after the death of the service user and/or after an employee or contractor has left the NHS.

All staff must ensure that personal information (e.g. about a service user) processed or kept for any purpose should not be kept for longer than is necessary for that purpose, as stated by the Data Protection Act 1998.

Service user Information may not be passed on to others without the service user’s consent except as permitted under Schedule 2 and 3 of the Data Protection Act 1998 or, where applicable, under the common law where there is an overriding public interest. Further guidance on disclosing service user information can also be found in the Trust’s Code of Conduct on Confidentiality.

8. Care Records Management - Definition

Records Management is a discipline which utilises an administrative system to direct and control the creation, version control, distribution, filing, retention, storage and disposal of records, in a way that is administratively and legally sound, whilst at the same time serving the operational needs of the Trust and preserving an appropriate historical record. The key components of Records Management are:

- record creation
- record keeping (including staff being aware of professional standards regarding record keeping)
- record maintenance (including tracking of record movements)
- access and disclosure
- appraisal
- archiving
- disposal
- retention

In the context of the care records management policy and associated procedural guidance, a care record is defined as a structured document that contains information (in any media) which has been
created or gathered as a result of the work of NHS employees or associated staff (e.g. LA staff) in relation to service users care including

- Service users health and social care records (electronic or paper based)
- X-ray and Imaging reports, and other images Microform (i.e. fiche/film)
- Audio and videotapes, cassettes, CD-ROM etc.
- Computer databases, output, and disks etc., and all other electronic records relating to service users included emails and scanned records and faxes
- Photographs
- Email and text messages

This list is not exhaustive.

8.1 **Records Management System**

The key objectives of a Records Management System comprises the following key elements:

8.2 **Responsibility and Accountability**

To provide a clear system of accountability and responsibility for record keeping and use.

It is important that all individuals in the Trust appreciate the need for responsibility and accountability in the creation, amendment, management, storage of and access to all care records.

8.3 **Record Quality**

To create and keep records which are adequate, consistent, and necessary for statutory, legal and business requirements in order to provide quality care, facilitate audit, fulfil the Trust’s responsibilities, and protect its legal and other rights.

Care records should be comprehensive, consistent, accurate and complete, the information they contain should be reliable and the authenticity should be able to be guaranteed. The quality of the record should be such that the context of the record can be interpreted and it is possible to identify who created or added to the record and when. Care records should show proof of their validity and authenticity so that any evidence derived from them is clearly credible and authoritative.

8.4 **Management**

To achieve systematic, orderly and consistent creation, retention, appraisal and disposal procedures for care records throughout their life cycle.

And that systems are such that care records can be efficiently retrieved by those who have a legitimate right to do so when and wherever needed. Care record-keeping systems and procedures should be easy to understand, clear, and efficient in terms of minimising staff time and optimising the use of space for storage.

8.5 **Security**

To provide systems which maintain appropriate confidentiality, security and integrity for records in their storage and use.

Records must be kept securely to protect the confidentiality and authenticity of their contents, and to provide further evidence of their validity in the event of a legal challenge.
8.6 Access
To provide clear and efficient access for employees and others who have a legitimate right of access to care records, and ensure compliance with Access to Health Records, Data Protection and Freedom of Information legislation.

8.7 Audit/Performance Management
To undertake a regular cycle of audit to monitor and measure the application of care records management and practice against agreed indicators and standards, and to implement any action that arises as a result of the audits.

8.8 Training
To provide targeted training and guidance on legal and ethical responsibilities and operational good practice for all staff involved in care records management so they understand what information should be recorded, how it should be recorded, why it should be recorded, how to validate it, how to correct errors and how to use the information.

Effective records management involves staff at all levels. Training and guidance enables staff to understand and implement policies, and facilitates the efficient implementation of good record keeping practices.

9. Record Keeping
Records are a valuable resource because of the information they contain. That information is only usable if it is correctly recorded in the first place, is regularly updated, and is easily accessible when it is needed. Information is essential to the delivery of high quality evidence-based health care on a day-to-day basis and an effective care records management system ensures that such information is properly managed and is available:

- To support the care process and continuity of care
- To support day to day business which underpins delivery of care
- To support evidence based practice
- To support sound administrative and managerial decision making
- To meet legal requirements, including requests from service users under access to health records legislation
- To assist medical and other audits
- To support improvements in clinical effectiveness through research and also to support archival functions by taking account of the historical importance of material and the needs of future research Whenever, and wherever there is a justified need for information.

9.1 Care records
The clinical care record is often the only way to quantify the quality of care a service user has received and there is a medico legal requirement to keep records. Where there is a dispute about the event or care courts often assume if is not documented it didn’t happen. The nearer to the event a record is made the more accurate it is likely to be.
The purposes of the care record are:

- To act as a working document for day-to-day recording of events and service user care
- To store a chronological account of the service user's care, illnesses, its context and who did what and to what effect
- To enable the clinician to communicate with themselves
- To aid communication between team members
- To allow continuity of approach in a continuing illness
- To record any special factors that appear to affect the service user or the service user's response to treatment
- To record any factors that might render the service user more vulnerable to an adverse reaction to management or treatment
- To record risk assessments to protect the service user and others
- To record the advice given to general practitioners, other care professionals and other agencies
- To record the information received from others, including carers
- To store a record to which the service user may have access
- To inform medico-legal investigations
- To inform clinical audit, governance and accreditation to assess clinical effectiveness, quality of care and cost effectiveness.
- To inform bodies handling complaints and inquiries
- To inform research
- To inform analyses of clinical activity
- To allow contributions to national data-sets, morbidity registers, etc.

It is essential therefore that a care record is created and maintained for all contact with service users and clients.

An entry must be made for every contact and at least once per shift on an inpatient ward.

Records of all contacts with service users must be complete and accurate in order that employees or their successors can undertake appropriate action in the context of their responsibilities, to facilitate audit or scrutiny as required to protect services user and staff and provide authentication of the records so that they are credible and authoritative.

The main clinical record in the Trust is that contained on the Trust Electronic Clinical Information System and as such all staff who have a need to document information about service users in relation to their care provision must do so electronically where the facility to do so exists.

For service users in HMP Manchester the main clinical record in use there is Systm-One and all records for patients will be recorded electronically.

Any information where it is not possible to record on electronically will need to be recorded and held manually, this may require a manual case folder to be created.

Where a manual case folder needs to be created staff should only use a Trust approved folder.
This case folder should then follow the service user as required throughout the service using approved tracking mechanisms and using the NHS number as a single numbering system.

9.3 Staff care records
It is highly likely that existing and past staff members have or are receiving care from the Trust. These records should be recorded and handled in the same way as any other service user record. That is they are confidential records and should be kept securely and accessed on a need to know basis by those who have authority to do so. As with any other service user the professional treating them must explain the why and how information is collected and how and where it is to be recorded and what it is to be used for.

If a staff member has any concerns about the recording of their information they should be encouraged to discuss this with their care professional.

10. Records Registration

In order to ensure records can be identified and retrieved when needed it is necessary, in most cases, to allocate a registration system to a set of records.

Registration is a system which allocates a unique identifier (number or alphabetical prefix) to each item, and which records that sequentially in a 'register' or index.

All care records should have a unique identifier where possible this should be the NHS number supplemented by the local casenote number.

NHS policy states the NHS number must be documented and used on all correspondence and documentation relating to a service user. All staff are responsible for ensuring this is the case for information they produce and that the NHS number is used as the unique identifier where possible.

If any new manual records systems are required to be created then staff must check with their local records manager who will advise on the supplementary numbering system to be used.

If any new electronic records systems containing service user information are to be created then the personal data form at APPENDIX O should be completed prior to its development. This is alongside any service request that may need to be made to IT if there IT implications

If the database requirements can be accommodated in Amigos or System-One then the request will be submitted for prioritisation to the relevant Development Priority Group.

If the requirement cannot be met by Trust systems then the request will be submitted to the Trust Records Management Group chaired by the Head of Information Governance (IG) and Records who will consider the record management and information governance issues and implications and advise whether the database can be created. Final approval for any such development will rest with I&IT Committee.

The Head of IG and Records will keep a records of all decisions made.

10.1 Creating case note folders
When a patient is referred and accepted for service or admitted to a ward then a case folder may be required for storage of some manual information that cannot be recorded on electronically.
Staff should ensure they check the electronic system to see if a manual record already exists for the service user. If it is clear that a new manual record needs to be created then this should only be done by the Records Management teams/approved administrators.

Out of hours or in an emergency situation a temporary file can be created by the ward/team using a temporary/interim case note (eventually this will be the NHS number or a temporary number if the NHS number cannot be traced).

The duty bleep holders will be provided with the procedure and list of temporary numbers to use by the records management team.

The next working day the local records manager should be informed of the need to create a permanent record which will be prepared and made available as a matter of urgency. The temporary number will be no longer be used and the ward/team will be required to ensure all paperwork is filed appropriately in the new case record.

10.2 **Avoiding the Risk of Duplication of Care records**

The existence of duplicate care notes poses a risk to service users as it is likely that important information necessary for the correct treatment of service users may be missed e.g. drugs and allergies and clinicians cannot be sure they are viewing the whole medical history of the user.

The continued use of the Trusts single electronic record supplemented by a single manual record where necessary will assist in diminishing the risk of duplication.

In the meantime in order to avoid the duplication of service user records and to ensure the care professional has access to all the relevant information about a service user staff should follow the “Procedure for ensuring full access to unified clinical information and records” at APPENDIX F.

If duplicate manual case-notes have been created by mistake for the same service user then the local records manager should be contacted and they will arrange for the notes to be merged and case-note tracking to be updated accordingly.

When creating an electronic record on staff should refer to the relevant guidance on the intranet which describes how to search for and create a new electronic record. If staff create a duplicate electronic record by mistake or identify duplicate records they should check thoroughly if they are duplicates. If this is confirmed they should follow the guidance in the procedure for handing these at APPENDIX M

10.3 **A&E /Crisis Resolution**

It is essential that a copy of the clinical/care record for service users admitted via A&E, Crisis Resolution is retained within the main care record to enable a full history to be maintained.

The service users GP should also be routinely sent a summary of the record. In most cases the A&E record will be created by the Acute host A&E department and may only be recorded electronically. In this case either a copy of the A&E record should be requested or a reference made in the notes and electronically as to the existence of this record.

In addition however it is essential that staff working with service users in A&E create a record if one does not exist and record their contacts and risks assessments undertaken in A&E and Crisis Resolution on the Trust’s electronic system.
Where data cannot be recorded electronically due to lack of appropriate functionality then a manual folder may be created as per the procedure contain within the appendices of this policy.

11 Minimum Standards for Service User Care Records

The Trust main care record is the electronic record which should be used by all Trust staff to document information. This is supplemented by a single multi disciplinary manual case record, which is only to be used to hold information that is not possible to record electronically.

The requirement to record care records electronically extends to all staff treating service users including locum medical and agency nursing and other staff. A procedure is currently in development to provide access to the clinical system for temporary locum and agency staff.

The Trust manual folder is to be used by all services in the Trust and replaces all other types of service user record folder currently used. This case folder meets the requirements for NHSLA standards.

The NHS number will be the main identifier for the manual record with the Trust and it is therefore essential in line with DoH policy that the NHS number is used on all manual casenote covers and on all correspondence whether generated electronically or involving service users.

Where manual case records still need to be used NHSLA, CQC and the professional body standards should be adhered to. The standards below relate to the NHSLA standards for the quality of record keeping and the ordering of and filing within case records.

<table>
<thead>
<tr>
<th>Number</th>
<th>Standard</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Records are bound and stored so that loss of is minimised.</td>
<td>The record should be robust. There should be no inside pockets or flaps as this can lead to misfiling or loss of documents. Polypockets / plastic wallets should not be used within the notes. A copy of messages should be stored in the clinical notes in a robust format i.e. Post it notes should not be used. Storage facilities should be secure and access limited to designated staff.</td>
</tr>
<tr>
<td>2</td>
<td>The health record contains clear instructions on the filing of documents.</td>
<td>Instructions for filing may be printed on the inside of the file or on the dividers</td>
</tr>
<tr>
<td>3</td>
<td>Care plan/CPA/Person centred plan is readily identifiable.</td>
<td>Mental Health Act/legal papers, ECT records admission and discharge letters should be easily identifiable using dividers/coloured borders. Instructions for the filing of these should be clear within the file (see above)</td>
</tr>
<tr>
<td>4</td>
<td>Machine produced recordings should be mounted and securely stored.</td>
<td>All machine produced recordings such as blood results and ECGs should be mounted and easily identifiable within the record. Instructions for the filing of these should be clear within the file (see above). The Trust advocates the use of secure store wallets for such documents where they cannot be safely mounted in the records.</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
</tr>
<tr>
<td>5</td>
<td>Records should contain a designated place for the recording of hypersensitivity reactions and other information relevant to professionals involved in the care of the service user eg Advanced directives, patient wishes.</td>
<td>Hypersensitivity and allergic reactions or other alert information should be recorded on the front sheet and include the designation of the person recording it and dated. On Amigos this information should be recorded in the special notes or CHORES as appropriate.</td>
</tr>
<tr>
<td>6</td>
<td>Storage arrangements should allow for 24/7 retrieval.</td>
<td>All records should be available on a 24/7 basis to support, A&amp;E and on call out of hours teams. There should be clearly documented arrangements for doing this, which are communicated, to all staff likely to need them. Amigos is the key record that staff should access 24/7 in acute settings an Systm One in HMP Manchester</td>
</tr>
<tr>
<td>7</td>
<td>There must be a mechanism for identifying records, which must not be destroyed.</td>
<td>The Trust has agreed that green stickers will be used to identify records, which are not to be destroyed, and this is documented within the Records Management Policy. It should also be made clear on the filing instructions for the record.</td>
</tr>
<tr>
<td>8</td>
<td>An author of an entry in a care record should be clearly and easily identifiable</td>
<td>Entries should have a signature and designation printed alongside the first entry and, in addition, where it has been agreed within the service a signature form must be completed and either filed within the case notes or held centrally.</td>
</tr>
</tbody>
</table>
11.1 Filing instructions for manual case notes
The filing instructions are either pre printed on the inside cover of the case notes or are printed on each divider within the case notes.

A copy of the filing protocol for each section within the manual care records is shown at APPENDIX B

12. Record Keeping

The purpose of the care record is to facilitate the safe care, treatment and support of a particular service user.

It is essential that staff follow the guidance in this policy and that of their professional bodies in ensuring they create and maintain good quality records. The guidance is equally applicable in most cases to electronic and manual records.

12.1 Record Keeping standards
Staff should use their professional judgement to decide what is relevant or not but care records should:

- Be factual, consistent, accurate, useful, **contemporaneous**
- Be non-judgemental
- Be thorough but concise
- Avoid unnecessary jargon using language that is understood by all who might have cause to read the notes.
- Avoid all acronyms other than those approved by the Medical Director (a full list of acronyms is available in the inside back cover of all new style case notes).
- Be written in black ink only (manual records only)
- Be written as soon as possible after an event has occurred (**contemporaneous**), either in real time or before the end of the shift in most cases. (a table of timescales for recording is shown at appendix J) such information should provide current information on the care and condition of the service user.
- Make clear if the date and time of the event differs from that when the records are written up, this should be clearly noted under the signature, printed name and position/grade.
- Include the length of any appointment, intervention, contact. (where appropriate for the service each entry should include details of the number of the current session along with the total number of sessions contracted (e.g. 5/16).
- Be written clearly, legibly and in such a manner that they cannot be erased.
- Be accurately dated, timed using the 24 hour clock recording the time and date the entry is made making reference to any significant time/dates in the entry. (On the electronic system this is done automatically by the system so the time and date recorded should be the date and time the event took place)
- Be signed, dated and timed with the printed name and designation of the professional writing the notes. (On the electronic system this would be the record maker and this must be recorded. The author is the person entering the data which may or may not be the same as the record maker) These details should be entered beneath each record entry in the case-notes
• Readable on any photocopies
• Have on every page in the notes the service users name, location and NHS number (the electronic system will do this automatically)
• Be used to record communications to/with all relevant agencies and professionals, paying due regard to confidentiality
• Be taken on Pre-printed patient history sheets for all handwritten case notes. These sheets should not be used for drafting. (N.B. a supply of lined writing paper is available for drafting letters, writing process notes etc.)
• Include all contacts, including telephone calls, emails etc between client and practitioner, calls to and from others involved in the care of the client, and non-attendances (both DNA and CNA) which should be recorded, dated, timed and signed by the practitioner.

In addition records should

• Be written, wherever possible, with the involvement of the service user or carer and in terms that the service user or carer will be able to understand
• Be consecutive. Where notes are recorded electronically a note should be made in the manual note that this is the case.
• Bound and stored so that loss of documents is minimised
• Contain a record of all key decisions and assessments
• Contain a record of all medicines prescribed. All entries should be dated timed and signed
• Identify problems that have arisen and the action taken to rectify them
• Provide evidence of the assessment undertaken, the care planned, the decisions made, the care delivered and the information shared
• Provide evidence of actions agreed with the service user (including consent to treatment and consent to share information)
• Identify the name and designation of the most senior care professional present responsible for decision making at the time an entry was made.
• On each occasion the professional responsible for the care changes, the name and designation of the new responsible professional and the data and time of the transfer should be recorded.
• Identify the consultant in charge of the episode of care
• Include an entry in the notes to explain if where there has been no entry in the notes for a significant period of time.
• Have any gaps on history sheets crossed through. Notes should be recorded as continuous entries, leaving no more than one blank line between separate entries. Blocks of more than four blank lines, e.g. at the bottom of the record sheet, should be clearly crossed through.
• Have machine tracings, scan results in secure store wallets where they are not easily secured in the notes.
• Have lab results attached to laboratory filing sheets.
• Contain a reference to where and if other records for the service user exist
• Have any student notes countersigned/authorised and dated by a qualified supervisor

Care records should include

• All relevant demographic details eg name address post code GP ethnicity, next of kin
- Care Co-ordinator details
- Carer details
- Legal status
- Alerts, allergies, advanced directives and risk factors
- Medical observations: examinations, tests, diagnoses, prognoses, prescriptions, other treatments, medicines
- Relevant disclosures by the service user – pertinent to understanding cause or effecting cure/treatment
- Facts presented to the service user
- Correspondence from the service user or other parties
- Discharge letters and summaries
- Interim reports
- Care plans and assessment
- Consent to treat and consent to share information

**Care records should not include**

- Unnecessary abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements
- Personal opinions regarding the service user (restrict to professional judgements on clinical matters)
- Personal opinions regarding other members of staff within the Trust or other health care professional
- Personal opinions regarding operational matters or used as a means of communicating operational issues and concerns – there are other process in the Trust to enable this
- The name(s) of third parties involved in a serious incident. The name should be included on the separate incident form for cross-referencing
- Correspondence generated from legal papers and complaints

**12.2 Record keeping errors**

If staff become aware of additional information that should have been recorded at the time of a previous event or interaction with a service user then under no circumstances should the original entry be amended but a new entry should be recorded making reference to the original event. This should be signed, dated and timed at the time of writing making reference to the date and time of the original event.

