Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Order of Filing in Hospital Casenotes Policy

This procedural document supersedes: Policy for the Order of Filing in Hospital Casenotes - CORP/REC 1 v.4

This policy should be used in conjunction with:

- **CORP/REC 5 - Clinical Records Policy**
- **CORP/REC 6 – Record Keeping Standards**
- **PAT/EC 2 - Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy**

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Name and Title of Author/Reviewer	Judy Lane
Date Revised	March 2018
Approved by (Committee/Group)	Clinical Records Committee
Ratified by	Policy Approval and Compliance Group
Date Ratified	21 March 2018
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Next Review date	March 2021
Target audience:	Trust-wide

Amendment Form

Brief details of the changes made:

Version	Date Issued	Brief Summary of Changes	Author
Version 5	4 April 2018	• Totalcare PAS to CaMIS PAS • PAS Tracker system replaced with Radio Frequency Identification (RFID) system • Introduction of location based filing	Judy Lane
Version 4	23 February 2015	• Updated into new Trust format • 4.7 Supplementary Instructions for filing Outsourcing Casenotes • 6.2 Audit reduced to 10 sets per week • Appendix D - updated to a PDF link • Equality Impact Assessment Form added at Appendix E	Julie Robinson
Version 3	December 2011	Major changes throughout - **PLEASE READ IN FULL**.	Christine Coates
Version 2	September 2009	• Contents page added • Items numbered • Introduction - Standards requirements updated • Appendix D (added) - Supplementary Guidance for Filing DNAR Directives	Christine Coates
Version 1	December 2007	Reviewed without change	Clinical Records Committee

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1 INTRODUCTION

This document has been developed to unify the procedure for creating hospital patient casenotes and for the filing of patient care documentation within the casenotes.

The order of filing within hospital casenotes is concerned with the provision of good quality casenotes that are easily accessible and presented in a structured format. It is essential that the casenotes conform to the structure specified in the casenote folder.

There is a need for the casenotes to follow the correct format in order that the Trust can fulfil its requirements in respect of the following:

- Clinical Governance
- Information Governance Framework
- DoH Records management Code of Practice (Replacing HSC 1999/053 – For the Record)
- Information Governance Toolkit
- Controls Assurance standards
- Healthcare Commission
- Audit Commission

2 EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 5).

3 DUTIES AND RESPONSIBILITIES

Patients who are newly registered on the Patient Administration System (PAS) and are labelled with district numbered barcode labels.

Pre-existing casenotes must be relabelled and tagged with an RFID tag at the beginning of every new episode of care; multiple folders must be relabelled as separate volumes of the district number. Each volume of the district number must be barcode labelled and tagged with an RFID tag and then individually tracked to the current location of the casenote folder.

The procedure for the order of filing is printed on the clinical history divider in the casenote folder.

4 PROCEDURE FOR CREATING A NEW CASENOTE FOLDER

4.1 Casenote Colour Coding

Prior to 02 10 2017 when casenotes were filed in a terminal filing system, a range of colour coded folders was used when creating a new casenote folder.

A colour was designated to each section of the filing system, when making up a new folder the correct colour flashed folder was selected i.e. appropriate to the last two digits of the district number:

00 – 09 YELLOW
10 – 19 RED
20 – 29 BUFF
30 – 39 BROWN
40 – 49 BLUE
50 – 59 LIGHT GREEN
60 – 69 PURPLE
70 - 79 PINK
80 - 89 DARK GREEN
90 – 99 ORANGE
e.g. D112 34 56 must have a Light Green Flashed Folder

From the 03 10 2017 location based filing was introduced, this negates the need to follow the above instruction

4.2 The Revised Order of Filing - 2011

The casenote folder has two spines, the order of filing is based around the two spines:

Front Spine – File Sequence:

Front of Front Spine:

a) Patient identification sheet (uppermost)
b) Patient identification labels
c) Copied Alert Notifications (where there are multiple folders)
d) DNACPR (do not attempt cardiopulmonary resuscitation) documents, latest uppermost

Back of Front Spine:

a) Pathology results immediately behind the **Reports and Investigations Divider**
Order of Results:
1. Chemical Pathology (uppermost)

2. Full Blood Count
3. Anticoagulant
4. Microbiology
5. Medical Imaging
6. Histopathology

b) Investigations behind the Pathology Results

Order of Investigations:

1. ECG (uppermost)
2. Exercise Test
3. Echo
4. 24hr Tape
5. Tilt Table Test
6. Endoscopy
7. Audiology
8. Orthoptic

Back Spine - File Sequence

Front of Back Spine

a) Behind the **Clinical History Divider**

Insert specialty dividers to create sub-divisions, followed by name tagged consultant episodes.

File multiple consultant episodes together, the latest episode uppermost:

- History Sheets
- Assessments
- IPOCS (Integrated Pathways of Care)
- Treatment history

File each consultant episode in chronological (date) order.

Attach the consultants name tag to the first document, file documents relating to the same episode behind chronologically.

File anaesthetic documentation behind an anaesthetic specialty divider.

File subsequent episodes of care on top of the last episode; attach a consultant name tag to the first document at the beginning of each episode.

Follow the above order of filing for each subsequent episode

b) Behind the Correspondence Divider

The first letter must be consultant name tagged, this will be the bottom letter in the consultants correspondence section.

File the consultants ongoing correspondence together chronologically, the most recent correspondence in the consultants section filed on top.

Back of Back Spine:

a) Behind the **Observation and Monitoring Divider**
File the latest episode uppermost:
Observation and monitoring history, and prescriptions to be filed chronologically.

b) Behind the **Consent Divider**
File the latest consent uppermost

- All documents must have a district numbered identification label attached.
- All documents contained in the folder must be secure.
- Patient's documents must not be attached to the outside of the folder.
- Medical records departments will not file casenotes containing loose filing, the casenotes will be returned to the sender along with the loose documents.

4.3 Supplementary Instructions for Filing 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) Directives

Also refer to PAT/EC 2 – Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).

The policy stipulates that:-

- DNACPR decisions must be documented on the regional form and filed behind the yellow hazard warning sheet at the front of the medical record.
- In the new casenote folders the DNACPR form must be filed on the front of the front spine, behind the patient identification sheet and the patient identification labels.
- Whilst the patient is in hospital the DNACPR form must remain in the casenotes, behind the identification documents.
- The most recent DNACPR form must be filed on top.
- Cancelled DNACPR forms which are no longer valid, must remain filed in the casenotes, must be signed and dated by the clinician responsible for cancelling the form. They must mark the form with two thick, dark diagonal lines across, and write CANCELLED in large capitals.

- All DNACPR decisions and cancelled decisions must be recorded and maintained by the clinician responsible, on the ALERT page in the new casenote folders, or on the yellow hazard warning sheet in the old casenotes.

Also refer to:-

Appendix 1 - Procedure for filing DNACPR forms in former Bassetlaw Hospital specific casenote

Appendix 2 - Procedure for filing DNACPR forms in former Doncaster Royal Infirmary/ Montagu Hospital specific casenotes.

4.4 Supplementary Instructions for Filing Integrated Pathways of Care (IPOC's)

IPOC's are a means of developing integrated records. An IPOC provides a contemporaneous, multi-disciplinary record of care for a specific patient or client group – for example, Total Hip Replacement or Myocardial Infarction.

Entries are made by all the healthcare professionals involved in the delivery of care to the patient and replace all other documentation previously used for the particular patient group.

The Trust has identified the development of IPOC's as the means by which the electronic record will be facilitated in advance of a full electronic record, IPOC's are progressively replacing uni-disciplinary records.

- Where an episode contains more than one IPOC module within an episode these must be filed chronologically, for example a Pain Management patient who has an assessment followed by a course of acupuncture and then a joint injection.
- If continuation pages are required, insert between each IPOC module. Separate continuation sheets must be used at each point in order to maintain a contemporaneous record. Use IPOC continuation sheets (WPR 20272) and not standard clinical history sheets.
- Space left on a continuation page at the end of the entry must be crossed through to prevent subsequent entries being made out of sequence.
- Where possible continuation sections are provided within IPOCs to avoid the unnecessary use of additional sheets.
- IPOCs must always be filed intact, do not separate the pages of an IPOC in order to file them in different sections of the casenote folder. (Appendix 3)
- The only page that can legally be removed from an IPOC is the audit trail, which is the last page of the IPOC. Please remove this by cutting down the dotted line in the margin, do not tear from the tear from the back page, tearing this also separates the front cover with the patient ID label from the IPOC.

4.5 Procedure for the Order of Filing in Former Hospital Specific Casenotes

The procedure for the order of filing in former hospital specific casenotes are printed in the relevant casenote folders, also refer to:-

Appendix 1 - Procedure for the order of filing in former Bassetlaw Hospital specific casenotes
Appendix 2 - Procedure for the order of filing in former Doncaster Royal Infirmary/ Montagu Hospital specific casenotes.

4.6 Supplementary Instructions for Filing Copy Outsourcing Casenotes

Any episodes of care undertaken within an outsourcing facility, the Trust will receive copy casenotes which will be filed behind an outsourcing divider, within the specialty volume to which it relates.