Erasers, correction fluid, or any other obliterating agents should never be used to cancel errors. A single line should be used to cross out and cancel mistakes or errors and this should be signed and dated by the person who has made the amendment, ensuring always that the person signing the record prints their name below the signature. This cancellation method should not obscure anything made in the original entry. The reason for the amendment must also be recorded.

If an error is detected within an electronic record entry once it is locked then staff should contact the systems administrator for advice on how to record this. A note will need to be made that the record was made in error but each system deals with this differently.
If on the electronic record information is written in the wrong record then the system administrator should be contacted for advice and assistance. An incident should be recorded on Datix.

If information is misfiled it should be removed from the folder and sent to the records manager in the care group of the service responsible for the misfiling to ensure the information is filed in the correct notes. An incident should be reported on Datix.

If a service user disagrees with the content of their record and it is agreed that the record is incorrect then a single line should be used to cross out and cancel mistakes or errors and this should be signed and dated by the person who has made the amendment, ensuring always that the person signing the record prints their name below the signature. This cancellation method should not obscure anything made in the original entry. The reason for the amendment must also be recorded.

If a service user disagrees with the content of their record and but the practitioner does not agree then a note that the service user disagrees with the records should be made and this should be signed and dated by the person who has made the amendment, ensuring always that the person signing the record prints their name below the signature.

If a service user requests information be permanently removed from their record then staff should seek advice from the Head of IG and Records.

Where a member of staff notices inaccuracy in records held or managed by other teams, they should inform the staff member and manager responsible.

12.3 Record content

The use of abbreviations in care records should be avoided at all times and are discouraged. If it is necessary to use abbreviations, they should be from the agreed list, has been formally approved by the Medical Director. All future amendments to this list must first be approved by the Medical Director via the Trust Records Manager.

Initial entries (e.g. at the assessment stage) are likely to include the following: an outline of the client’s needs; identified risk factors; a clinical formulation; an agreed action plan; details of agreed goals; details of the type of therapy being offered.

Details regarding the client’s consent to treatment should be included, along with notes to the effect that the risks and benefits of treatment, the range of available therapies and information about alternative therapies have been explained to the client.

Details regarding the clients consent to sharing information should be clearly documented in the notes.

Each entry, including recordings of subsequent sessions (treatment stage), should be an accurate reflection of what has taken place and is likely to include an account of the session, i.e. a summary of events, areas covered and any observed changes that occurred during the session.

Other details that practitioners may wish to record include: changes in insight, emotion, behaviour or circumstances since the previous session (these could represent either an improvement or worsening); details of progress with plans, tasks etc. agreed in the previous session if deemed appropriate; changes observed in the client’s presentation.

Details of changes in the practitioner’s view of the problem or client may also be recorded, as well as a note of any joint decisions made during the session; any homework or tasks to be undertaken.
by either the client or the practitioner before the next session; and any issues that need to be taken up at the next session.

Christmas cards and letters of appreciation do not usually form part of the record. However, they may be of interest to the Corporate Services Manager/Freedom of Information Lead since these would be regarded as “compliments/ complaints/ comments”. In cases where cards and letters are considered part of the clinical record, e.g. when they contain messages and comments similar to that which might be contained in an ordinary letter, they should be retained in the case note file.

Process notes do not form part of the healthcare record if the material they contain is already recorded in the case notes, i.e. in the case note file. Under the Data Protection Act, however, they are classified as “discoverable documents” and could be brought to court as extra information about a case. They should therefore be filed securely, separately from the case note file.

Where available standards proformas should be used for admission, handover, discharge.

12.4 Third party information –
Where information is given by the service user about a third party and is of a sensitive nature it should not be used in care notes unless it has clinical relevance.

Where a third party has been present at a clinical intervention the records should document this. The full name and relationship to the service user should be documented if known. The appropriate electronic system user guide explains how to do this within the electronic record.

Where two members of staff are present at a clinical intervention then this should be documented.

Where two members of staff are present at the intervention and they need to document a differing account of the intervention due then both entries should be recorded by the individuals (other present form on Amigos should not be used in this instance). Otherwise the names and profession of each member of staff should be recorded and both should sign the manual record to show they have witnessed the event.

If a single entry is to be made the person making the entry should indicate the other staff member present and the other person would countersign following electronic system guidance.

It must be made clear in the notes if information is provided by a third party. Where there is written reported speech it should be in inverted commas. The name of the person providing the information and details of the relationship to the service user should be documented.

12.5 Records and the legal system
Any record requested by a court is a legal document, therefore any information notes of any intervention, treatment, event, conversation etc with a service user (as an aide memoir) would be considered to be a care record even if a full record of the interaction is also recorded. Informal notes should be filed in the service user notes.

A registered care professional has a legal duty of care to a service user. Record keeping should demonstrate that professionals have understood and honoured their duty of care. This is by demonstrating that all reasonable steps have been taken to care for the patient and that any actions or omissions have not compromised service user safety. Staff should document why they acted in such a manner and that they have taken reasonable steps to reduce the risk of harm to the service user and others.
12.6 Recording Consent to share information
Staff should record in the Service user’s record if the service user has been provided with, understands the notice/leaflet regarding information sharing, and has consented to sharing any part of their information.

Where a service user refuses to share any part of their information this should be recorded in the service user’s manual record and in the appropriate place on the electronic system they are using.

The information not to be shared and who it is not to be shared with should be recorded e.g. a box should be drawn round it and it should be annotated in such a way as to make clear that such are the client’s wishes and it should be dated and time stamped. That information must not then be shared (unless there is a legal requirement or an overriding public interest in disclosure). Legally, there are certain circumstances where this can be challenged and the information would have to be disclosed – for example, a criminal act.

Service users should be asked at regular intervals if this requirement not to share information is still valid and a note made in the records accordingly.

12.7 Lost records
Care records must be treated with care and handled and stored securely. The loss of a care records can have serious consequences for the service user as critical information may not be available. This in turn could have severe consequences for the Trust.

When it is identified that a record is lost this must be reported via the Trust incident reporting procedure as an incident and will be subject to a thorough investigation once the record has been deemed to have been lost.

If is not possible to locate the records then a duplicate should be created following the procedure contained in the appendices of this policy. It should clearly be marked on the duplicate set that it is a duplicate. If the records are subsequently found then the duplicate set should be merged into the original

Further details on the lost or missing records procedure is at APPENDIX L

12.8 New care record documentation
In order to ensure the provision of safe, effective quality of care it is essential that the Trust operates using consistent, effective and standardised systems and documentation.

Staff should not create or introduce any new documentation or modify any existing documentation without the necessary approval via the Trust Records Management Group

One of the functions of this group is to oversee the implementation and approval of all types of clinical documentation used within the Trust. Therefore before any document can be used within a set of Trust care records they must first be approved by the Records Management Group.

If any new record collections containing personal information about service users are to be created that is not already being collected elsewhere then a personal data report along with the proposed data collection tool, form etc should be sent to the Trust Records Management Group for approval. This will ensure the requirements of the Data Protection Act are met in that the Trust has a record of the information it holds and processes. The personal data report form at APPENDIX O should be submitted and be provided with the proposed data collection tool.
The first consideration will be to establish if this document should/could be developed electronically if so then a request for change will be made to the appropriate prioritisation development group where it will be prioritized for development and a likely timescale for development and implementation agreed.

On approval of a manual document to be filed in the notes the form originator (creator) will be issued with a document registration number and a filing location reference.

These two pieces of information must appear at the bottom of the front page of the appropriate document and it is important that they appear at the bottom left hand corner of the front page of the document.

The registration number and filing reference should appear in Arial 8pt typeface. The filing location will detail the section within a set of case-notes where the document should be filed.

Example of a series of Registration numbers and filing locations/sections are:

- Section 17 Leave Form - HRDG/05.001
- Risk Assessment - HRDG/09.003

The filing scheme above is made up of four components, which are:

1. HRDG – Document Approval Committee
2. 05 – Year of approval
3. .001 – Document Registration number for the year of approval
4. The filing location of the documentation which can be found on the bottom right hand corner of each proforma document.

12.9 Filing
It is vital to the provision of safe, effective, quality care that where paper records still need to be used that any paperwork is filed immediately after it is generated/received.

All staff (irrespective of job or grade) will be responsible for the filing of any paperwork that they generate in relation to a service user. i.e. if a nurse on a ward generated a new piece of information on a service user then they will be responsible for filing that completed document within the case-note folder of that service user.

If papers are not filed accordingly, case-note folders and loose papers will be returned to the originating department or the department or individual who requested the test or report to rectify this matter. In line with this if a member of staff receives any correspondence or papers, in relation to their job, they are responsible for the filing of those papers within the care record.

With specific respect to laboratory reports were these are not provided electronically, these should only be filed once they have been seen and signed off by a doctor.

CPA records should be recorded electronically and do not need to be filed in care-notes but a copy must be provided to the service user by the CPA author or ward/support staff. The tick box should be completed on Amigos to state the service user has received a copy.
If a clinical serious untoward incident report has been completed on Datix regarding a service user the number of the incident should be recorded on Amigos on the CHORES screen alongside the basic description of the incident.

12.10 Filing of Legal Papers and Complaints
These papers are not relevant to clinical care and are often not disclosable, unlike the clinical record. Therefore, correspondence generated from legal cases and complaints must not be filed within the clinical record. However, when a report is generated to assist in a legal case, this may be relevant to clinical decision-making and this report should be filed within the clinical record.

Copies of Mental Health Act including tribunal papers should however be filed in case-notes by the Trust Mental Health Act Administrators.

Copies of coroners reports should also be filed in the notes where not recorded electronically.

12.11 Filing of Observation Forms
Observation forms which are used to record that a service user’s condition has been checked on by a member of nursing staff on a ward are a part of the care records and as such should be filed in the main Health Care Record folder along with all other documentation. They should not be filed in separate folders or kept apart from the principle service user record.

12.12 Electronic record entries
Where records are recorded electronically there is no requirement to retain a manual copy in the notes.

12.13 Contact recording
All entries that can be should be made on Amigos/Systm One must be signed off by the author (this is who has formulated the content). It is therefore essential that all staff check the electronic system for any information relating to the service user. If this is not contained on the electronic record then the manual record should be consulted.

It is not necessary to print from records of contacts and file in the manual notes but where there is a possibility that other staff do not have access to the electronic system a note should be made in the manual records to state the information is recorded electronically.

12.14 Timeliness of recording
In general all events and activity recording should be completed by the end of the shift in which they occurred. The standards for timeliness of recording are included at APPENDIX J

12.15 Carers assessment/records
Where it has been identified that the service user has a carer the carers details and their subsequent assessments should be recorded electronically.

12.16 Use of Year Stickers on Care Records
The purpose of year stickers is to ensure that it is easy to identify if a service user was seen in a particular year or not. This system also enables fast effective weeding of case-notes each year when it is necessary to weed the record libraries for old case-notes for archiving or destruction. Year stickers should be applied on an annual basis to service user manual records.

If a service user is first seen, in a new year, as an outpatient/community patient then it is the responsibility of the “medical records” or relevant department/team to apply the year sticker. If a service user is an inpatient on a ward on the 1st January or is first seen as an inpatient that year
then it is the responsibility of the ward to apply the year sticker. Wards may obtain year stickers from their respective out-patient department.

Each service user being seen in a calendar year i.e. between 1st January and 31st December should have a year sticker for that year applied to the edge of the case-note folder. This sticker should be applied only once to each volume and each consecutive year that the service user is seen a new year sticker for that year should be applied to the case-note folder and all corresponding volumes for that service user.

12.17 **Volumising procedure (i.e. splitting and cross-referencing oversize case notes.)**

Large oversized casenotes are difficult to manage and handle and as such important paperwork is likely to become loose and be lost.

Manual case notes should not be in excess of 8cms thick because they become unmanageable in the operational clinical area and should be therefore split into volumes.

- The casenotes should be split on a chronological basis with the most recent documentation in the latest volume and the casenotes should be checked meticulously for current episodes of care.
- The newly created volume must contain the full risk assessment, care plans, most recent CPA forms and further information cross referenced to the previous volume.
- The alert sheet must be transferred from the old to the new volume with a copy retained in the old volume.
- The ‘old’ case notes should be checked for loose filing and all documentation secured to the body of the folder in the appropriate location.
- The volumes should then be clearly marked by circulating the “Volume 1”, “Volume 2” on the outside front cover and the start and end date of Volume 1 and the start date of Volume 2 being clearly recorded on the inside front cover of the case notes.
- Older volumes should be crossed through and “Volume Closed” written clearly on the front cover. No further documentation should be inserted into closed volumes.
- The closed volume should have year of last attendance sticker affixed, which corresponds to the year of the last documented attendance in that volume. (N.B. When culling records for destruction, all volumes must be destroyed. This sticker will only refer to the date the retention period is calculated from if it is the last volume of notes.)
- The electronic record should be updated to indicate that there are multiple volumes of case notes.
- The most recent volume should always be used and tracked on electronically in the normal way.
- If older volumes are requested these must also be tracked electronically
- All volumes should be retained in the service locality that the service user received the most recent treatment

12.17.1 **Use of the volume numbering system**
Along the front of the casenote folder are a series of pre printed numbers ranging from 1 to 11. When creating a new volume you should circle the number that indicates that volume and ensure that on all volumes for that service user underline the total number of volumes.

Thus, creating a new volume, which was volume 5 the numbers should look like this:

```
1 2 3 4 5  6  7  8  9 10 11
```

Volume 1 of this service users records should then look like this:

```
1 2 3 4 5  6  7  8  9 10 11
```

Circle the number of the current volume on that set of casenotes and underline the total number of volumes in existence on all existing volumes.

12.17.2 **Volume recording on Amigos**
For the procedure to record manual casenote volumes on Amigos staff should referred to the Amigos users guides on the intranet.

12.18 **Continuity of recording in Health Records where services are devolved or service users are transferred.**
Where services are devolved from an acute to a care trust, or vice versa, the original Trust may need to remain accountable for the service it provided, and may need to be capable of picking up treatment again in the future.

The Trust taking over the service needs to be able to provide continuity of care and to account both to service users and possibly to the transferring trust for the services it is providing. Therefore, if feasible both trusts need to keep records of the service they provided and any relevant information about transfers of responsibility between them. Therefore the Trust should have it's own carerecord for all transferred service users.

The safest way to effect the transfer would be for the transferring Trust to copy any relevant records for transfer to the receiving trust with details of the responsibilities being transferred. The receiving trust would then start a new record with the transferred copies. If the receiving Trust is already working electronically, the transferred records should be linked in some way.

Due to the volumes of records concerned though this may not be possible and the manual records may be transferred to the new Trust and be managed by them. The services users however will need to be informed of this as part of that transfer process.
Both trusts should then apply their own retention and disposal arrangements to the records they hold. As far as the transferring trust is concerned, the service user episode ends at the point of transfer.

If the service provided is a small part of an ongoing care process then a transfer of care/discharge summary should be sent back to the original Trust at the end of the care spell. If both Trusts are involved in providing ongoing but different services, which have relevance to each other, they should devise appropriate approaches to more regular communication.

Where notes are requested from another organisation regarding the treatment of a service user with the Trust the request for those notes must contain a disclaimer explaining that in the event of a subject access request the Trust will disclose the information as appropriate and in line with the Trust Access to records policy and procedure.

If a service user's care transfers between services within the Trust then their original record must be transferred. (This process will become more streamlined with the move to an electronic records and a single case folder and numbering system.)

12.19 Collating Records Following the Death of a Client
Wherever possible, following the death of a client, records should be collated and filed together within the main medical record. Information relating to deaths will be obtained via the national Personal Demographics Service during the process for checking and validating NHS numbers. Lists of the deaths will be circulated by the informatics department to relevant records departments for them to action.

When a death is reported into a service, that service should record the death on the appropriate electronic system ASAP and notify their local records manager.

The local records manager of the service area the service user was last treated in will ensure the records are collated and removed to the area designated for the storage of deceased records.

Case-note tracking systems will need to be updated to reflect this action.

12.20 Copying of Care Records
Procedures for the dealing with access requests and copies of care records as laid down in the Data Protection Act 1998 for living individuals and in the Access to Health Records Act 1990 for deceased individuals can be found in the Access to Records Policy.

If a client is being assessed or treated outside the Trust relevant documentation can be copied and sent to the treating care professional. Original records should not be sent.

If a service user's care transfers between services within the Trust then their original record must be transferred. (This process will become more streamlined with the move to an electronic records and a single case folder and numbering system.)

In the event of a death of a patient on the wards the original notes must not be sent with the body to the mortuary but a copy prepared and sent.

13 Information Quality Assurance
It is important that all staff receive appropriate training in record creation, use and maintenance,
including having an understanding of:

- What they are recording and how it should be recorded;
- Why they are recording it;
- How to validate information with the service user or carers or against other records – to ensure that staff are recording the correct data;
- How to identify and correct errors – so that staff know how to correct errors and how to report errors if they find them;
- The use of information – so staff understand what the records are used for (and therefore why timeliness, accuracy and completeness of recording is so important); and
- How to update information and add in information from other sources.

13.1 Checking information with service users
In order to maintain the integrity of information and to ensure that service user data remains as up to date as possible it is essential that staff check details held. The source will usually be the service user (or their guardians or carers), or may be their notes or clinical correspondence. These checks should occur whenever the service user presents or where their records are being updated, for example:

- Whenever the service user attends an outpatient user appointment
- If the service rings in to book an appointment
- on admission
- Whenever referrals are received via GP letters, as GP’s are often the first to know about changes of address etc.
- At regular intervals with community service users

If any details have changed, all key systems must be updated immediately.

The electronic record should always be checked for any changes to service user information prior to a contact or visit to ensure the member of staff has the accurate details

13.2 Collating records following a serious untoward incident
In the event of an SUI involving a service user relating to a sudden unexplained death, homicide, or the case notes must be secured to prevent any alterations being made that could impact on anyone involved in the case. This also allows the Trust to ensure all information is safeguarded pending any investigation.

The securing of care notes maybe requested by any Executive director, Head of Patient Safety, Head of IG and Records, Corporate Services Manager. They should also request any electronic records to be sealed by the Clinical Systems Manager.

The original care notes must be received and held by any Executive director, Head of Patient Safety Head of IG and Records, Corporate Services Manager or the Trust Records Manager. If necessary then a copy of the notes must be made within 2 working days and provided to the service in case the service user is still receiving treatment ( in this case a new volume should be created or for example a coroners report is required.

For electronic records the Medical Director or Director of Nursing and Governance must authorise staff to be able to continue to write to the record)
Access to the care notes once sealed will be permitted or denied by the Medical Director or Director of Nursing and Therapies or their delegated authority.

Records must be kept of any access permitted to the original notes whilst held at HQ.