5 EDUCATION AND TRAINING

Staff must be advised through local induction that following the agreed order of filing is a mandatory requirement.

Training for members of staff who handle casenotes is a mandatory requirement. Individual mangers are responsible for training their staff; training materials are available from the Health Records Manager.

6 MONITORING COMPLIANCE AND EFFECTIVENESS

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
The standard of completed of documents	Clinical Audit	Monthly	Audit and Effectiveness Forum
The quality of the order of filing in records	Medical Records	Weekly	Areas of concerns must be escalated to the medical records management who will address the issue with individual staff members

6.1 Clinical Audit

CORP/REC 6 – Record Keeping Standards identifies the core standards for good record keeping practice in this Trust. The core standards identified are used by clinical staff as a basis for continued documentation audit. Quarterly audit reports are submitted to the Department of CARE who formulate and submit the Trust quarterly report and action plans to the Clinical Records Committee.

2017 Casenote Review Audit - Data c

6.2 Casenote Structure, Filing and Tracking Audit

Each medical records department must monitor compliance with this policy by undertaking a weekly spot check of 10 casenotes using the audit form attached.

Each set of 10 forms must be submitted to the Health Records Manager for analysis. The department of clinical audit and effectiveness (CARE) will formulate weekly and quarterly reports for the clinical records committee to review and action. Audit and action reports will be submitted to the Patient Safety Review Group.

(See Appendix 4)

7 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- CORP/REC 5 - Clinical Records Policy
- CORP/REC 6 – Record Keeping Standards
- PAT/EC 2 - Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
- CORP/EMP 4 – Fair Treatment for All Policy
- CORP/EMP 27 – Equality Analysis Policy

8 REFERENCES

DoH and social care Records Management Code of Practice published July 2016 (Replacing HSC 1999/053 – For the Record)

Academy of Royal Colleges Medical Records Keeping Standards

APPENDIX 1 – PROCEDURE FOR THE ORDER OF FILING IN FORMER BASSETLAW HOSPITAL SPECIFIC CASENOTES

Each set of casenotes has within it, two spines, the front spine and the back spine. It is around these spines that the guidelines for the order of filing is built.

Specialty dividers must be inserted into the casenotes, to create sub-divisions for each of the specialties.

The Agreed Order of Filing:-

1. **FRONT OF FRONT SPINE**
   - Patient's identification sheet.
   - Patient's identification labels.
   - Alert notification divider
   - DNACPR Directives

2. **BACK OF FRONT SPINE – CLINICAL RECORDS**
   - **Specialty divider.**
   - History Sheet displaying a patient's identification label, with patient's full address, date of birth, hospital number and corresponding consultant name tag attached.
   - Multi-disciplinary record, Integrated Pathway of Care (IPOC) if appropriate.
   - All copy letters to be filed in date order, behind the latest History Sheet or IPOC.

3. **FRONT OF REAR SPINE**
   - Standard investigation dividers (formerly mount sheets).
   - Other recorded investigation results, e.g. ECG.

4. **BACK OF REAR SPINE**
   - Prescription & Administration Record.
   - Nursing History Sheets, in strict date order.
   - Reports from Allied Health Professionals departments e.g. Physiotherapy, Occupational Therapy, Dietetics etc.

5. **THE BACK POCKET WAS REMOVED FROM USE WITH EFFECT FROM 1ST OCTOBER 1999**.

Bassetlaw Hospital casenotes are provided with colour coded flashes. The colour coding must be adhered to, see the system of colour coding Bassetlaw Hospital Casenotes below.

Bassetlaw Hospital – Casenote Colour Coding System

00 – 09	Green
10 – 19	Orange
20 – 29	Dark Blue
30 – 39	Beige
40 – 49	Purple
50 – 59	Light Blue
60 – 69	Pink
70 – 79	Yellow
80 – 89	Brown
90 – 99	Red

Patient record folders are flashed with the above colours. The appropriate coloured coded folder must be used. e.g. Bassetlaw number 364092 will have a red flashed folder.

Instructions for the use of the Alert Notification Divider in Bassetlaw Hospital Casenotes

The alert Notification divider within the general clinical record is medico-legally important.

All drug allergies and sensitivities, and all previous reactions and incidents must be recorded.

Negative results and patient reports of 'no known allergies' must also be recorded.

The alert notification divider must be completed on the patients first attendance at the hospital, then reviewed on each subsequent attendance and added to where appropriate.

All health professionals involved in the patients care are responsible for recording alert notifications. It is acceptable for alert notification stickers currently in use within the hospital to be attached, if appropriate.