The Care Group Managers or Heads of Service will be responsible for ensuring all records are obtained and sent securely to Trust HQ.

Following a request for notes following an SUI they must be collated with one working day and sent to Trust HQ following working day to the requestor. Any delay in this must be reported immediately to the requestor. A copy of the records held electronically will also need to be provided in this timescale.

Care notes must be tracked and transported in a secure tamper proof bag (local records managers should be contacted to provide a tamper proof bag and seal) or tamper proof envelope.

Once the investigation is complete the original records will be returned to the relevant service. Any copy notes will be destroyed via confidential waste.

Records must be kept of any access to the original notes whilst held at HQ.

The forms SUI 1, SUI 2 and SUI 3 are to be used in this process see APPENDIX D

13.3 Audit of Care Records
Each year a sample of all health and social care records of 50% of specialties in all media forms, will be subject to an audit as per the IG Toolkit.

The audit will look at the quality of the record keeping in light of the various professional standards and good practice on care record keeping.

Any recommendations or details of deficiencies identified in the audit will be included in an action plan and assurance that the recommendations and actions are acted upon will be monitored by the appropriate Governance committee.

In addition it is a requirement that all supervisors within supervision with their professional care staff should routinely audit and monitor the quality and content of the care records created by each member of their team. Managers and supervisor should routinely audit inpatient records and at least 10% of their team case load over a period of six months.

If supervisors find significant record keeping issues they will be required to put in place action plans to remedy the problems identified.

Example audit tool is contained at APPENDIX L

14 Tracking of Records
Accurate recording and knowledge of the whereabouts of all records is essential if the information they contain is to be located quickly and efficiently. One of the main reasons why records get misplaced or lost is because their next destination is not recorded anywhere.
A well thought-out tracking system – manual or electronic – should meet all user needs with regards to record management and be supported by adequate equipment. It should provide an up-to-date and easily accessible movement history and audit trail. The success of any tracking system depends on the people using it and therefore all staff who use care records must be made aware of its importance and given adequate training and updating when necessary.

Tracking mechanisms should record the following (minimum) information:

- The item reference number or other identifier – NHS number
- A description of the item (e.g. the file title or service user name)
- Volume number(s) being loaned if there is more than one volume
- The person, unit or department, or organisation to whom it is being sent
- The address or telephone number of the person/department/clinic/ward etc or organisation to whom it is being sent.
- The date and time of the transfer of the item from the permanent home or records library to the receiving person or clinic
- The date of return of the item to its permanent home or record library

14.1 Tracking of Care Records

Care records are a vital source of information for any medical organisation when treating a service user and it is therefore imperative that care records are available to practitioners when seeing or treating a service user. For this reason it is sensible that organisations dealing in large numbers of care records implement a tracking system, be it manual or computerised.

All clinical entries should be made electronically rather than on paper based records however it is accepted that this is not always possible as the facility to record such information may not yet exist. Until such time as the Trust no longer requires paper notes the movement of any and all care records within or outside of the trust must be tracked on the electronic system.

It is the responsibility of anyone removing care records from their current location to a new location or transferring them by means of transport systems of any description (i.e. by hand or taxi etc) to another location to ensure that they track the location of the care records.

Failure to track care records is one of the main reasons that records are not always available when required and are not always capable of being found in their last known location. Staff should ensure they make arrangement to have such records tracked by an appropriately authorised member of staff within the Trust if unable to do so themselves eg. an Amigos User.

The benefits of using an electronic method to track records is that anyone with appropriate access to the clinical system will be able to instantly see the location of a service user record and request or find such record(s) expediently in the event that they are required or in an emergency.

For example within Amigos there is a section of the tracking system whereby it is possible to track individual volumes of service user records, i.e. if a service user with has 6 volumes it would be possible to keep volumes 1 to 4 in file and remove for clinic and track the last volume alone.

It is vital therefore that the existence all records and all volumes relating to service users have been registered.

Until the tracking functionality is fully electronic in the interim the “Interim Protocol for Casenote Tracking” (APPENDIX H ) should be followed.
14.2 24/7 Retrieval of Care Records
Because of the very nature of admissions and emergency admissions of service users to hospital it is imperative that existing mental health care records are both available and accessible 24 hour a day, 7 days a week. As there is both a requirement and need for permanent access to care records and the fact that clerical staff only work “office hours” it is incumbent upon the Trust to ensure that delegated members of staff are able to find and access care records “Out of Hours”

In the first instance as the main care record Amigos should always be accessed first to retrieve information as this will contain the most up to date for current or recent service users. If the service user is found to have been known to service previously and it is felt necessary to obtain data out of hours from the manual case record then for further information on access to case records out of hours (17:00hrs – 09:00 hrs) and at weekends and Bank Holidays please refer to the Care Records 24/7 Access Procedure APPENDIX G

As a minimum following an urgent admission the care professionals should have access to the latest risk assessment, summary of the last episode of care and A&E/CRHT details. These should be on Amigos. If not then the assessing clinician should ensure the necessary information is made available to the admitting ward on admission.

15 Records in Transit
In order to ensure availability, maintain security and reduce the risk of the loss of records, original Trust care notes should not be sent outside the Trust. Any external organisation requesting access should view them on Trust premises, or be provided a copy in line with the Access to Records Policy.

If records are to be transported using taxis or courier only contracted companies who have signed up to the Trust third party confidentiality agreement should be used.

15.1 Labelling and Packing
If manual care records are being delivered to another location they should be enclosed in sealed tamper proof bags or envelopes for transfer. Any records that may be damaged in transit should be enclosed in suitable padding or containers.

For larger quantities, records should be boxed in suitable secure boxes or containers for their protection. Each box or envelope should be addressed clearly and marked confidential with the senders name and address on the reverse of the envelope.

There are various options if records are to be mailed, such as recorded delivery, registered mail etc. When choosing which option staff should consider the following:-

- Will the records be protected from damage, unauthorised access or theft?
- Is the level of security offered appropriate to the degree of importance, sensitivity or confidentiality of the records?
- Does the mail provider offer ‘track and trace’ options and is a signature required on delivery?

The Trust advises that confidential documents and care records or information should be packed in the following manner:
15.2 Confidential Information
If confidential information is being transported or moved then it should be in a tamper proof bag with the appropriate seal available from the local records managers or tamper proof envelopes along with and the name and address of the person to whom it is being sent. Internal envelopes should NOT be used.

The number of the seal should then be recorded by the sender on the AMIGOS Case-note Tracking system under the section headed “comments”. For manual tracking systems the seal number should be written on the manual tracking system. The pouch should have the name and ward or department of the receiver in the address panel. If quantities of notes are being transported then they should be transported using secured Courier Boxes.

15.3 Handling and Transporting Records
Care Records in transit should not be left unaccompanied or alone in the presence of unauthorised staff. If care records are to be left unaccompanied in a location other than that to which they have been tracked to then they must be secured in a locked room (the local records department should be informed of this and the location of the records if they are to be left there for any length of time e.g. longer than 2 hours).

If records are to be transported using taxis or courier only contracted companies who have signed up to the Trust third party confidentiality agreement should be used.

In addition when handling care records;

- No-one should eat, drink or smoke near the records.
- Care records being carried on-site e.g. from the archive storage to the department, should be enclosed in an envelope.
- Records should be handled carefully when being loaded, transported or unloaded.
- Records should never be thrown.
- Records should be packed carefully into vehicles to ensure that the movement of the vehicle will not damage them.
- Vehicles must be fully covered so that records are protected from exposure to weather, excessive light and other risks such as theft.
- No other materials that could cause risks to records (such as chemicals) should be transported with records.
- Notes should not be left in unattended vehicles
- Records of any description should NOT be left in vehicles overnight.

15.4 Taking Records off Site
Records should only ever be taken off site with the approval of the local records manager.

The authorisation form B should be completed and signed by the manager with an indication given on the form as to whether the approval is temporary or not e.g. in the case of a community mental health team client records may need to be taken off site whenever a visit is made and therefore approval would only need to be given once for permanent staff or for the necessary time period for temporary staff, not each time a record is removed.

Form A APPENDIX C is to be used for the occasional request by those who would not normally access care records in the course of their duties but who may need to do so now and again eg to investigate an SUI.
Security of these records should be paramount, especially in the case of confidential or care records. Only those records required for visiting service users in the community should be removed. Ideally, records should not be removed for general administration purposes e.g. writing reports.

Records should never be left unattended e.g. in the car. If the record is to be taken home (with the approval of the line manager), the records must be stored securely within the home e.g. locked cupboard, safe. Care must be taken in order that other members of the family or visitors to the house cannot gain access to the records.

It is essential that any such records are tracked out of the department so that staff are aware of the location of the record. The information to track the record should include:

- Date removed
- Service user details (name & and date of birth/reference number (NHS number))
- Name of healthcare professional who has taken them
- Purpose removed for

Records should be tracked out to the individual using them on as per the tracking procedure.

Records should be carried in a secured case and not carried ‘loosely’, as this increases the risk of dropping the record and losing some of the contents.

If more than fifty records are to be moved at any one time them the bulk transfer procedure needs to be invoked and approval sought from the Caldicott Guardian and Head of IG and Records.

16 Retention and Destruction of Records

The length of the retention period depends upon the type of record and its importance to the business of the Trust. The destruction of records is an irreversible act, whilst the cost of keeping them can be high and continuing.

All records should be retained for the minimum periods prescribed by the Department of Health document “Record Management – Code of Practice (Part I) and (Part II). If a particular record is not listed within this document, advice must be sought from the Trust Records Manager who will establish the retention period in consultation with the Local Records Manager/Medical Director and the department concerned (and if necessary the Department of Health).

The NHS Records Management Code of Practice retention schedule details a Minimum Retention Period for each type of health record. Records (whatever the media) may be retained for longer than the minimum period. However, records should not ordinarily be retained for more than 30 years.

Where a retention period longer than 30 years is required (e.g. to be preserved for historical purposes), or for any pre-1948 records, The National Archives should be consulted. Organisations should remember that records containing personal information are subject to the Data Protection Act 1998.

The following types of record are covered by this retention schedule (regardless of the media on which they are held, including paper, electronic, images and sound, and including all records of NHS service users treated on behalf of the NHS in the private healthcare sector):
• service user health records (electronic or paper-based);
• records of private service users seen on NHS premises;
• Accident & Emergency, birth and all other registers;
• theatre, minor operations and other related registers;
• X-ray and imaging reports, output and images;
• photographs, slides and other images;
• microform (i.e. microfiche/microfilm); audio & video tapes, cassettes, CDs, DVD;
• e-mails;
• computerised records; and scanned documents.

A copy of the retention periods relating to health records is shown in APPENDIX E?

16.1 Social Care Records Management Retention
Social care record management falls outside the scope of the NHS code of practice but similar standards should be adopted by social care practitioners.

The NHS Code of practice however states that where a record is held jointly by health and social care professionals then it should be held for the longer minimum retention period.

Retention periods for records containing social care information is as shown in the following table

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Period of Retention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health in the Community</td>
<td></td>
</tr>
<tr>
<td>If detained under MH Act</td>
<td>20 Years following closure</td>
</tr>
<tr>
<td>If have been under Child Care Proceedings or Investigations</td>
<td>Until child’s 75 birthday, or if the child dies before his/her 18th birthday, 15 years after the child's death.</td>
</tr>
<tr>
<td>All Others</td>
<td>10 Years following closure</td>
</tr>
</tbody>
</table>

Staff seconded from the local authority should therefore use the Trust electronic system as the main care record and where it is not possible to record information electronically due to lack of functionality they should use the Trust approved manual record folder

16.2 Marking Records for Permanent Preservation
Where it has been identified that a record should be preserved permanently e.g. care records of individuals who commit suicide, in line with guidance from the Centre for Suicide Prevention, the record should be marked up in this manner.

Health professional may also wish to retain records for permanent preservation e.g. for research purposes. This request should be discussed with the Caldicott Guardian and a if approved a DO NOT DESTROY sticker should be applied and the reason for retaining the record clearly documented in the record

The Local Records Manager is responsible for ensuring staff are aware of the mechanism in place for identifying and marking these records to ensure they are not destroyed.
In the case of all records, the record will be labelled with a green label marked “DO NOT DESTROY” to ensure that when records are being weeded for destruction they are easily identifiable.

In the case of electronic records these should also be updated in special notes and case note tracking module documenting the reason for retaining the record.

Records marked “DO NOT DESTROY”, which are for permanent preservation, should be stored in an appropriate storage/archive facility. Details of which are available from Local Records Managers or the Trust Records Manager.

17 **Weeding and Destruction of Unwanted Records**

In order to ensure compliance with the Data Protection Act 1998 and ensure that NHS retention schedules are adhered to it is necessary to identify on a routine basis those records that need to be destroyed.

It is the responsibility of the local records managers to ensure that as a minimum once a year those records which are due for destruction are identified. It is however recommended that this procedure should take place more frequently.

Once a list of records have been identified for destruction then approval to destroy the records should be obtained from the lead clinician for the care group/service or the Caldicott Guardian.

For electronic records a report of those records due for destruction will be produced for the lead clinician to approve.

NOTE – to ensure that records are not destroyed in error it is important to check the details of all records that may exist for an individual to ensure they do fall within the relevant timescales for destruction. It is also necessary to do some random checks of records identified for destruction to ensure that there are not likely to be any records that should be destroyed eg research records.

As the care records contain sensitive or confidential information it is vital that confidentiality is safeguarded at every stage and that the method used to destroy such records is fully effective and secures their complete illegibility. Normally this will involve shredding, pulping, or incineration. This can be done on site, or via an approved contractor. Advice can be sought from the Trust Records Manager - a brief description should be kept of everything that has been destroyed, when, and by whom.

When care records are destroyed a record should be kept of the service user’s name and NHS and hospital number, a description of the record and the date the record was destroyed. This list of destroyed records should be retained permanently and held securely within the department. Along with this the Amigos should also be updated to reflect destruction of care records.

When notes or records are destroyed a Certificate of Destruction should be obtained from the company or organisation destroying the records. This certificate should also be kept safe with the list of those records destroyed.

Where there is an electronic record to be destroyed then the demographic information should be retained but all other clinical information removed and a note added to the Amigos record to explain that all clinical details have been removed.
18 Record Storage

18.1 Storage of Electronic Records
Health records which are stored on the electronic systems are covered by the Trust’s IT security measures.

18.2 Storage of Manual Care Records
Staff who are involved in handling manual care records are responsible for ensuring that they are safeguarded against loss, damage, or unauthorised access. Manual care records must be stored in secure areas.

All library areas housing care records must have a keypad lock or secure locking mechanism in order to maintain confidentiality and safeguard against unauthorised access. When a room containing care records is left unattended, it should be locked.

Manual care records should also be stored in an environment which does not cause damage or decay to the record or to any documentation within it. All documents within the record should be fixed securely to prevent damage or loss.

Records rooms are subject to the same health and safety precautions as any other room in the Trust. For each room used to store manual care records in the Trust there should be a current dated fire safety report and also a current dated health and safety assessment available. This is the responsibility of whichever member of staff is responsible for the safety of the building in which the records room is housed, and the assessments should be carried out by the appointed local officer.

Any actions which arise from these reports are the responsibility of the local manager or administrator responsible for the records, and also the local Information Governance (IG) Lead. Where risks are identified these should be assessed and if necessary placed on the Trust’s Risk Register.

18.3 Storage of Non-paper Care Records or Documents
Parts of the health record may be stored as other media, such as audiotapes, films, CDs and videotapes. In addition, some records may have been migrated to microfiche. These are still care records and as such subject to the same legislation and precautions as manual or electronic care records.

Where these additional records exist, films should be stored in dust-free metal cans and placed horizontally on metal shelves. Microfiche, sound recordings and videotapes should be stored in metal, cardboard or inert plastic containers, and placed vertically on metal shelving.

18.4 Storage of archived records
There are a number of archiving facilities in the Trust. The will be reviewed in line with the Records Management Review and other long term or alternative storage media will be considered.

For current facilities records should either be placed directly on shelves or in archive boxes which should not be over filled and contain a list of contents on the lid including the case note/NHS number specialty and date due for destruction.

For records on shelves the local records manager should ensure a manual record is kept in a storage book/spreadsheet or on against the service users electronic record.
For records in off site storage the box number and location should be recorded on the electronic tracking module.

Records delivered to the archive facility must be stored on shelves or in the appropriate place within 7 days to allow retrieval safely.

Local records managers will ensure that for records storage areas in their area of responsibility these are audited regularly and that records are culled and or retrieved as required.

18.5 Scanning
The Trust is hoping to invest in a scanning/electronic document management solution to address problems with records storage and to reduce the risk to service users having multiple case notes which are part manual part electronic.

Any scanning will be undertaken in accordance with British standards and in particular the Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically (BIP 0008)

Once in electronic format manual records will be disposed of in accordance with the appropriate standards and retention schedules.

19. Training
The Chief Executive and senior managers are personally accountable for the quality of Records Management within their organisation, and all line managers and supervisors must ensure that their staff, whether administrative or clinical, are adequately trained and apply the appropriate guidelines and professional standards.

In line with the Trust Mandatory Training policy, the Trust will ensure that those staff who are affected by this policy will be provided with the necessary guidance, awareness and training as appropriate to their responsibilities based on the outcome of the training needs analysis undertaken by the Learning and Development Department.

This will ensure that staff will receive the appropriate training in records management and good record keeping and this may be delivered by the NHS IG Toolkit e-learning programme or Trust accredited learning tools, supplemented by additional workshops seminars and guidance published via the intranet to ensure awareness of local care records issues.

20 Dissemination, Implementation and Access to this Document
This policy and associated procedural guidance once ratified will be disseminated by the Head of Regulation Compliance and Quality Improvement through the Trust Communication Channels as agreed with the Communications Department.

The document will be made available on the Trust intranet site.

The policy also forms part of the training that is available for all staff on good record keeping.

This policy will be subject to regular review as part of the process for Document Control.
Any updates to record keeping guidance and procedures will be published by way of guidance notes communicated via the Trust Communications Team. This document will be updated to include these updates at the next review.

21 Monitoring the effectiveness and Compliance with this Procedural Guide

The process for monitoring both the compliance and effectiveness of this policy and associated procedural guidance, will be through the regular use of review, audit and surveys as outlined in the monitoring table section of the Service User Record Management Policy.

Audits against record keeping standards should be undertaken by line managers/supervisors on a regular basis in supervision with staff. An annual audit will be undertaken in line with the IG toolkit.

A suggested audit tool is contained in the appendices to this standard operating procedure associated which may be used to measure quality of records and entries along with adherence to basic record keeping standards across all areas of the Trust.

In addition internal audit may as part of their annual audit plan undertake an annual audit which will look at knowledge of existence, implementation and compliance of the policy and at the effectiveness of the care record management system within the Trust.

Where there is evidence that there is a lack of knowledge or a need for further implementation or compliance an action plan will be developed. These action plans will be implemented by the Trust Record Management Group which is a sub group of the Trust Information Governance Group.

All Audit Reports and Action Plans will be monitored by the appropriate Governance Committee, Audit Committee and the Trust Information Governance Group and the I&IT Committee.

The Trust will also establish regular reporting of KPI’s which may include:

   a. Case Note Availability;
   b. Use of and Effectiveness of Case Note Tracking Systems
   d. Retention and Disposal/Destruction of paper and electronic records.

22. References

   - Data Protection Act 1998 : Records Management
   - Department of Health : Confidentiality: NHS Code of Practice
   - Nursing and Midwifery Council: Code of Professional Conduct
   - HSC1999/12 Caldicott Guardians
   - Information Governance Toolkit
   - CQC Regulations
   - NHSLA Standards
   - Clinical Psychology and Case Notes BPS DCP 2000
   - College of Occupational Therapists Code of Ethics and Professional Conduct College of Occupational Therapists (Revised 2005)
If you need to have this information translated into another language please contact the Mental Health Linkwork Scheme on 0161 276 5269 or e-mail linkworkers.mentalhealth@nhs.net. If you require it in larger print, Braille, audio or other formats please contact the Communication Team on 0161 882 1093 or e-mail communications.admin@mhsc.nhs.uk
LEGISLATION AND NATIONAL POLICY

Freedom of Information Act 2000
The Freedom of Information Act 2000 has been enacted by parliament and came into force on 1st January 2005.

It has been enacted to ensure that individuals have access to all types of publicly available documents and information. This includes access, where required, to medical records subject to certain exemptions and exceptions.

The Freedom of Information Act and also the Lord Chancellor’s Codes of Practice (issued under s. 45 & s. 46 of the Act) stipulates the manner in which records are to be kept, maintained and made available. As a central part of making information available to individuals there is guidance on charges that may be levied for making such information available.

Records Management: NHS Code of Practice
In March 2006 the Department of Health issued a revised Records Management: NHS Code of Practice, which was a document issued in 2 parts. The primary function of this document was to improve the management of NHS records and to clarify retention periods of certain data. The document outlined

- the legal obligations for all NHS bodies to keep proper records,
- the actions needed from Chief Executives and other managers to fulfil these obligations,
- guide-lines on good practice,
- the requirements to select records for permanent preservation

The circular explained the need for a Trust-wide records management strategy to be drawn up and agreed, including arrangements to monitor progress and compliance.

The Data Protection Act 1998
Since March 2000 the key legislation governing the protection and use of identifiable person based information has been the Data Protection Act 19989. The Act does not apply to information relating to the deceased.

The Act gives seven rights to individuals in respect of their own personal data held by others, they are:

- Right of subject access
- Right to prevent processing likely to cause damage or distress
- Right to prevent processing for the purpose of direct marketing
- Rights in relation to automated decision taking
- Right to take action for compensation if the individual suffers damage
- Right to take action to rectify, block, erase or destroy inaccurate data
- Right to make a request to the Commissioner for an assessment to be made as to whether any provision of the Act has been contravened.
The Data Protection Act applies to ‘personal data’, that is, data about identifiable living individuals. Those who decide how and why personal data are processed (data controllers), must comply with the rules of good information handling, known as the “Data Protection Principles”, and the other requirements of the Data Protection Act.

**Access to Health Records 1990**

The Data Protection Act 1998 supersedes the Access to Health Records Act 1990 apart from the sections dealing with access to information about deceased individuals. The Access to Health Records Act 1990 provides rights of access to the health records of deceased individuals for their personal representatives and others having a claim on the deceased’s estate. In other circumstances, disclosure of health records relating to the deceased should satisfy common law duty of confidence requirements.

**The Caldicott Review**

In March 1996, guidance on The Protection and Use of Service user Information was published by the Department of Health. This guidance required that when the use of service user information was justified, only the minimum necessary information should be used and it should be anonymised wherever possible. In the light of that requirement the Chief Medical Officer established the Caldicott Committee to review the transfer of all service user-identifiable information from NHS organisations to other NHS or non-NHS bodies for purposes other than direct care, medical research or where there is a statutory requirement, to ensure that current practice complies with the Departmental guidance.

On completion of the work, the committee concluded that, whilst there was no significant evidence of unjustified use of service user-identifiable information, there was a general lack of awareness throughout the NHS of existing guidance on confidentiality and security, increasing the risk of error or misuse.

The Caldicott committee’s report, published in December 1997, included 16 recommendations, which related to ensuring best practice in the use of information flows between organisations.

**NHSLA Clinical Risk Management Standards**

The NHS Litigation Authority (NHSLA) was established to provide a means for NHS trusts to fund the cost of clinical negligence litigation and to encourage and support effective management of claims and risk. The scheme covers claims arising from incidents on or after 1 April 1995. If trusts comply with the standards, they should benefit from the investment in risk management by having fewer claims and paying lower scheme contributions.

The standard for Health Records requires Trusts to have a comprehensive system for the completion, use, storage and retrieval of health records.
FILING PROTOCOL FOR CARE RECORDS

The purpose of this document is to enable care practitioners within the Trust to ascertain where various information recording documents are to be filed within the health and social care records used by the Trust. Whilst this document is unable to list every type of document that we use it is intended as a guide and any queries on documentation should be sent direct to the Trust Records Manager.

<table>
<thead>
<tr>
<th>HEALTH RECORD SECTION</th>
<th>WHAT SHOULD BE FILED HERE</th>
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<tbody>
<tr>
<td>ALERTS</td>
<td>• Allergies/hyposensitivities</td>
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<td></td>
<td>• Advanced Directives (Living Will)</td>
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<td>• Not for Resuscitation</td>
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<td></td>
<td>• Confidentiality Statement</td>
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<td>• Service user Wishes</td>
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<td></td>
<td>• Religious Consent Form</td>
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<tr>
<td></td>
<td>• Safety Profile</td>
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<tr>
<td></td>
<td>• CHORES</td>
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<tr>
<td>DEMOGRAPHICS</td>
<td>• Demographic Front Sheet</td>
</tr>
<tr>
<td></td>
<td>• Admission Sheet</td>
</tr>
<tr>
<td></td>
<td>• Service user Description Form</td>
</tr>
<tr>
<td></td>
<td>• Admission Check List (Behind most recent Admission front sheet)</td>
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<tr>
<td></td>
<td>• All admission papers should be filed behind the most recent (corresponding) Admission sheet</td>
</tr>
<tr>
<td></td>
<td>• Service users Property List</td>
</tr>
<tr>
<td>ASSESSMENTS/RISK ASSESSMENT</td>
<td>• Risk assessment</td>
</tr>
<tr>
<td></td>
<td>• Risk assessment follow up</td>
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<td></td>
<td>• MANCAS</td>
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<td>• MASH</td>
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<td></td>
<td>• Sleep Assessment</td>
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<tr>
<td></td>
<td>• Observation Forms</td>
</tr>
<tr>
<td>CARE PLAN/REVIEWS/CRISIS</td>
<td>• CPA</td>
</tr>
<tr>
<td>CARE PLAN</td>
<td>• Care Plan Indexes</td>
</tr>
<tr>
<td></td>
<td>• In-patient Care Plans</td>
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<tr>
<td></td>
<td>• Safety Care Plan</td>
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<td></td>
<td>• Crisis Care Plan</td>
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<tr>
<td></td>
<td>• Nursing plans</td>
</tr>
<tr>
<td>PRACTITIONER CASENOTES</td>
<td>• History Sheets</td>
</tr>
<tr>
<td></td>
<td>• Care Pathways</td>
</tr>
</tbody>
</table>
### CARE PATHWAYS
- A&E Casualty Cards
- Contacts
- Ward Rounds

### HEALTH RECORD SECTION

#### CORRESPONDENCE/DISCHARGE SUMMARY AND OTHER
- Referral Letters
- Discharge Letters
- GP Letters
- Clinic Letters
- Letters to Service users
- Appointment Letters
- DNA Letters
- (General Correspondence) incoming and outgoing
- Returned Letters (from Royal Mail)
- Copy Letters (on plain paper only **not** letter headed paper)
- DSS Requests & Reports
- DLA Requests & Reports

#### MEDICAL INVESTIGATIONS
- MountSheets (which should have lab reports attached to them when provided)
- Other Investigation Reports
- Fluid Balance Charts
- Weight Charts
- Physical Examinations
- Bloods
- EEG Reports
- ECG Reports
- MountSheets
- ECG/EKG/EEG Reports
- Secure-Stor Folders
  - ECG/EKG/EEG Tracings
  - ECT Tracings
  - Photographs

#### TREATMENT
- Prescription Cards & Forms
- Consent Forms
- ECT Treatment Pack (when completed)
- Depot Injection Records
- Acupuncture Records
- OPD Prescription Forms
- Discharge Prescription
- Fluid Prescription
- Injection Record Card
- Repeat Prescription Sheets
- Electroplexy Treatment Record
- Anticoagulant Therapy
- Blood Pressure Charts
- Temperature Charts

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### MENTAL HEALTH ACT
- Any Mental Health Act Papers including Reports concerning Mental Health Act
- Service users Right Forms
- Section 17 Leave Forms
- Social Circumstance Report
- MHA Tribunal Papers
- MH Act Commission Papers
- AWOL Forms
- Copy section papers
- Consent to Treatment under the Mental Health Act

### CASE SUMMARY & REPORTS
- Outside Medical Notes i.e. copies of records from other organisations, NHS Trusts or other constituent parts of the Trust.
- Medical reports for Solicitors & Insurance purposes and Courts
- Coroners reports

### WHAT NOT TO INCLUDE IN CASENOTES
- SUI Forms
- Health Records Access Requests
- Complaints Forms
- Complaints Correspondence
- Complaints Responses
- Incident Reports

Under no circumstances should any papers be stored in plastic wallets inside Care Record folders. If it is necessary for records to be stored in a wallet within the Health Care Record then the “Secure-Stor” or “Secure-Stor+” wallets must be used as provided by the Trust via the Local Record Managers.
I request authorisation to take the below mentioned records off-site in order to carry out the duties of my post. I have read and agree to abide by the guidance in the Care Records Management Policy on taking records off-site.

Signed: ………………………………………………………………………………………………..

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
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<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
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</table>

I authorise the above named member of staff to take the above records offsite (please tick one of the following options).

☐ This authorisation is temporary in order for the above staff member to carry out the duties required of the post, from …………………….. (date) to ……………………..(date)

Signed: ………………………………………………………………………………………………..

<table>
<thead>
<tr>
<th>Line Manager Name</th>
<th>Job Title</th>
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<th>Location</th>
<th>Date</th>
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ON COMPLETION THIS FORM SHOULD BE RETAINED BY THE SITE MEDICAL RECORDS MANAGER AND A PHOTOCOPY SHOULD BE SUPPLIED TO THE INDIVIDUAL TO WHOM PERMISSION HAS BEEN GRANTED TO TAKE NOTES OFF SITE.
AUTHORISATION FORM - B

FOR TAKING RECORDS OFF SITE – regular occurrence

I request authorisation to take the below mentioned records off-site in order to carry out the duties of my post. I have read and agree to abide by the guidance in the Care Records Management Policy on taking records off-site.

Signed: ...........................................................................................................

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
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<tr>
<td>Location</td>
<td>Date</td>
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</tbody>
</table>

| Reason for taking records off site: e.g. Home Visit |

| Record type: e.g. CMHT Patient records |

I authorise the above named member of staff to take the above records offsite (please tick one of the following options).

- [ ] This is a one-off authorisation for all records of this type necessary to carry out the duties required of the post.

- [ ] This authorisation is temporary in order for the above staff member to carry out the duties required of the post, from ………………………….. (date) to …………………………..(date)

Signed: ..................................................

<table>
<thead>
<tr>
<th>Line Manager Name</th>
<th>Job Title</th>
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</thead>
<tbody>
<tr>
<td>Location</td>
<td>Date</td>
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</table>

ON COMPLETION THIS FORM SHOULD BE RETAINED BY THE SITE MEDICAL RECORDS MANAGER AND A PHOTOCOPY SHOULD BE SUPPLIED TO THE INDIVIDUAL TO WHOM PERMISSION HAS BEEN GRANTED TO TAKE NOTES OFF SITE.
Form SUI 1

Proforma to be completed for the securing of case notes (both paper and electronic) following a sudden unexplained death/homicide

Date securing procedure invoked: ........................................................................................................................................

Date of Incident: ...........................................  Incident Number: ..............................................

Client Name: ..............................................

Date of Birth: ...........................................  NHS Number: ..............................................

District Number ..............................................

Date of death: ........................................................................................................................................

Description of record(s) held and locations

<table>
<thead>
<tr>
<th>Type of record/ casenote number</th>
<th>No. of Volumes</th>
<th>Location</th>
<th>Lead Clinician</th>
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<tr>
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</table>

Original Paper case Note sealed by:

Name ..............................................  Location ..............................................  Date ..............................................

No of seal/serial number of envelope ..............................................

Signature: ........................................................................................................................................

Original Electronic case Notes sealed by CIS Manager

Name ..............................................  Location ..............................................  Date ..............................................

Signature: ........................................................................................................................................
<table>
<thead>
<tr>
<th>Sealed paper case notes received by:</th>
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<th>Location</th>
<th>Date</th>
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<tr>
<th>Paper Notes photocopied by:</th>
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<th>Signature and date</th>
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<tr>
<th>Paper copy of Notes resealed by:</th>
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Procedure for completion of the proforma (SUI 1) for the securing of case notes following a sudden unexplained death/homicide/

Form SUI 1

Date securing procedure involed
This would normally be the date of the incident but not always be the case if a delay has occurred in being informed of the incident.

Date of incident
The actual date the incident took place

Incident No.
The No. given on the top right hand side of the incident form

Client name, DOB, NHS number
Must be completed to identify the client

Date of death or safeguarding incident
The date of death or incident should be documented here.

Description of record(s) held and location
It is essential that all case notes are collated and sent to the Head of Patient Safety. All case notes (paper and electronic) for all services involved must be identified and sent. Each service should be listed along with the number of volumes held in that service and who the lead clinician is e.g. medical file-lead consultant name, CMHT file, Care Coordinator name etc.

Original case notes sealed by
The person(s) responsible for sealing the case notes, both paper and electronic, must complete these details

No. of seal/serial no. of envelope
If the bag (of paper records) held by the Local Records Manager is used the No. on the seal should be documented here. If the tamper proof envelope is used there will be a serial No. on the envelope that should be documented here.

If an electronic record then the CIS Manager should sign, date and time the sealing of the electronic record.

Sealed case notes sent to
The name and addresses, or encrypted email address, location and date the case notes are sent must be completed here along with a signature of the person sending them.

At this stage the form will be sent along with the sealed bag containing the paper notes. Further completion will be competed at Trust HQ. In the case of electronic records the form can be scanned and transferred with the electronic records.
Form SUI 2

Authorised Access to Secured Notes

Client Name: 

Date of Birth: 
NHS Number: 

Name and contact details of person requesting access: 

Date of Request: 

Reasons for requiring access: 

Supervised access granted by: 

Notes accessed by: 

In the presence of: 

Name and contact details of person requesting access: 

Date of request: 

Reasons for requiring access: 

Supervised access granted by: 

Notes accessed by: 

In the presence of: 

<table>
<thead>
<tr>
<th>Name</th>
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In the presence of:
Procedure for completion of the proforma (SUI 2) for Authorised Access to secured notes.

Form SUI 2

If the records are accessed by anyone Form SUI 2 of the proforma must be completed as follows:

Client Name, DoB, NHS numbers: This is to ensure the correct client details are recorded on each page of the proforma.

Name and contact details of Person requiring access: Full details must be recorded here to ensure a full audit trail.

Date of request: The date the above person requests access must be recorded here.

Reason for requiring access: The reason access is required must be clearly documented. A decision to grant access, made by one of the following, can only be considered if this is completed.

Permission to grant access can be given by one of the following:

Director of Nursing and Therapies
Medical Director

If neither Director is available, the following may consider access depending on the urgency of the request:

Deputy Director of Nursing and Therapies
Associate Medical Director
Head of Patient Safety
Head of IG and Records
Information Governance Manager

Supervised access granted by: The person granting access must ensure this is documented here. **NB. Only supervised access is permitted and arrangements must be made for a member of staff from the Corporate/Clinical Governance dept. to remain with the person being given access.**

Notes accessed by: The name, date and signature of the person being granted access must be documented.

In the presence of: The person staying with the above individual whilst the notes are accessed must be completed here.

*Further need to access the notes can be completed on further copies of this form. Each time any individual requires access this must be documented. Permission to access the notes must be considered each time it is required. Because an individual has been granted access on one occasion does not mean access will be granted on all occasions.*
Form SUI3  
De-securing of Notes

Client Name:  

Date of Birth  
NHS number  
District Number  

Type of Record  No. of Volumes  Location  Lead Clinician  


Secured Notes returned to:

Name  Location  Date  

By:

Name  Location  Date  

Signature  

Notes received by:

Name  Location  Date  

Signature  

Once signed on receipt of delivery of case notes return this form to the Information Governance Manager
Procedure for completion of the Form SUI3 - De-securing of notes.

Once the notes are no longer required to be held securely they will be returned to the location that originally sent the notes on Form SU1.

The following must be completed:

| **Client Name, DoB, NHS and District numbers:** | This is to ensure the correct client details are recorded on each page of the proforma. |
| **Description of record(s) held/Casenote numbers and Location** | This is to ensure a description is held of the record(s) listed being returned. |
| **Secured notes returned to:** | The name, location and date must be completed |
| **By: name, location, date and signature** | The person returning the notes must be completed here. |
| **Received by:** | The name and location of the person receiving the notes must be completed here and they must sign and date the receipt. |

*This form must then be returned to the Information Governance Manager.*

*NB. Ensure the records are tracked to their correct location and the volume number is accurate.*
Appendix E  TRUST APPROVED CLINICAL ABBREVIATIONS and RECORD KEEPING INSTRUCTIONS

STANDARDS FOR RECORD KEEPING
"TIDY CASENOTES AID EFFECTIVE PATIENT CARE"

1. It is the responsibility of all staff to maintain the standard of casenotes.

2. Each document must clearly identify the patient with the name, NHS number and hospital number.

3. All entries must be clearly written in BLACK ink. Clinical records must be clear, accurate and compiled as close to the time of interaction as possible or defined by your own professional body. In any event such information must be recorded within the casenotes within 12 hours of the event, episode or contract.

4. The Casenotes must report the relevant findings in the health and care of the person receiving the treatment, note all decisions made, information given to the service user and evaluation of the treatment provided.

5. Treatment plans should be recorded as soon as possible following admission. Along with this, reports should always be written in the casenotes when a) treatment changes, b) investigation results are received and c) when the patient's health changes.

6. All entries must be dated – DD/MM/YYYY, timed (using 24 hour clock HH:MM) and signed along with the author's printed name and designation and must be written in chronological order ensuring that each healthcare professional follows on from the last person making an entry in the casenotes.