- The patient's name and number must be clearly identified.
- All entries must be timed, dated and signed stating designation.
- The medical records library staff are responsible for the transfer of the divider to the current volume, when creating a new volume within the library.
- A photocopy of the divider must be taken and filed into all earlier volumes.
- Where a new volume of the patient's record is created outside the library, the person creating the volume is responsible for photocopying and transferring the divider.

- Ward clerks are responsible for ensuring the safe storage of the document if it is removed from the general medical record, and transferred to the current ward record. Also for the return of the alert notification divider to the general record on completion of treatment or discharge from the ward.

- An alert notification sticker must be attached to the patient's identification sheet inside the casenotes whenever the alert notification divider is transferred to the ward record or removed for the purpose of creating a new volume.

Filing of the Alert Notification Divider in Bassetlaw Hospital Casenotes

The alert notification divider must be filed behind the patient identification sheet on the front of the front spine.

APPENDIX 2 – PROCEDURE FOR THE ORDER OF FILING IN FORMER DONCASTER ROYAL INFIRMARY/MONTAGU HOSPITAL SPECIFIC CASENOTES

1. DRI/Montagu General Casenotes – Structure (with Gold Dividers)

HMR1- Patient Identification Card (with / without DNR status)
* DNACPR documents
HMR1 (IP) - Cumulative Admission sheet

* Cancelled DNACPR directive forms must be filed in the main body of the casenotes. The Yellow Hazard warning sheet will have been amended by the senior doctor concerned.

* When the patient is discharged the DNACPR directive form should be filed in the main body of the casenotes. The yellow hazard warning sheet should have been amended.

Clinical Section – filed in chronological order within consultant's section

Consultants' individual problem lists
Copies of Accident & Emergency cards if patient is admitted via A&E
HMR 4 documents – filed in chronological order / IPOCs
HMR 5 operation notes
HMR 6 consent forms – *unless these have anaesthetic notes on the back, in which case they should be filed in the Anaesthetic section.*
Waiting list slip
HMR 8 Social Worker report
HMR 120 Endoscopy sheet

Documents such as Audiology reports, Visual fields, Centile charts HMR F investigation list, medical photographs and Vascular lab reports should also be filed in this section.

Correspondence – most recent on top within consultant's section

All incoming and outgoing letters, including outpatient and inpatient referral letters and discharge summaries, filed in chronological order, most recent on top. Letters relating to each consultant should be filed together, identified by name tag. When starting a new consultant section, if the first letter is A5, insert a plain A4 sheet with the name tag on.

Investigations – most recent on top within consultant's section
(may either be A4 printed reports or smaller print-outs attached to colour-matched mount sheets)

Clinical Chemistry print outs
Haematology – behind red card WPR 5571
Blood Bank – behind purple card WPR 5581
Coagulation – behind pink card WPR 5591
Microbiology – behind dark blue card WPR 5601
Medical Imaging – behind light blue card WPR 5630
Histology – behind grey card WPR 5611

Other investigations, filed chronologically in HMR number order:

HMR 100	Peak Flow
HMR 106	ECG
HMR 110	Echocardiograms
Stress Test	
Vascular	

Anaesthetics – filed chronologically, by episode

Any Consent to Operation forms with anaesthetic details on the back.
HMR 5b Post-anaesthetic recovery
HMR 6 Daycase record form

Allied Health Professionals – filed chronologically (Formerly Paramedical)

Physiotherapy
Speech Therapy
Dietitian
Occupational Therapy

Nursing – HMR 7 documents, filed chronologically, by episode

Nursing assessment form
Waterlow
Nutrition Risk
Patient Handling
Patient Transfer
Care Plans: evaluation, ward round, daily plans etc
Discharge Action Plan

Observation charts: (in HMR order)	HMR 122	Fluid prescription and administration
	HMR 123	Blood transfusion
	HMR 127	Diabetic chart
	HMR 200	TPR chart (must all be kept)
	HMR 210	Fluid balance summary (if summarised, daily sheets can be destroyed)
	HMR 211	Urine, weight and height

Other non-numbered documents.

Drug charts, filed together, in chronological order:

HMR 111 Drug prescription and administration records

Labels
Should be attached to the inside of the back cover of the casenotes. The treatment number on the labels should always match the treatment number on the cover of the casenotes – it is important that no other labels are kept in the folder.

All documents must be securely filed in the folder. No casenotes should be returned to file with loose or paperclipped documents.