7. Abbreviations must not be used unless they are contained in the "Trust Approved Clinical Abbreviations" list on the inside back cover of this casenote folder. Judgement statements and exclamation marks MUST NOT be used in these casenotes.

8. Do not pass these records on to any other healthcare professional, ward or department without first making a record of the transfer in the relevant tracking system. Failure to comply with this instruction may lead to disciplinary proceedings.

9. All investigation reports must be signed by medical staff before being filed in the casenotes.

10. All errors must be scored out using a single line and should be signed along with the date and designation of the person deleting the entry. Under no circumstances should correcting fluid be used. In connection with this, it is strictly forbidden to remove or correct anything within this record after the event has occurred, as this may constitute a criminal offence.

11. Always secure loose sheets into the casenote folder using the plastic fastening clip. Always punch holes in the sheet and use the Secure-Stor wallets for holding loose sheets which can not otherwise be secured in the casenote folder. Under no circumstances should plastic wallets be used in this casenote folder.

12. It is the responsibility of the ward/department that is in possession of the casenotes at the time of the episode to ensure that all papers are appropriately filed. "If you created it – you file it."

13. If these casenotes are to be permanently preserved then a "DO NOT DESTROY" sticker should be applied to the front of each volume of the patient's casenotes.

14. These casenotes should be returned to the appropriate records library when they are not in active use.

15. For further information refer to your own professional body.

ACCESS TO HEALTH RECORDS

The service user has the right under the Data Protection Act 1998 to access their health records. Contact your health records department or Medico-Legal Clerk for further advice.
TRUST APPROVED CLINICAL ABBREVIATIONS

BD - Twice Daily
OD - Once Daily
OM - One in the Morning
ON - One at Night
PRN - When Required
QDS or QID - Four Times Daily
TDS - Three Times Daily

Acceptable Abbreviations for describing Classes of drugs:
AChE - Acetyl Cholinesterases
BDZ - Benzodiazepines
MAOI - Mono Amine Oxidase Inhibitors
SNRI - Serotonin Noradrenaline Reuptake Inhibitors
SSRI - Selective Serotonin Reuptake Inhibitors
TCA - TriCyclic Antidepressants
A&E - Accident & Emergency
AA - Alcoholics Anonymous
ADL - Active Daily Living
ASW - Approved Social Worker
b/bhe - Behaviour(al)
BMI - Body Mass Index
BP - Blood Pressure
Bro - Brother
BT - Behavioural Therapy
CAB - Citizens Advice Bureau
CAT - Cognitive Behaviour Therapy
CM - Care Manager
CMHT - Community Mental Health Team
CND - Cancelled
Cont’d - Continued
CPA - Care Programme Approach
CPN - Community Psychiatric Nurse
CT - Computerised Tomography
CVA - Cerebro Vascular Accident
DBT - Dialectical Behaviour Therapy
DLA - Disability Living Allowance
DN - District Nurse
DNA - Did Not Attend
DTR - Daily Thought Record
DV - Domiciliary Visit
D/w - Discussed With
ECG - Electro Cardiogram
EMDR - Eye Movement Densitization and Reprocessing
FBC - Full Blood Count
Fds - Friends
FU - Follow Up
GAD - Generalised Anxiety Disorder
GI - Gastro Intestinal
Grp - Group
GP - General Practitioner
Hx - History of
IPT - Interpersonal Psychotherapy
kg - Kilograms
L - Left
MANCAS - Manchester Care and Assessment Schedule
Mane - In the Morning
MI - Myocardial Infarction
MMSE - Mini Mental State Examination
MMSU - Midstream Sample of Urine
MPT - Mentalization Based Therapy
Mtg - Meeting
MSE - Mental State Examination
NAD - Nothing Abnormal Detected
NATs - Negative Automatic Thoughts
No. - Number
Nocte - At Night
OCD - Obsessive-compulsive Disorder
OT - Occupational Therapist
PCMHT - Primary Care Mental Health Team
PCT - Primary Care Trust
PPH - Previous Psychiatric History
PSI - Psychosocial Intervention
Pt - Patient
PTSD - Post-traumatic Stress Disorder
Qs - Questions
R - Right
RGN - Registered General Nurse
RMN - Registered Mental Nurse
Rx - Medical Treatment
Sis - Sister
S.S. - Social Services
SFT - Schema Focussed Therapy
SW - Social Worker
TBA - To be arranged
TI - Technical Instructor (OT)
TIA - Trans Ischaemic Attack
Tx - Treatment
U&Es - Urea & Electrolytes
+ve - Positive
-ve - Negative
Δ - Diagnosis
↑ - Increase
↓ - Decrease
# - Fracture
Σ - The sum of
ECG or (EKG) - Electro-cardiogram
ECT - Electro Convulsive Therapy
EEG - Electro Encephalogram
MHA - Mental Health Act
IN CONTEXT
FH - Family History
HPC - History of Presenting Complaint
MS - Mental State
OE - On Examination
PC - Presenting Complaint
PFH - Previous Family History
PPH - Previous Psychiatric History

ALL AMENDMENTS OR ADDITIONS TO THIS LIST MUST FIRST BE APPROVED BY THE MEDICAL DIRECTOR.
APPENDIX F

PROCEDURE FOR ENSURING FULL ACCESS TO UNIFIED CLINICAL INFORMATION AND RECORDS

INTRODUCTION

The existence of duplicate or alternative clinical notes (i.e. another set of records for the same service user) poses a risk to service users and the organisation as it is likely that important information necessary for the correct treatment of service users may be missed e.g. drugs and allergies and clinicians cannot be sure they are viewing the whole medical history of the user.

There will be some circumstances in which it is impossible to detect if a service user has more than one set of clinical notes e.g. when the service user deliberately provides false information. However these instances will be rare and therefore in order to minimise the risk, all service users (if they are able to do so) on admission to the Trust should be asked if they have ever been treated in any other part of the Trust before. Staff should be clear to service users what they mean by other parts of the Trust.

The following is the procedure for the ensuring the care professional has access to all necessary information about a service user on presentation to the Trust.

AMIGOS clinical information system, contains the following;

- Master service user index of all service users in contact with the trust past and present.
- Casenote tracking module
- Outservice user clinic management module
- Inpatient user management module
- Care planning and assessment module
- Risk assessment and risk events/alerts
- Mental Health Act
- Diagnosis coding
- Clinical/contact noting
- Clinical letters/discharge documentation

The AMIGOS system is available and accessible across the trust, citywide.

It is therefore now possible to identify all known service users by accessing the case note module to check if they have notes in any part of the city. The Trust will be phasing out paper based tracking systems and will use the casenote tracking module of AMIGOS for all service user records.

In addition to this it is also possible to access up to date clinical information from care plans, assessments, contact records and risk information which is recorded on AMIGOS.
The AMIGOS system also allows for the recording of alerts/warning to alert the member of staff to any potential risks.

**SERVICE USERS PRESENTING AT THE TRUST**

AMIGOS should always be checked for the existence of a service user’s record.

If there is no record for the service user then a new AMIGOS record should be created and a new casenote folder should be set up for the service user. If, however, the service user is simply presenting at A&E then it is not necessary to create a casenote folder, as the contact and risk assessment should be documented on AMIGOS.

If the service user is in HMP Manchester then they should be recorded on Systm-One but AMIGOS checked for existence of other records as AMIGOS is available in the prison.

Checking AMIGOS will provide vital information for a clinician about a service user if they have been treated within the Trust before. This will give the clinician access to the following information:

- General Service user Demographic Details
- Section 117 review and any Home Office restrictions or supervised discharges
- Nearest relative
- Health Care Professional Contact Details who are currently or have worked with the service user before
- Care Co-ordinator details
- CPA Requirements and needs
- Crisis Plan
- Risk Management Details
- Medication details at time of last CPA Review
- Advance Directives of the service user e.g. Living Will
- Unmet Needs of the Service user
- Carer Details
- Instant Alerts/warnings
- Previous admissions details
- Risk indicators
- Contacts and correspondence

If on checking AMIGOS for the existence of a service user record it is discovered that the service user has casenotes in another part of the city and it is determined that these casenotes are required in order to treat the service user then a request should be made of the other site to have the casenotes transported or a summary of the last episode and the latest risk assessment in the casenotes sent to the requesting site immediately on request.

In normal office hours, Monday – Friday between 8:30am and 5:00pm the request should be to the respective records department.

Out of hours the request should be as per the access to care notes 24/7 procedure via the duty bleep holder at the requesting site. On receiving such a request the duty bleep holder should
contact their counterpart at the site where the notes being requested are held and ask for the casenotes or a summary of the last episode of care to be sent to the requesting site (Ward or Department).

In all instances where casenotes themselves are transported they should be tracked on the current tracking system.

DUPLICATE PAPER RECORDS – ADDITIONAL PROCEDURE

In addition to the above procedure the following additional process will also be undertaken as an additional measure.

- On registration all new service users to the Trust should be checked on AMIGOS to identify if they have been treated previously within the Trust and thereby already have records in other parts of the Trust.

- If a service user is found to have records in another part of the Trust, the respective site should apply a white “THIS SERVICE USER HAS OTHER NOTES” sticker to the outside front cover of the service users Casenote folder detailing where in the Trust other notes are available and the corresponding Casenote numbers. This will ensure that the clinician is notified and the additional records can be made available if required.

The need for this process will diminish over time with the increased use of the Trust Clinical System and the move towards a single manual folder for each service user.
APPENDIX G

CARE RECORDS 24/7 ACCESS PROCEDURE

INTRODUCTION

Because of the very nature of admissions and emergency admissions of patients to hospital it is imperative that existing care records are both available and accessible 24 hours a day, 7 days a week. As there is both a requirement and a need for permanent access to clinical records and the fact that clerical staff only work “normal office hours” it is incumbent upon the Trust to ensure that delegated members of staff are able to find and access clinical records “Out of Hours”.

The Trust has an electronic record and captures much of the information but not all the information that the care professional may need thus this procedure has been implemented in order to ensure that if required care records are available to Clinicians and Health Care Professionals in both office hours and Out-of-Hours.

ACCESS TO CARE RECORDS DURING NORMAL OFFICE HOURS

During normal office hours ALL access to clinical records MUST be via a legitimate request to the Records Department at the respective site:

- North 0161 720 2023 or 2001
- South 0161 291 6775
- Central 0161 276 5365, 5366 or 5332

NORTH REQUESTS

Requests for clinical records may be made by telephone, however, they should to be collected in person and at the time of collection a valid identity badge will be requested and MUST be produced if notes are to be released. The identity badge must be from either Manchester Mental Health & Social Care Trust.

SOUTH REQUESTS

Requests for clinical records may be made by telephone, however, they should to be collected in person, if the request is urgent. At the time of collection a valid identity badge must be produced before Casenotes will be released. The identity badge must be from Manchester Mental Health & Social Care Trust. Notes not collected in person will be placed in the internal mail system.

Between the hours of 9am and 4pm all calls should be made to the Records Library on the above number for South. If there is no answer on the above telephone number the Library Clerk will probably be in another room and will return shortly. If your request is urgent and you are unable to contact the Library Clerk then you should contact Laureate House Reception on 0161 291 6960 or 6961 and request the casenotes from them. As reception is usually very busy they may not be able to look for casenotes immediately but will eventually look for the Casenotes for you and return your call.
CENTRAL REQUESTS

Requests for clinical records may be made by telephone, however, they need to be collected in person. At the time of collecting Casenotes a valid identity badge must be produced before Casenotes will be released. The identity badge must be from Manchester Mental Health and Social Care Trust.

Between the hours of 8:45am and 5pm all calls should be made to the above telephone number for Central.

ACCESS TO CARE RECORDS OUTSIDE OF NORMAL OFFICE HOURS (INCLUDING BANK HOLIDAYS)

NORTH REQUESTS

Outside of normal Office Hours i.e. 5pm – 9am and at all times during weekends and Bank Holidays access to clinical records should be via the Psychiatric Nursing Bleep Holder. Anyone requiring legitimate access to clinical records should contact the Psychiatric Nursing Bleep Holder (details appear at the end of this document). Before Casenotes can be released a valid identity badge must be provided for examination by the Bleep Holder.

SOUTH REQUESTS

Office hours i.e. 9pm – 9am and at all times during weekends and Bank Holidays access to clinical records should be via the Psychiatric Nursing Bleep Holder. Anyone who requires legitimate access to clinical records should contact the Psychiatric Nursing Bleep Holder (details of the Psychiatric Nurse Bleep Holders can be found at the end of this document) and should provide basic details of the patients for whom clinical records are being sought. Before Casenotes can be released a valid identity badge must be provided for examination by the Bleep Holder.

CENTRAL REQUESTS

Senior House Officers on-call requiring access to medical records outside of normal office hours i.e. 5pm to 8:45am and at all times during weekends and Bank Holidays access to clinical records should be made by first contacting Security on 0161 276 4550 and arranging to meet them inside the hospital, in a well lit area. Security will require a valid identity badge to be produced before they will accompany you to the Records Library.

Once your identity has been verified Security will escort you to the Records Library in the Rawnsley Building and will ensure that you gain access to the required room(s) to retrieve the Casenotes.

Other persons requiring legitimate access to medical records out of hours should contact the Night Team Managers, based at the Edale Unit, who will look for Casenotes out of hours. The Night Team Managers can be contacted on the Psychiatric Nursing Bleep.

BOOKING OUT CASENOTES
You are reminded that if you remove Casenotes from the Records Library or from any other room within the hospital you **MUST** ensure that you trace out the Casenotes from their current location using the tracing systems in place at the current time.

Failure to trace out Casenotes can lead to them going missing and patients not being treated properly or in time. If you take notes YOU are responsible for tracing them out.

**CONTACTS**

<table>
<thead>
<tr>
<th>North</th>
<th>Outpatients, Inpatients &amp; Community</th>
<th>Alison Scully</th>
<th>0161 720 2419</th>
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<tbody>
<tr>
<td>South</td>
<td>Outpatients, Inpatients &amp; Community</td>
<td>Anita Arrigonie</td>
<td>0161 291 6913</td>
</tr>
<tr>
<td>Central</td>
<td>Outpatients, &amp; Community Community CWR Team</td>
<td>Angela Sharples</td>
<td>0161 276 5356 0161 882 1000</td>
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PCMHT Contact team admin
North 0161 231 0017
Central 0161 861 2236
South 0161 946 8260

Community Alcohol admin contact 0161 234 5050
Physical Activity Service admin contact 0161 230 1823

**TRUST PSYCHIATRIC NURSING BLEEP HOLDERS**

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<td>4070</td>
<td>0161 795 4567</td>
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<tr>
<td>SOUTH</td>
<td>526</td>
<td>0161 998 7070</td>
</tr>
<tr>
<td>CENTRAL</td>
<td>2013</td>
<td>0161 276 1234</td>
</tr>
</tbody>
</table>
APPENDIX H

CASENOTE TRACKING PROCEDURE - INTERIM PROTOCOL FOR CASE NOTE TRACKING

INTRODUCTION

This protocol is being implemented across the Trust to ensure that patient case notes are easily traceable and may thus be available when a patient is to be treated, admitted or for other legitimate purposes as may from time to time be necessary.

This protocol is an interim solution until such time as computerised case note tracking is available across the Trust and all appropriate staff members have been trained (via AMIGOS). As a result of this the protocol will be changed when necessary.

SOUTH

1. All persons who have access to case notes must ensure that whenever they remove them from either the Records Library or their current location they track them out to wherever they are going to, i.e. Out Patient Clinics, Wards, Secretaries, Doctors or elsewhere.

2. When case notes are returned to the Records Library they must be tracked back to the Library on AMIGOS by the person returning them.

3. It is the responsibility of the person removing case notes from their current location to ensure that they track them out to their new location.

NORTH, CENTRAL & other Community Services

1. TAKING CASENOTES FROM THE RECORDS LIBRARY

1.1 When Casenotes are removed from the Records Library the person removing them must complete a Tracer Card for each set of notes removed. The Tracer Card should be completed in black ink and should clearly show:

   a) The date the Casenotes were removed from the Records Library
   b) Where the Casenotes are being taken to i.e. Clinic details and date of clinic or doctor or department name and reason for removal e.g. report, Clinical Audit, Medico Legal etc.
   c) Initials of the person taking the Casenotes and telephone extension number.

2. TAKING CASENOTES FROM A FORTHCOMING CLINIC

2.1 If it is necessary to remove a set of Casenotes from an already compiled forthcoming clinic then the person removing such notes should complete a NEW Tracer Card and place this in the “pulled” clinic to alert the Clinic Clerk as to where such notes may be
found. The Tracer Board in the Records Library must also be completed with the same details.

3. **TAKING CASENOTES FROM SOMEWHERE OTHER THAN THE RECORDS LIBRARY OR A FORTHCOMING CLINIC**

3.1 If taking Casenotes from anywhere other than the Records Library or a forthcoming clinic then Casenotes should be traced out from this place in a Tracer Book which each Secretary and Department should maintain. The cover of each tracer book must be clearly marked with the name of the Secretary or Department, (the names of the consultants – if maintained by a secretary) and the date when the book commenced and date when the book ceased to be used for current entries.

3.2 It is the responsibility of each person taking notes from a secretary or department to ensure that they complete the Tracer Book.

3.3 All entries in the Tracer Book must be made under the letter of the Surname of the Patient whose notes are being taken.

3.4 It is the responsibility of each Secretary or Department to ensure that their Tracer Book is readily available for inspection by anyone who may require a set of Casenotes but is unable to find them in that office. It is advised that at the end of each evening the Tracer Book is left on the Secretary’s Desk or another Desk within the Department to enable on-call staff to access them easily.

3.5 Secretaries returning Casenotes to the Records Library for routine filing will not be required to book out Casenotes to the Library in their Tracer Book.

**TAKING CASENOTES OFF SITE**

1. Anyone wishing to take case notes off-site should first obtain authorisation from the Designated Local Records Manager.

   Authorisation for removing case notes from a site must be obtained using the “Authorisation Form - For Taking Records Off Site” (APPENDIX C).

2. On completion of the authorisation form a photocopy should be given to the person to whom authorisation has been given and the original form should be returned to the Designated Local Records Manager for safe keeping (These forms may be required from time to time for audit purposes).

3. If you are required to remove Medical Records from a site on a frequent basis to enable you to hold a clinic off site or visit patients in their home then you will not be required to obtain a different Authorisation Form for each clinic or session. In these instances you will be granted authorisation for a specified period of time i.e. 12 months (renewable each year). This authorisation will NOT cover you if you later wish to take notes off site for any other purpose e.g. Clinical Audit or research.
RECORDS MANAGEMENT CODE OF PRACTICE HEALTH RECORDS RETENTION SCHEDULES

Please click the link below to Records Management NHS Code of Practice site.

http://systems.hscic.gov.uk/infogov/links/recordscop2.pdf
### PROFESSIONAL DUTIES AND TIME FRAMES FOR CLINICAL RECORDING

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<tr>
<td>1</td>
<td>Inpatient and other acute service activity (including A&amp;E Liaison, and SAFIRE) should be recorded in real time where possible and as a maximum within 2 hours or by the end of shift (whichever is soonest)</td>
</tr>
<tr>
<td>2</td>
<td>CRHT contacts should be recorded in real time where possible and as a maximum within 2 hours or by the end of shift (whichever is soonest)</td>
</tr>
<tr>
<td>3</td>
<td>Contacts for all community-based services should be recorded as soon as practically possible and as a maximum within 24 hours.</td>
</tr>
<tr>
<td>4</td>
<td>CPA and Mancas entries should be recorded within 24 hours</td>
</tr>
<tr>
<td>5</td>
<td>CHOURES and Risk Summary entries should be recorded in real time where possible and as a maximum within 2 hours or by the end of shift (whichever is soonest)</td>
</tr>
<tr>
<td>6</td>
<td>Full details of a patient's legal status should be recorded at the time of admission where possible and as a maximum by the end of shift</td>
</tr>
<tr>
<td>7</td>
<td>Outpatient activity – all attendance statuses and outcomes to be completed in real time where possible or within 2 working days where clinics are held off site</td>
</tr>
<tr>
<td>8</td>
<td>Referrals must be recorded within 24 hours of receipt</td>
</tr>
<tr>
<td>9</td>
<td>Discharges from all non-inpatient services should be recorded within 2 working days</td>
</tr>
<tr>
<td>10</td>
<td>Changes to demographic information (change of address, change of GP practice, date of death etc) should be recorded within 24 hours of notification</td>
</tr>
<tr>
<td>11.</td>
<td><strong>Notification to GP of admission</strong> to in-patient Unit, signed by a member of the Consultant’s team, should be sent to the GP and Medical Records on the day of admission, and no later than within <strong>24 hours of admission</strong>.</td>
</tr>
<tr>
<td>12</td>
<td><strong>Admission history, psychiatric assessment and physical examination</strong> will be recorded within <strong>24 hours</strong> of admission</td>
</tr>
<tr>
<td>13</td>
<td><strong>Clinic letters</strong> should be sent within five working days dictated and signed</td>
</tr>
<tr>
<td>14</td>
<td><strong>Notification to GP of movement</strong> of patients between wards that provide a different function, for example Step up - Adult Acute to PICU. Adult Acute to Rehabilitation and Recovery or Step down - From PICU to Adult Acute ward, within <strong>24 hours</strong> of the movement taking place</td>
</tr>
<tr>
<td>15</td>
<td><strong>Discharge notification/summary</strong>, signed by a member of the Consultant’s team should be sent to the GP and Medical Records on the day of discharge, <strong>within 24 hours</strong> of the movement taking place</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>and no later than within 24 hours of discharge</strong></td>
<td></td>
</tr>
<tr>
<td><strong>16</strong></td>
<td><strong>Discharge letter</strong> to be completed and sent to the GP and other relevant external agencies within <strong>10 calendar days</strong> of <strong>discharge from in patients</strong>.</td>
</tr>
<tr>
<td><strong>17</strong></td>
<td><strong>Discharge letter</strong> to be completed and sent to the GP and other relevant external agencies within <strong>10 calendar days</strong> of <strong>discharge from Service</strong>.</td>
</tr>
</tbody>
</table>
### APPENDIX K

**AUDIT TOOL**

**NHSLA and IG Records Audit 2013**

Date of audit ----/--/----- Audit number ___________________________

Person undertaking audit and designation _____________________________

**Locality**

- North  
- South  
- Central  
- Citywide

**Care Setting**

- Adult Urgent Care  
- Later Life  
- Psychological Services  
- HMP

- Manchester  
- Health and Well Being  
- Recovery and Rehab

**Patient Type**

- Inpatient  
- Outpatient  
- Community  
- Psychology

**Notes audited**

- paper  
- electronic  
- both

NHS number ____________________  
TEAM code from sample ____________________

<table>
<thead>
<tr>
<th>Patient Details</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>There is a record sheet or summary of patient details immediately accessible</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The record sheet includes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- The Service User Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- District number (local patient ID)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Date of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- GP details</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Ethnicity
- Address
- Postcode
- NHS number
- Gender
- Marital status
- Next of kin
- Contact telephone number

**Condition of the record**

The contents of the record are securely fastened and there are no loose or unfiled items (including machine produced recordings)

All such loose items above are secured in a secure – stor envelope and not in plastic wallets

Contents are filed neatly in the correct sections according to the design of the record and the filing instructions

The overall file presentation is good, neat, tidy. Not too full and falling apart.

Lab results attached on the lab mount sheets as appropriate

Observation forms are filed in the notes

Mental Health Act Papers are filed in the correct section

Information is filed in the wrong patient notes

If the patient was admitted via A&E a copy of the A&E record is available in the notes

**Documentation Practice**
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the NHS number on the cover of the manual note</td>
<td></td>
</tr>
<tr>
<td>Are all volumes clearly marked and identified correctly</td>
<td></td>
</tr>
<tr>
<td>Is the appropriate year sticker on the cover of the note</td>
<td></td>
</tr>
<tr>
<td>Is there reference to where other care records exist for the service user</td>
<td></td>
</tr>
<tr>
<td>Patient identifier is recorded on each page (since December 2009 this should be NHS number)</td>
<td></td>
</tr>
<tr>
<td>Each page in the notes is numbered (paper notes)</td>
<td></td>
</tr>
<tr>
<td>Paper notes are written in black ink</td>
<td></td>
</tr>
<tr>
<td>If there are any spaces on history sheets there is a line drawn through the spaces</td>
<td></td>
</tr>
<tr>
<td>Has correction fluid been used in the notes</td>
<td></td>
</tr>
<tr>
<td>Are errors crossed with a single line, initialed and dated (for electronic records a note should be evident on the entry that is was made in error)</td>
<td></td>
</tr>
<tr>
<td>Has NHS number been used on all correspondence since December 2009</td>
<td></td>
</tr>
<tr>
<td>All entries in the notes signed and the name and designation/profession of the author printed?</td>
<td></td>
</tr>
<tr>
<td>All entries on Amigos signed with the name and designation/profession of the record maker</td>
<td></td>
</tr>
<tr>
<td>Are student records countersigned and dated by a qualified supervisor</td>
<td></td>
</tr>
<tr>
<td>All entries are timed and dated</td>
<td></td>
</tr>
<tr>
<td>All entries are filed in chronological order and in line with the file instructions</td>
<td></td>
</tr>
<tr>
<td>All entries are contemporaneous</td>
<td></td>
</tr>
<tr>
<td>All entries are concise, factual, relevant, accurate &amp; objective</td>
<td></td>
</tr>
<tr>
<td>Have any unauthorised abbreviations or inappropriate slang or other language been used</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>The notes are written in terms that the patient can understand (where appropriate)</td>
<td></td>
</tr>
<tr>
<td>There are no inappropriate statements or information documented in the notes</td>
<td></td>
</tr>
<tr>
<td>Records are completely legible including prescription sheets</td>
<td></td>
</tr>
<tr>
<td>Information/documentation is easily identifiable and located assessments/risk assessments</td>
<td></td>
</tr>
<tr>
<td>- Care plans/treatment plans</td>
<td></td>
</tr>
<tr>
<td>- Progress notes/daily entries/ward rounds</td>
<td></td>
</tr>
<tr>
<td>- Discharge records</td>
<td></td>
</tr>
<tr>
<td>- Goals</td>
<td></td>
</tr>
<tr>
<td>Incidents, near misses, drug errors etc recorded in the notes</td>
<td></td>
</tr>
<tr>
<td>Allergies and other hypersensitivities are recorded in an appropriate place and easily identified</td>
<td></td>
</tr>
<tr>
<td>All allergies and other hypersensitivities are dated and signed</td>
<td></td>
</tr>
<tr>
<td>Significant risk issues and other alerts are recorded</td>
<td></td>
</tr>
<tr>
<td>There is evidence that all relevant verbal communication about care and treatment recorded</td>
<td></td>
</tr>
<tr>
<td>Third party information is clearly identified</td>
<td></td>
</tr>
<tr>
<td>Legal status is recorded for all inpatients</td>
<td></td>
</tr>
<tr>
<td>There are no apparent gaps in information. If there is a gap of more than 6 months is the reason for this recorded</td>
<td></td>
</tr>
<tr>
<td>Records are written as soon as possible after the event in accordance with the Data Quality Policy and Service User Record Management Policy</td>
<td></td>
</tr>
<tr>
<td>Records are written at an appropriate frequency in accordance with the Data Quality Policy and Service User Record Management Policy</td>
<td></td>
</tr>
<tr>
<td>Current Care Co-ordinator is recorded</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Current Team code is recorded</td>
<td></td>
</tr>
<tr>
<td>Carers details are recorded where a carer is identified</td>
<td></td>
</tr>
<tr>
<td>Current diagnosis is recorded</td>
<td></td>
</tr>
<tr>
<td>Referral dates are clearly recorded</td>
<td></td>
</tr>
<tr>
<td>Admission dates are clearly recorded</td>
<td></td>
</tr>
<tr>
<td>Discharge dates are clearly recorded</td>
<td></td>
</tr>
<tr>
<td>Appointment dates are clearly recorded</td>
<td></td>
</tr>
<tr>
<td>Contact dates clearly recorded</td>
<td></td>
</tr>
<tr>
<td>Consent</td>
<td></td>
</tr>
<tr>
<td>There is a consent to treat record for each episode of treatment where applicable and</td>
<td></td>
</tr>
<tr>
<td>State if written or verbal</td>
<td></td>
</tr>
<tr>
<td>- Discussion of benefits and anticipated outcome is recorded</td>
<td></td>
</tr>
<tr>
<td>- Discussion of risks and complications is recorded</td>
<td></td>
</tr>
<tr>
<td>- Discussion of alternative or no treatment recorded</td>
<td></td>
</tr>
<tr>
<td>Consent to share information is recorded</td>
<td></td>
</tr>
<tr>
<td>Don’t not resuscitate wishes are recorded</td>
<td></td>
</tr>
<tr>
<td>Advance directives and patient wishes are recorded</td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td></td>
</tr>
<tr>
<td>There is an up to date legible prescription/medication card</td>
<td></td>
</tr>
<tr>
<td>All drug entries dated and signed</td>
<td></td>
</tr>
<tr>
<td>All entries are clear and legible e.g. drug, frequency, route, duration</td>
<td></td>
</tr>
<tr>
<td>All entries for prescribing medications signed by authorised</td>
<td></td>
</tr>
</tbody>
</table>
**practitioner**

*All entries for dispensing medications are legible, dated, timed and signed*

*Allergy status is recorded including record of no allergies*

**Practitioner entries**

*There is an entry/report for each/every intervention with a care professional (Doctor, OT, Social Worker, Nurse, CPN, Psychologist, Support worker etc)*

*There is an entry at least once per shift for inpatients*

  *This entry is recorded before the end of the shift*

*There is an entry for each contact/appointment etc*

  *This entry is recorded on the same day*

  *This entry is recorded within 2 working days*

*Are all entries legible*

*Are all in black ink*

*Are all signed*

*Are all dated*

*Are all author/record makers (Amigos) identifiable and designation identifiable*

*Are all entries timed*

*Are there ECT entries/contacts*

*Are all entries legible*

*Are all in black ink*

*Are all signed*
<table>
<thead>
<tr>
<th>Are all dated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all author/record makers (Amigos) identifiable and designation identifiable</td>
</tr>
<tr>
<td>Are all entries timed</td>
</tr>
<tr>
<td>Is there a consent to treatment form</td>
</tr>
<tr>
<td>Are there A&amp;E entries/contacts</td>
</tr>
<tr>
<td>Are all entries legible</td>
</tr>
<tr>
<td>Are all in black ink</td>
</tr>
<tr>
<td>Are all signed</td>
</tr>
<tr>
<td>Are all dated</td>
</tr>
<tr>
<td>Are all author/record makers (Amigos) identifiable and designation identifiable</td>
</tr>
<tr>
<td>Are all entries timed</td>
</tr>
<tr>
<td>Assessment records reflect care provided and include</td>
</tr>
<tr>
<td>Referrer recorded</td>
</tr>
<tr>
<td>Reason for admission/referral recorded</td>
</tr>
<tr>
<td>Presenting complaint recorded</td>
</tr>
<tr>
<td>Date of admission/referral recorded</td>
</tr>
<tr>
<td>Admitting clinician recorded</td>
</tr>
<tr>
<td>The most senior professional present when changes to care/treatment made is recorded</td>
</tr>
<tr>
<td>The consultant in charge of the episode is recorded</td>
</tr>
<tr>
<td>Initial assessment/risk assessment been recorded</td>
</tr>
<tr>
<td>Date and time of assessment recorded</td>
</tr>
<tr>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Is there a MANCAS needs assessment completed and documented in the notes.</td>
</tr>
<tr>
<td>Diagnosis recorded</td>
</tr>
<tr>
<td>Treatment plans recorded</td>
</tr>
<tr>
<td>Requested investigations recorded with reason required</td>
</tr>
<tr>
<td>Physical health assessments/examinations recorded</td>
</tr>
<tr>
<td>Falls assessments recorded</td>
</tr>
<tr>
<td>Allergy status recorded on the assessment</td>
</tr>
<tr>
<td>Care plan reflects care provided</td>
</tr>
<tr>
<td>Is there evidence the service user has been involved in the needs assessment</td>
</tr>
<tr>
<td>Is there a recent care plan</td>
</tr>
<tr>
<td>Is there evidence the service user has been involved in the development of the care plan</td>
</tr>
<tr>
<td>Is the care plan based on the assessment of needs</td>
</tr>
<tr>
<td>Is there evidence the care plan has been/being implemented</td>
</tr>
<tr>
<td>Are name and designation of all those involved in the formulation of the care plan recorded</td>
</tr>
<tr>
<td>Are desired outcomes and goals identified</td>
</tr>
<tr>
<td>Has the care plan been reviewed in the last 12 months</td>
</tr>
<tr>
<td>Are variances and changes to care plans recorded with clear rationale</td>
</tr>
<tr>
<td>Is there a recent risk assessment</td>
</tr>
<tr>
<td>Has the risk assessment been reviewed/followed up regularly</td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Is there evidence the risk assessment had been updated to reflect any significant change in risk factors</td>
</tr>
<tr>
<td>Is the risk matrix completed in Amigos and up to date</td>
</tr>
<tr>
<td>Is the risk assessment dated the day it was completed</td>
</tr>
<tr>
<td>Is there evidence the service user has been involved in the risk assessment process</td>
</tr>
<tr>
<td>Is advice/information given to patients recorded</td>
</tr>
<tr>
<td><strong>Transfer of Care/Discharge arrangements</strong></td>
</tr>
<tr>
<td>There is a discharge/transfer planning sheet</td>
</tr>
<tr>
<td>There is a multi professional discharge/transfer process and include external agencies where appropriate</td>
</tr>
<tr>
<td>The discharge/transfer date is recorded</td>
</tr>
<tr>
<td>The discharge/transfer destination is recorded</td>
</tr>
<tr>
<td>Arrangements for continuing care/transfer are recorded</td>
</tr>
<tr>
<td>Instructions have been relayed to those who are to provide ongoing care and this is recorded</td>
</tr>
<tr>
<td><strong>Discharge letter/summary available and containing</strong></td>
</tr>
<tr>
<td>Date of admission</td>
</tr>
<tr>
<td>Date of discharge</td>
</tr>
<tr>
<td>Presenting complaint</td>
</tr>
<tr>
<td>Diagnosis</td>
</tr>
<tr>
<td>Treatment / investigations</td>
</tr>
<tr>
<td>Medication details (clear and legible)</td>
</tr>
<tr>
<td>Outpatient appt date</td>
</tr>
<tr>
<td>Follow up plans</td>
</tr>
<tr>
<td><strong>Letter dated within 10 working days of discharge</strong></td>
</tr>
<tr>
<td><strong>Letter dated within 5 working days of discharge</strong></td>
</tr>
<tr>
<td><strong>Information regarding risk alerts, allergies, infection control has been relayed</strong></td>
</tr>
<tr>
<td><strong>Information given to patients and their carers and relatives about the discharge/transfer has been recorded</strong></td>
</tr>
<tr>
<td><strong>Is there a seven day follow up contact following discharge</strong></td>
</tr>
<tr>
<td><strong>Does the overall record demonstrate continuity of care</strong></td>
</tr>
<tr>
<td><strong>Does the overall record provide a clear account of assessment, risk assessment, care planning and delivery</strong></td>
</tr>
</tbody>
</table>

**Additional comments or observations re quality and standard of the notes**
MISSING/DUPLICATE RECORDS PROCEDURE

1. A missing case note is one that cannot be found or is not available when required for a patient contact by a care professional.

2. When this occurs the following steps must be taken:
   i. Complete the case note location checklist
   ii. Enter into the missing notes register
   iii. report the missing notes to the supervisor/responsible manager
   iv. supervisor/manager to undertake a thorough search
   v. a Datix incident should be recorded
   vi. the Caldicott Guardian should be consulted as to whether to inform the service user or carer

3. A log must be kept of all case notes which are missing when required for a patient contact by a care professional. (2ii above)

4. When the manager responsible for health records or a designated deputy, has confirmed that the case notes are missing a duplicate set of case notes can be created, the Log of Duplicate Case notes should be completed. AMIGOS should be updated to show that a duplicate folder is in circulation and the duplicate folder should be tracked indicating clearly that it is a duplicate folder.

5. Only medical records staff may create a duplicate set of case notes. This must be recorded using the duplicate case notes creation log.

6. A search must be made for all missing case notes in the missing case notes register on a regular basis (two weekly). The dates that searches are conducted should be entered in the log together with the person who undertook the search.

7. When a set of case notes has been missing for six months it is reasonable to assume that the original set of case notes has been lost. Accordingly a the Datix Incident report should be updated.

8. When/if the original case notes are located the following procedure should be followed:
   i. complete the missing case notes register to indicate that the original case notes have been located.
   ii. Merge the duplicate folder with the original set of case notes that have been located following Trust Filing Plan.
   iii. Remove the indicator from AMIGOS showing that a duplicate folder is in circulation.
   iv. Update the tracking system with the location of the merged case notes.
9. The Manager responsible for health records should complete a report of missing and duplicate records to the Information Governance Manager.

10. The Information Governance Manager should complete a quarterly report of missing and duplicate records to the Trust Information Governance Group.