2. DRI/Montagu Hospital General Casenotes – Old Structure (without Gold Dividers)

CLINICAL – ALL BEHIND EXISTING

1. HMR 1 Patient Identification Card (with / without DNR status)
2. HMR1 (IP) Cumulative Admission sheet
3. HMR 2 Interim discharge notification (yellow copy) GP letter
4. Yellow ambulance form
5. Handwritten GP referral letter (non-elective admissions) / copy of A/E card
6. DNR document (if applicable)
7. HMR 4 clinical notes with consultant's sticker / IPOCs
8. Other GP referral letters and correspondence
9. HMR 5 Operation record
10. HMR 5b Post anaesthetic recovery
11. HMR 6 consent forms
12. HMR 120 Endoscopy forms
13. HMR 9 Dietitians

INVESTIGATIONS – ALL IN FRONT OF EXISTING, IN DATE ORDER

15. Clinical chemistry
16. Haematology
17. Blood Bank
18. Coagulation
19. Microbiology / Virology
20. Medical Imaging
21. Histology
22. HMR 100 Peak flow
23. Vito

24. HMR 110 Echocardiograms
25. Stress test
26. Vascular Lab
27. Drug chart
28. Heparin chart
29. HMR 116 Occupational Therapy
30. HMR 122 Parenteral fluid
31. HMR 123 Blood Transfusion record
32. HMR 124 Bronchoscopy report
33. HMR 126 Head injury observation chart
34. HMR 127 Diabetic chart
35. HMR 200 TPR chart
36. HMR 210 24hour fluid balance summary
37. Record of intravenous fluid therapy
38. HMR 211 Urine, weight and height chart
39. BM chart
40. Stool chart
41. Syringe driver chart
42. Social workers
43. HMR 7 Endoscopy

NURSING – ALL TOGETHER AFTER EXISTING

44. Nursing assessment forms
45. Waterlow
46. Nutritional risk
47. Patient handling
48. Transfer
49. Care Plan
50. Discharge Action Plan
51. Drug charts

Each consultant has his or her own section in the casenotes.
If the patient has already been admitted under the same consultant, file behind that section.
New consultant sections should be set up after existing sections.

Labels
Should be attached to the inside of the back cover of the casenotes. The treatment number on the labels should always match the treatment number on the cover of the casenotes – it is important that no other labels are kept in the folder.

All documents must be securely filed in the folder. Casenotes must not be returned to file with loose or paperclipped documents.

APPENDIX 3 – PROCEDURE FOR FILING IPOCs IN FORMER HOSPITAL SPECIFIC CASENOTES

Filing Sequence:

1. DRI / Montagu casenotes – new structure (with Gold Dividers)

- IPOCs with HMR4 filing reference numbers – contemporaneously within the Clinical section, filed by individual consultant and identified by the relevant name tag
- IPOCs with HMR5 filing reference numbers – contemporaneously within the Anaesthetics section of the notes

2. DRI / Montagu casenotes – old structure (without Gold Dividers)

- IPOCs with HMR4 filing reference numbers – filed by individual consultant and identified by the relevant name tag in chronological order
- IPOCs with HMR5 filing reference numbers – filed within the relevant consultant's section in HMR number and chronological order

3. Bassetlaw casenotes

- IPOCs with HMR4 filing reference numbers – contemporaneously on the back of the front spine under the relevant specialty divider, filed by individual consultant and identified by the relevant name tag.

- IPOCs with HMR5 filing reference numbers – contemporaneously on the back of the front spine under the Anaesthetic specialty divider.

IPOCs should always be filed intact. It is not permissible to separate the pages of an IPOC in order to file them in different sections of the casenote folder. The only page that can legally be removed from an IPOC is the Audit Trail, which is the last page of the IPOC. Please ensure that this is removed by cutting down the dotted line in the margin and not by tearing the back page (as this also separates the front cover with the patient ID label).

APPENDIX 4 – CASENOTE STRUCTURE, FILING AND TRACKING AUDIT FORM

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Clinic Preparation Audit Form

Date	Patient Number	F/Sheet & Labels	Section	Recon Slip	Relevant Volume	Tagged/ Tracked	Specialty	Temp	Comments
01/01/1900	D1234567	✓	✓	✓	✓	Example ✓	✓	X	

APPENDIX 5 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Order of Filing in Hospital Casenotes	Performance	Judy Lane	Existing policy	09.03.2018

1) Who is responsible for this policy? Performance

2) Describe the purpose of the service / function / policy / project/ strategy To provide guidance on filing in hospital casenotes

3) Are there any associated objectives? National casenote standards –Records Code of Practice

4) What factors contribute or detract from achieving intended outcomes? Non-compliance

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact**

6) Is there any scope for new measures which would promote equality No

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 √	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: March 2021

Checked by: Emma Challans **Date: 09.03.2018**