**MISSING NOTES REGISTER**

- Any notes that are unable to be located after completion of the Case note location checklist, details **must** be entered into this register.
- A two weekly check **must** take place.
- If a duplicate case note folder is created complete **LOG OF DUPLICATE CASE NOTESCREATED**
- Once notes have been located complete the date located against the entry in the missing notes register.
- If notes still not located leave entry in until the end of the month and if still outstanding transfer details to following months sheet. The month end sheet **must** then be given to the Records Manager.
- When notes have been missing for 6 months complete Datix report
# CASE NOTE LOCATION CHECKLIST – NORTH

**Patients Name:** _____________________________ **P number** ________________

**Notes requested by:** ____________________ **for** __________________

**Date requested** ________________________

**Locations:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CURRENT FILE Check full row and transpose number</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>AMIGOS (Different number, general data entries)</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>ARCHES</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>OVERSPILL</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>CMHT</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>CMHT</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>FILING BOXES IN SECRETARIES</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>TYPING BOXES IN SECRETARIES</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>SECRETARY</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>ARCHES FILING TO GO</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>PULLED CLINICS</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>DOCTORS TRAYS IN SECS OFFICE</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>CONSULTANTS OFFICE</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>WARD (If recent discharge/SUI)</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>JUNIOR DOCTORS COMMON ROOM</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>MEDICO LEGAL (Gill General Office)</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>ALISON SCULLY</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>LOCALITY DIRECTOR/PA (SUI)</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>(In-Patient CSM)</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>SUI SHELF</td>
<td>Date: ______________</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Date: ______________</td>
</tr>
</tbody>
</table>

*In- Patient CSM*
CASE NOTE LOCATION CHECKLIST – South

Patients Name: _____________________________ PX number ____________________

Notes requested by: ____________________ for ____________________

Date requested ________________________

Locations:

CURRENT FILE Check full row and transpose number □ Date: ______________

AMIGOS (Different number, general data entries) □ Date: ______________

BRONTE Archive □ Date: ______________

BRIAN HORE UNIT □ Date: ______________

CMHT □ Date: ______________

A&E LIASON □ Date: ______________

FILING BOXES IN SECRETARIES □ Date: ______________

TYPING BOXES IN SECRETARIES □ Date: ______________

SECRETARY □ Date: ______________

PIGEON HOLES □ Date: ______________

PULLED CLINICS □ Date: ______________

DOCTORS TRAYS IN SECS OFFICE □ Date: ______________

CONSULTANTS OFFICE □ Date: ______________

WARD (If recent discharge/SUI) □ Date: ______________

JUNIOR DOCTORS office □ Date: ______________

MEDICO LEGAL (Geoff General Office) □ Date: ______________

ANITA ARRIGONIE □ Date: ______________

LOCALITY DIRECTOR/PA (SUI) □ Date: ______________

If notes are not located enter details in missing notes register
If notes are required for a clinic - copy this form and place it with the clinic

CASE NOTE LOCATION CHECKLIST – CENTRAL

Patients Name: _____________________________ J Number ___________________

Notes requested by: ____________________  for ____________________

Date requested ________________________

Locations:

CURRENT FILE Check full row and transpose number □  Date: ______________

AMIGOS  (Different number, general data entries) □  Date: ______________

SCANNING □  Date: ______________

OVERSPILL(October Ward) □  Date: ______________

CMHT East □  Date: ______________

CMHT Central □  Date: ______________

CMHT West □  Date: ______________

CMHT Chorlton/Whalley Range □  Date: ______________

FILING CABINETS IN SECRETARIES OFFICES □  Date: ______________

CRISIS TEAM □  Date: ______________

SECRETARY □  Date: ______________

OVERSPILL BOXES IN FILE ROOM □  Date: ______________

PULLED CLINICS □  Date: ______________

DOCTORS TRAYS IN SECS OFFICE □  Date: ______________

CONSULTANTS OFFICE □  Date: ______________

WARD (If recent discharge/SUI) □  Date: ______________

JUNIOR DOCTORS COMMON ROOM □  Date: ______________

MEDICO LEGAL (Margaret Hardmans Office) □  Date: ______________

MARGARET HARDMAN □  Date: ______________
If notes are not located enter details in missing notes register
If notes are required for a clinic - copy this form and place it with the clinic
## LOG OF DUPLICATE CASE NOTES CREATED - SITE: …………………….

<table>
<thead>
<tr>
<th>MONTH</th>
<th>SHEET NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patients Name</th>
<th>Case note number</th>
<th>Duplicate folder created (Date)</th>
<th>Reason for creation of duplicate folder</th>
<th>Person creating duplicate folder (Name (printed))</th>
<th>AMIGOS updated</th>
<th>Notes located (enter date)</th>
<th>Duplicate and Original folder merged by (Name)</th>
<th>AMIGOS updated (Date)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

The end of the month outstanding missing notes must be transferred to the next month’s sheet and this form must be given to the Records Manager.
MISSING NOTES REGISTER - SITE: ..............................

MONTH  ........................................................................... SHEET NUMBER  ..............

<table>
<thead>
<tr>
<th>Patients Name</th>
<th>Case note number</th>
<th>Date last tracked out</th>
<th>Tracked to</th>
<th>Missing date</th>
<th>Check 1 Date initials</th>
<th>Check 2 Date initials</th>
<th>Notes located (enter date)</th>
<th>Notes missing 6 months – Datix completed (Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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At the end of the month outstanding missing notes must be transferred to the next month’s sheet and this form must be given to the Records Manager.
APPENDIX M

AMIGOS PROCEDURE FOR DUPLICATE/CONFUSED RECORDS

The System Applications Officer will have first responsibility for dealing with these situations. Contact details are

- Email: AMIGOS.info@mhsc.nhs.uk
- Fax: 0161 882 1360
- Phone: 0161 882 1084

Duplicate Records

Overview
If there are two or more AMIGOS records relating to the same client, then these records must be merged. Duplicate records represent risk – to the client, to care staff and to the Trust in terms of breach of legislation.

Every effort must be made to make sure this only happens if the client is definitely the same on both records.

Once identified and confirmed, the records should be merged as soon as possible and certainly within one working week.

If for any reason the merge is delayed or if a specific and significant risk exists with these records, a Special Notes alert entry should be made onto both records. These should be archived after the merge.

Identifying need for a merge.

This may come from staff with direct involvement with the client that have either noticed the duplication or have realised they have created a duplicate record. All staff are trained to recognise and report possible duplicate records during basic training.

The request must be received in a traceable format – i.e. signed and faxed Form 2003 Request to Merge Records on AMIGOS (available on the Trust intranet) or emailed to the AMIGOS.info@mhsc.nhs.uk address to perform the merge. If emailed, this must be kept by the receiving officer.

In either case the staff must explicitly identify in writing any discrepancies between the two datasets and state which version of each is correct.

If there are significant differences (e.g. address and DOB different) they must explain in writing why they think the two records are for the same person.

This may also come from an internal audit process (such as the NHS number trace routines performed by the Information Department or regular audit reports by the System Applications Officer) where the staff involved do not know the client.
Determining factors may include;

- Identical (or very similar) demographics or by matching NHS numbers.

- If the data is slightly different the decision can be supported by the evidence of history of one data item on the other record.

- Different addresses. Can be obtained from AMIGOS in PAS\History (remove the “Registration Only” tick and tick “Show Deleted” to get all records) or using the address history in the NHS Summary Care Record (SCR).

- Different GP. Can be obtained from AMIGOS in PAS\History (remove the “Registration Only” tick and tick “Show Deleted” to get all records) or using the address history in the NHS Summary Care Record (SCR).

- Discrepancies in name or minor spelling mistakes in the name.

- Different dates of birth, e.g. 1/3/44 and 13/3/44 which could be an administrative error.

- Marital Status – this may change

- Ethnic Origin, this may be blank on one record but not on the other.

Before merging any records ensure that you check that the relevant data is correct.

If you have any doubt as to the validity of the data ask for confirmation in writing (i.e. Email or fax) from the person requesting the merge.

Consider alternative sources such as the client’s GP (especially Dates of Birth, NHS Numbers) or the NHS Summary Care Record. (National Health Service Portal: https://portal.national.ncrs.nhs.uk/portal/dtthen, Launch Summary Care Record) - you will need a Smartcard with valid access rights to use this facility.

Some points to note

Sometimes Dates of Birth are guessed in order to enter records onto the system. This most frequently happens in A&E and by the SAFE Team and will be of the form 01/01/XXXX where XXXX is the guessed year of birth.

Be aware that the NHS Summary Care Record may not have been updated or even informed recently.

Missing data or conflicting data can also sometimes be found by checking entries made in the general data section of AMIGOS.
Performing the merge (Only to be done by appropriate staff)

Determine the district numbers for the two records concerned.

Click on the 'File' menu on AMIGOS and then on the 'Merge Records' option.

The record with the most up to date data should be regarded as 'dominant'

Type in this number, in the dominant district number box.

Type the second district number to be merged in the subordinate district number box.

Click on the merge button. A flag will pop up on the screen at this point. If the data shown on this flag is the data you are expecting then click on continue. Some records may still be susceptible for merging if the demographic data is not identical. (See above 1.2.2)

At this point any conflicting data between the files will be displayed on the screen. The data present in the dominant file will persist in the merged file if you continue here. Click on 'continue' if appropriate for merging.

Once finished the merged record will be loaded in AMIGOS. Check that the correct and current data has been pulled through.

On the bottom right of the PAS/Identity screen click on the 'M' button. Here you can view all data on the individual records merged. Check that no data has been lost (e.g. Ethnic Origin being overwritten by a blank or when both of the records contained some of the correct data) and edit the record if necessary.

Housekeeping

Email the person who requested the merge to let them know the duplicate records have been dealt with.

If the merged record has two casenote numbers for the same department, contact the relevant administrative staff to inform them of the need to perform a paper record merge.

The System Applications Officer should be informed following the merge to allow a log to be kept of duplicate record creation. Email AMIGOS.info@mhsc.nhs.uk making it clear that the merge has taken place but is to be logged.
Audit Of Duplicate Record Creation

This is only for the System Applications Officer to perform.

Log on to Query Analyzer using your appropriate details.

Run the following script, replacing XXXXXXX and YYYYYYYYY with the first and second district numbers respectively.

```sql
select top 2 a.patientid, a.userid, l.username, l.firstname, l.surname, a.at, a.request
from audit a
left outer join lami l on a.userid=l.id
where patientid = XXXXXXX
order by at asc
```

Using the data in the 'At' columns of the output of this script, determine which record was created first and which second.

Make a note of who created the second record, when it was created, whether the details entered matched the existing record - and anything else that occurs to you as significant, in the file S:\CIS Department\General\Audit\Merge Creators.xls

If the second record was created within 1 hour of the first, flag the log entry as 'Replication lag' - we can excuse these people.

- If the second record creator has userid = '-1001', log the creator as 'iPM'
- If the second record creator has userid = 'NULL', log the creator as imported
- If there were no significant differences in the demographic data between the two records at point of creation of the second record, record 'NONE' in the differences column.

Confused Records

Overview
If it is identified that a confused record exists (i.e. one record with details and entries relating to two or more clients) then the details must be separated.

These are likely to be spotted by staff from all areas and roles – clinical, administrative and from the Information Department when running batch checks of NHS numbers.

If spotted, they must be reported immediately to the System Applications Officer preferably via the AMIGOS.info@mhsc.nhs.uk email

This could indicate one of two situations
Incorrect entry – an entry or entries have been inappropriately entered into the wrong record.

Incorrect merge – two or more records have been wrongly identified as corresponding and merged into one.

These may be indicated:

- by existence of previous conflicting names
- by a known client record having inappropriate changes
- by the existence of many incorrect entries

Such records must be corrected as a matter of urgency. The CIS Department will aim to deal with them within one working week.

Some cases will require extensive research and input from clinical and medical records staff. These cases may take longer but every effort will be made to deal with them as soon as possible.

**Correcting Confused Records**

**Incorrect Entries**

Currently AMIGOS does not support deletion of entries even by system administrators. The only possible course of action is to overwrite (effectively a strike-through) the text of the entry to make the error clear. The original entry will be preserved on the database should it need to be checked or audited.

If discovered the author of the incorrect entry should be emailed with the message below. The steps outlined in the message can be taken by the author directly.

Whoever discovers the incorrect entry should also notify the System Applications Officer for checking and logging.

Message to email to author of Incorrect Entry
Incorrect Merges

If it is suspected that a record has been incorrectly merged the System Applications Officer must be notified immediately. An Special Notes message should also be made to alert other staff to the suspicion. This should be archived once resolved.

The System Applications Officer will investigate the situation.

If possible the AMIGOS facility to un-merge the records will be employed. This may result in many incorrect entries that then need to be dealt with according to the steps above.

If not possible manual processes may have to be employed.

Audit Of Confused Record Creation

This is only for the System Applications Officer to perform.

Log all creations of confused records and which category they fall into.

Analysis and Further Actions

The log will be examined regularly by the CIS Manager. If points of practice or system changes are indicated in order to prevent further creation of duplicate records, this will be...
forwarded to the relevant parties for action.

If individual repeat offenders are identified notify them of the need to change practice and copy in their manager.

If they persist then this will be escalated to the relevant CSM.

Points of general practice will be discussed with Operational Managers and be escalated if necessary to the Locality Directors and/or Chief Operating Officer.

System Changes deemed to be effective will be discussed amongst the IM&T Management Team and if appropriate consulted with clinical and operational departments.
STANDARDS FOR DISCHARGE SUMMARY AND DISCHARGE LETTER

The Discharge Letter referred to in clause 18.9 of the NHS contract shall contain basic clinical information about the Service User’s treatment, including, without limitation:

(i) the Service User’s demographics to whom the Discharge Letter refers;
(ii) the dates of the Service User’s admission and discharge;
(iii) the name of the Service User’s responsible lead clinician, Care Co-ordinator and/or Key Worker at the time of the Service User’s discharge and to whom questions about the contents of the Discharge Letter may be addressed, and complete and accurate contact details (including a telephone number) for that person;
(iv) details of any medication prescribed at the time of discharge;
(v) any other relevant or necessary information or instructions, including follow-up arrangements and appointments; and the Service User’s status under the 1983 Act at the time of discharge.

Discharge Summary means a summary of information relevant to each Service User to be produced by the Provider, which shall be easily legible and shall, without limitation, contain:

(i) the Service User’s demographics;
(ii) the date of the Service User’s admission and discharge by the Provider;
(iii) details of any Services provided to the Service User, including any specific interventions eg psychological therapies, ECT, medication prescribed diagnostic or physical care needs met;
(iv) a summary of all confirmed and tentative diagnoses made during the Service User’s admission and ICD-10 code;
(v) details of any medication prescribed at the time of the Service User’s discharge and any adverse reactions or allergies to medications or treatments observed in the Service User during admission;
(vi) the name of the responsible clinician and/or Key Worker at the time of the Service User’s discharge and to whom questions about the contents of the Discharge Summary may be addressed, and complete and accurate contact details (including a telephone number) for that person;
(vii) any immediate post-discharge requirement from the primary healthcare team;
(viii) any planned follow-up arrangements or out-patient appointments;
(ix) whether the Service User has any relevant infection, including but not limited to MRSA;
(x) the Service User’s status under the 1983 Act at the time of admission, any changes to such status during the admission, and such status on discharge; and which shall, where required, be accompanied by a certification of sickness;
Proposed New Data Collections/Systems Registration

The Trust has reviewed its protocols for assisting clinicians and managers in setting up disparate computerised Personal Identifiable Data (PID) information systems. Whilst the Trust's strategy is always to keep PID information integral with its main systems, this may be too restrictive for short term audits, research projects and for work that cannot be covered by the main information systems.

If you are considering collecting and storing PID information, particularly on a computer, you will find the following questionnaire to be of assistance.

Please note that individual requests will need to meet the requirements of current legislation i.e. Data Protection Act and the Caldicott recommendations with respect to demonstrable benefits and reasonable justification for holding PID information.

The Six Caldicott Principles for Justifying Access to PID Information:

- Formal justification of purpose
- Information transferred only when absolutely necessary
- Only the minimum required
- Need to know access controls
- All to understand their responsibilities
- Comply with and understand the law.

All applications for new information systems/data collections must be accompanied by a completed questionnaire which must be submitted to the IG Manager for approval at TIGG (Trust Information Governance Group). In cases where a quick decision is required then the Caldicott Guardian can approve but this must then be ratified at the next TIGG meeting.

N.B. All staff must not process PID information on their personally owned equipment.

When staff leave the organisation, all PID information, in their possession, including backups and copies, must be returned to the Trust, anonymised or deleted. Exceptions can only be granted if one of the following conditions apply:

- Permission is given by the Caldicott Guardian
- Research Ethics Committee approval has been granted.
- Staff hold the data under their own Data Protection registration and take responsibility for its security.

If you have any queries regarding this registration document please contact the Information Governance Manager

Proposed New Data Collections/Systems Registration Questionnaire

Please complete the following questionnaire for each new collection of data within your department containing personal identifiable information held either on a computer/laptop or manually and return to: Information Governance Manager, Manchester Mental Health and Social care Trust, Chorlton House, 70 Manchester Road, Chorlton, Manchester, M21 9UN
<table>
<thead>
<tr>
<th>Department Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name</td>
<td>Job Title</td>
</tr>
</tbody>
</table>

1. **Title Record**

2. **Format e.g. paper**

3. **Datasets collected (tick all that apply)**
   - □ Name
   - □ Dob
   - □ Gender
   - □ Address
   - □ Racial/Ethnic origin
   - □ Religion
   - □ Physical or mental health or condition
   - □ Financial
   - □ Next of kin
   - □ GP
   - □ Health professional
   - □ Location
   - □ Case Note No:
   - □ NHS No:

4. **What is the purpose of collecting the data? E.g. statistical analysis, clinical information, research etc,**

5. **What are the benefits to service users/clinicians in collecting this data?**

6. **What are the risk of not collecting this data?**

7. **Who provides the information?**
   - Patient
   - Staff
   - Other (specify)

8. **Are checks in place to ensure the information is kept up to date?**

9. **If yes, how will this be achieved?**
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Is the information disclosed internally? If so,</td>
<td>Yes/No</td>
<td>8a. If yes, to whom is it disclosed?</td>
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<td></td>
<td></td>
<td>8b. Why is it disclosed?</td>
</tr>
<tr>
<td>11. Is the information disclosed external? If so, to whom and why?</td>
<td>Yes/No</td>
<td>9a. If yes, to whom is it disclosed?</td>
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<td></td>
<td>9b. Why is it disclosed?</td>
</tr>
<tr>
<td>12. If the information is to be held on computer, where on the computer will it be held? (tick one that applies)</td>
<td>Hard drive □ Network (specify) □</td>
<td>Other (specify) □</td>
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<tr>
<td>13. What are the security arrangements for holding the information? E.g. locked filing cabinets, keypad access areas etc.</td>
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<tr>
<td>14. Who has access to the information? List all staff groups that apply, e.g. admin staff, care workers, social services staff etc.</td>
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<td>......................................................</td>
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<tr>
<td>15. Who manages the information within the department?</td>
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<td>......................................................</td>
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<tr>
<td>16. Who is the Information Asset Owner (IAO)?</td>
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<tr>
<td>17. Has a retention period been identified for the data?</td>
<td>Yes/No</td>
<td>......................................................</td>
</tr>
<tr>
<td>18. If yes, how is this to be implemented?</td>
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<td>......................................................</td>
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<tr>
<td>19. Has a risk assessment been completed?</td>
<td>Yes: Please attach completed risk assessment</td>
<td>No: Please undertake a risk assessment. What are the risks if this data is not collected? ...................................................... What are the risks if the data is collected? ......................................................</td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>20. Can the data required be developed/collection from AMIGOS?</td>
<td>Yes</td>
<td>No: Please follow the AMIGOS change request procedure</td>
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<tr>
<td>21. Has a privacy impact assessment been undertaken and all issues have a plan for resolution? Please give details of issues and resolution.</td>
<td>Yes □</td>
<td>No □</td>
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<td>Please see the “Privacy Impact Assessment Policy” on the Intranet.</td>
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<td>22. Do you intend to use skills from within your department to develop and support a software application for managing this dataset?</td>
<td>Yes □</td>
<td>No □</td>
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<tr>
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<td>(If you answered No to question 20, please go to question 21, otherwise please go to question 22)</td>
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<tr>
<td>23. Have you identified funding from your own budget to commission an external supplier to develop the software application on your behalf?</td>
<td>Yes □</td>
<td>No □</td>
</tr>
<tr>
<td>24. Do you require assistance from the IM&amp;T Department to support the system or provide back-up?</td>
<td>Yes □</td>
<td>No □</td>
</tr>
<tr>
<td>25. If making your own back-ups on what media will you store them?</td>
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</tbody>
</table>
26. Please state the timescales for collection of the data.

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<tbody>
<tr>
<td>Start Date:</td>
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<tr>
<td>End Date:</td>
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</table>

**Approved by:**

TIGG or Caldicott Guardian: .................................................................

Date .................................................................
BUFF FOLDER PROCEDURE – North Manchester Locality

The following Trust services mainly record their documentation on the trust’s AMIGOS system. These are referred to as electronic records.

- Liaison
- Older Age Liaison
- Crisis Resolution Home Treatment (CRHT)
- SAFIRE

As not all Trust documentation is electronic, manual records still need to be issued to patients new to services. In these cases a coloured document wallet is issued, and this is recorded in the comment box of the case note section of AMIGOS. In some cases a different identifier (case note number) is issued. (See table below*):

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>NUMBER</th>
<th>FOLDER USED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liaison</td>
<td>NL000000*</td>
<td>Green document wallet</td>
</tr>
<tr>
<td>Older age Liaison</td>
<td>P0000000</td>
<td>Buff document wallet</td>
</tr>
<tr>
<td>CRHT</td>
<td>P0000000</td>
<td>Buff document wallet</td>
</tr>
<tr>
<td>SAFIRE (Ward Attender)</td>
<td>P1000000*</td>
<td>Blue document wallet</td>
</tr>
</tbody>
</table>

Where a patient has been allocated a P00 number and buff wallet folder and is referred to full services i.e., in or out patient a Trust case note folder will be issued, and the contents of the document wallet transferred into it.

Where a patient has been issued either a NL or P1 number and not a P00 number and has a document wallet, and is referred to full services i.e. in-patient or out patient a Trust case note folder will be issued, and the contents of the document wallet transferred into it. A P00 number will also be issued and the NL or P1 number will be withdrawn in the case note section of AMIGOS.
Appendix Q (Should this be R)

Audio / Visual Recording Procedure

<table>
<thead>
<tr>
<th>Title</th>
<th>Procedure for Audio/Visual Recording</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim</td>
<td>To provide instruction on the audio / visual recording of clinical sessions. To outline the process for identification, storage, retention and destruction of recorded material.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Developed by</th>
<th>Nicola Reid – Clinical Psychologist</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Updated by Deborah Forshaw Head of IG and Records</td>
</tr>
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<th>Manchester Mental Health and Social Care Trust</th>
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<td>Reference to</td>
<td>The British Psychological Society: Code of Ethics and Conduct, 2009</td>
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<td>Data Protection Act, 1998</td>
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<td>Department of Health: Confidentiality: NHS Code of Practice, 2003</td>
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<td>Department of Health: Good practice in consent implementation guide, 2001</td>
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<td>Department of Health: Records Management Code of Practice, Part 2, 2009</td>
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<td>Department of Health: Mental Capacity Act, 2005</td>
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<td>Health Professions Council: Standards of conduct, performance and ethics, 2008</td>
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| Application | For use by all staff |

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<th>Version Date Consultation</th>
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<td>Draft v1 20/10/10</td>
<td>Issued to Head of Psychology Services</td>
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<tr>
<td>(South) for review</td>
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<tr>
<td>Draft v2 11/11/10</td>
<td>Issued to Head of Psychology Services</td>
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Appendix 1 10
Consent form for audio/visual recording sessions
1. **Introduction**

The use of audio, video or digital recording within clinical sessions can often be beneficial to both care professional and client.

This procedure provides instruction to staff on the audio, video or digital recording of sessions for a variety of purposes.

This procedure outlines the requirements for obtaining consent, storing and destroying recorded material.

A consent form for use with this procedure is in Appendix 1.

2. **Definitions**

This procedure applies to all staff, to staff seconded into these services, to volunteers working for these services, students training within these services and agency staff.

For the purpose of this procedure, “clients” are defined as anyone receiving treatment/care from staff employed by Manchester Mental Health and Social Care Trust (MMHSCT), either as an inpatient or outpatient.

For the purpose of this procedure, “clinical sessions” are defined as a pre-arranged interaction between staff and clients and the term includes therapy sessions and interviews with clients for research projects.

All staff must safeguard the integrity, confidentiality and availability of patient identifiable (sensitive) information. This includes information recorded using audio, video or digital recording devices.

For the purpose of this procedure, recording devices are defined as:

- Audio tape recorders
- Video tape recorders
- Digital recorders

All recordings must be made using Trust equipment. Personal mobile phones or Blackberries with recording capabilities must not be used under any circumstances.

3. **Obtaining consent**

Consent relating to the audio or visual recording of clinical sessions involving any individual should be obtained in the same manner as obtaining consent for recording and use of any other material containing patient identifiable information:

- Consent must be “informed consent”, i.e. a clear and voluntary indication of preference or choice, given in writing and with any available options and consequences clearly explained. This should include information relating to why the recording is being made, any benefits to the therapy process, the purpose for which it will be used, who will see it / listen to it, how it will be stored and labelled and how long it will remain in existence.

- Recordings made as part of the health record cannot be removed from the record and can only be destroyed in line with the Department of Health (DOH) guidelines.

- The consent form should be signed by both the client and the clinician and any other individuals who may be included in the recording (e.g. an
The consent form should be dated to cover the duration of the clinical sessions.

- Completed consent forms must be filed within the health record folder and/or scanned onto AMIGOS.

- The services of an interpreter should be available for any non-English speaking clients.

- Where recordings are made for research purposes, and there is doubt about the client's capacity to give consent to being recorded, researchers must explain in their research proposals how they will comply with the requirements of the Mental Capacity Act 2005 Code of Practice. Researchers may include participants lacking capacity if these safeguards are in place. The general process for approving research (see below) must be followed. All decisions about capacity and best interests should be recorded in the clinical notes.

- Where recordings are made for educational purposes (e.g. as part of professional training) and it is proposed to use subjects whose capacity to consent is at issue, the same Mental Capacity Act considerations and safeguards will apply. Such proposals should be submitted to the Trust's Information Governance group for scrutiny and approval. The potential for misuse of such recordings should be carefully considered and appropriate safeguards put in place.

- Consent given for recording sessions for educational and research purposes can be withdrawn at any time. In these instances, the recording must be stopped and recordings destroyed.

- If recordings have been made for education, research or publication purposes, (including external training groups, seminars etc), a discussion should take place at the end of clinical sessions to confirm that the client still consents to the material being used for that purpose. The client must receive full information regarding the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain.

- Staff should ensure that clients are under no pressure to give their permission for the recording to be made.

Confidentiality

The DOH Guide ‘Confidentiality – NHS Code of Practice’ identifies audio, video or digital recordings of clients as "patient identifiable information".

The DOH guide to “Good practice in consent implementation” advises, “video recordings made for clinical purposes form part of a patient’s record”.

As such, the principles of confidentiality, which apply to all patient identifiable information, including electronic and manual health records, should also apply to audio, video and digital recordings.

Further information can be obtained from the following Trust policies and guidelines:
5.0 Practical Application

5.1 Recording
The recording should take place in a suitable environment to minimise stress to the client or participant concerned and account for issues of privacy and dignity. The recording process should be explained clearly to the client or participant and any questions or concerns addressed prior to beginning recording.

Recording should be stopped at any time if the client or participant becomes distressed or upset by the recording process. The member of staff can stop clinical sessions if they consider the client or participant is too upset to continue. Details should be recorded within the client’s patient record (where they exist).

5.2 Identification
Use of clear identification, such as that used for clinical health records apply if the recording forms part of the clinical health record.

The identification process used for labelling recorded material should be explained to the client or participant concerned. Recordings must be clearly labelled, e.g. using a client’s NHS number to maintain client confidentiality, and enable cross-referencing to paper clinical health records (where they exist) to allow for future archiving requirements. Recordings must be labelled with the date of the recording and the clinician’s initials.

5.3 Retention, Destruction and Storage
Audio, video and digital recordings should be securely stored in metal or inert plastic containers (e.g. within lockable filing cabinets or storage cupboards).

Trust provided portable devices used to temporarily store digital recordings must be encrypted.

Trust provided portable devices must not be used as a permanent or indefinite storage mechanism.

Digital recordings must be transferred, as soon as possible to a secure networked drive and removed without hesitation from any Trust provided portable device.

Where tapes or DVDs form part of the health record, a method for storing the tapes or DVDs (with the paper clinical health record where it exists) should be developed and recordings archived to off-site storage facilities, in line with local procedures. Should it be necessary to transport recordings of clinical therapy sessions (e.g. if students need to send tapes or DVDs to supervisors for assignments / marking purposes), this should be done in person where possible. This may also be done by secure encrypted electronic transfer eg from one nhs net account to another (The Trust email policy will provide additional guidance).
Digital recordings can only be transported if they are stored on an encrypted Trust storage device and password encrypted. The password should be sent separately. Recordings for non-clinical use must not be stored as part of the clinical health record and disposed of in a confidential manner within timescales agreed with the client. Please refer to section on “research purposes” for guidance on storage of recordings made as part of a research project.

The timescale for retaining recordings and the method of disposal and destruction must be explained to the client. The DOH Records Management Code of Practice (Part 2) outlines the timescales for which records must be kept and should be referred to. For example, in accordance with the DOH Records Management Code of Practice (Part 2), audio, video or digital recordings which are part of a mental health record, clinical psychology record or psychotherapy record must be kept for 20 years after the date of last contact. This timescale should be adopted for recordings which are deemed part of the clinical health record.

Recordings not deemed to be part of the health record should be destroyed in line with available Trust policy; staff who need to dispose of audio or video recordings should contact the Information Management & Technology Department on 0161 882 1081 for further guidance.

Further information can be obtained from the following Trust policies and guidelines:

- Portable Computing Policy
- Policy for Conducting Research and Development
- Information Security Policy
- Removable Media Policy
- Email Use Policy

6. **The Process**

Acceptable use of Audio or Visual recording may include the following:

- For the purpose of recording the process and progress of clinical sessions.
- As a record for the client.
- For the purpose of clinical supervision.
- For training purposes for professionally involved Trust staff.
- For use as part of a work assignment.
- For research purposes (where the research project has appropriate Trust and Ethical approval).

6.1 **For the purpose of clinical sessions**

- The rationale for recording the session (e.g. to record the process and progress of clinical sessions) should be discussed with the client.
- The recording forms part of the patient record if it has been made as part of the clinical process and should be retained for the same minimum retention period as other records kept.
- The clinician and client should read and sign a consent form agreeing timescales and responsibilities.
- Both parties should keep a copy of the consent form.
• The clinician should make notes of the process within the health record folder and store the consent form in an appropriate section of the folder.
• The client would be able to view/ listen to the tape and/or apply for a copy of the recording or a transcript of the recording under the Data Protection Act as a Subject Access Request. This would not apply to group therapy sessions.

6.2 As a record for the client

• The rationale for making the recording, e.g. for exposure work or to reflect on the session, should be discussed with the client. In these instances the tape still forms part of the patient record.
• Where the client wishes to record a session for other reasons, the clinician must give their written consent to be recorded.
• The clinician and client should read and sign a consent form agreeing timescales and responsibilities.
• Both parties should keep a copy of the consent form.
• The clinician should make notes of the process within the health record folder and store the consent form in an appropriate section of the folder.
• Any recorded material taken by the client will be responsibility of the client, i.e. storage and confidentiality of information, outside therapy sessions.

6.3 For the purpose of clinical supervision

• The rationale for making the recording, i.e. to be shared with another member of Trust staff and used for analysis and discussion relating to the individual clinician’s training and development or discussion of clinical issues.
• The clinician and client should read and sign a consent form agreeing timescales and responsibilities.
• Both parties should keep a copy of the consent form.
• The clinician should make notes of the process within the health record folder and store the consent form in an appropriate section of the folder.

6.4 For training purposes for professionally involved Trust staff

• The rationale for recording the session should be discussed with the client, (e.g. to be used during a teaching session provided by the clinician to another group of internal or external NHS staff). This might include Trainee Clinical Psychologists undertaking training, or a cohort of mixed-profession NHS staff undertaking a Diploma in Cognitive Therapy.
• The clinician and client should read and sign a consent form agreeing timescales and responsibilities.
• Both parties should keep a copy of the consent form.
• Identification and storage of tapes and disposal or destruction methods (e.g. returning tape to client or confidential destruction after an agreed time period) are the responsibility of the clinician.

6.5 For the use of a work assignment

• The rationale for the recording must be discussed with the client, e.g. when clinicians need to provide recorded sessions of clinical work as part of an evaluation for training for a professional qualification.

• The client should be provided with sufficient relevant details of the training being undertaken, including who would view / listen to the recordings and the environment in which recordings would be screened.

• The clinician and client should read and sign a consent form agreeing timescales and responsibilities.

• Both parties should keep a copy of the consent form.

• Identification and storage of tapes and disposal or destruction methods (e.g. returning tape to client or confidential destruction after an agreed time period) are the responsibility of the clinician.

• Where a recording is handed in for assessment and marking, the responsibility for the confidential handling and storage of tapes lies with administrative or clinical staff attached to the Course or department/service running the course, and in line with Trust procedures.

• Where a clinician employed by another Trust attends a training course run by MMHSCT, and brings with them client information from their employing Trust, the responsibility for the use, confidential storage and eventual destruction of any recording lies with the clinician, based on their employing Trust’s policies. MMHSCT should not retain a copy of the recording.

6.6 For research purposes

For the purpose of this procedure, it should be assumed that clients would be recognisable from the recorded material. Anyone proposing to make recordings as part of a research project should contact the Research & Development Office on 0161 276 3311 in the first instance for guidance on obtaining Trust Management approval of the research. Trust Management approval is dependant upon the project receiving a favourable ethical opinion. Where recordings are made as part of a Trust approved research project, the arrangements for retention, storage and destruction of recordings will be carried out as specified in the protocol which has received a favourable Research Ethics Committee (REC) opinion and Trust management approval. Where recordings are to be made as part of a research project, the protocol and REC application should specify the arrangements for:

• Recording process and environment
• The consent process
• Identification of recording media
• Retention periods, storage and security of recordings
• Method of transportation of recordings
• Destruction of recordings.

The above should also comply with current Trust policy. The research patient information sheet and consent form should clearly specify how the recordings will be used, including arrangements for “direct quotations”.

• A copy of the patient information sheet should be given to the participant.
• A copy of the signed consent form should be placed within the participant’s health record and a copy given to the participant to keep.
• Further information can be found within the ‘Research and Development Policy’ and by contacting the Research and Development Office on 0161 276 3311.

7. Consultation and review

This procedure was written after consultation with the Psychological Services Management Group and has been used as a local procedure for Psychological Services staff and was agreed by the Information Governance department. It has been reviewed and amended to become a procedure for all services. It will be further reviewed and updated as necessary in line with organisational, legislative or other changes and advice from appropriate professional bodies.

Updated November 2011
Appendix 1

Consent Form for Audio / Visual recording

Client Consent to Audio/Visual Recording

Name of client / participant / family member:

NHS Number:

DOB:

I agree to allow audio / visual recording* of therapy sessions between myself and ______________________(name of clinician)

on: ___ / ___ / ___ (single date of recording) or for on-going contact, recording

to commence on ___ / ___ / ___ until ___ / ___ / ___ or likely duration __________________

NB: these declarations do not apply to “group therapy sessions”.

Please complete as many of the following declarations as apply:

(1) Recording as part of the clinical health record:

I understand that once recorded, the recording will form part of my health record and will be identified/ stored and destroyed in line with Trust policy and current legislation. I understand that any recordings that are part of the health record, cannot be
removed. I can request a copy of recordings as per the guidance of the Data Protection Act 1998.

Signed: .................................. Date: ..........................................................

(2) Recording made for client’s own use or copies provided:

I understand that I will be responsible for the confidentiality and secure storage and disposal of the information contained within any recordings I receive from my clinician.

Signed: .................................. Date: ..........................................................

(3) Recording made for teaching or training purposes:

I understand that other NHS staff or identified named individuals undergoing or providing training may view the recording; the arrangements for secure and confidential identification, storage and ultimate destruction of the recordings have been explained to me. I understand that I can ask for a copy of the recording and I can withdraw consent at any time.

Signed: .................................. Date: ..........................................................

(4) Recording made for research purposes:

I understand that the recordings will be used for research purposes and have been informed of arrangements for the secure storage, confidential identification and ultimate destruction of the recordings. I understand that I can ask for a copy of the recording and I can withdraw consent at any time.
(5) **Recordings of clients unable to give consent**
A clear explanation of the reason for recording sessions has been given to me and I give consent for the recordings to be made. I understand the arrangements for the secure and confidential storage and identification of recordings, the timescale for retention and method of destruction of recordings.

Signed: ........................................ Name:........................................

Relationship to client:....................... Date:.................................

*If recording is research related, this will be covered in research proposal so the above should be taken out. If recording is for educational/training purposes the person should take a proposal to do this to the info governance group first—just completing this form would not suffice.*

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**Confirmation of Consent, to be completed by clinician:**

I have provided the client or their representative with a clear explanation of the reason for recording sessions. I have provided details of arrangements for the secure and confidential storage and identification of the recordings, the timescale for retention and the method of destruction. We have agreed and recorded timescales for destruction of recordings where this applies, as detailed below:

-----------------------------------------------------------------------------------------------------------------------------

Signed: ............................ Name:........................................Date:..............

Designation:..........................................................
Consent of Clinician to Participate in Recording Therapy Sessions for Client's Personal use

I agree to this session being recorded  Y/N

I agree a copy of the recording to be provided to the client for their personal use. Y/N

If a copy is not to be provided please state reason

...........................................................................................................................................................................

Signed: ............................. Name: ................................. Date: ..................

Designation:........................................................................................................