Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Please Note: This policy is currently under review and is still fit for purpose.

Clinical Records Policy

This procedural document supersedes: Clinical Records Policy – CORP/REC 5.v.4

Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Executive Sponsor(s):	David Purdue – Director of Nursing, Midwifery and Allied Health Professionals
Name and Title of Author/Reviewer	Judy Lane, Patient Services Manager,
Date revised	September 2019
Approved by (Committee/Group)	Clinical Records Committee – September 2019 Policy Approval and Compliance Group
Date Approved	12 November 2019
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Next Review Date	September 2022
Target audience:	Trust-wide

Amendment Form

Brief details of the changes made:

Version	Date	Brief Summary of Changes	Author
Version 5	20 Dec 2019	• Updated from CaMIS casenote tracking module to iFIT • Documentation Officer changed to IPOC coordinator • PAS changed to CaMIS throughout	Judy Lane
Version 4	11 April 2017	• Changes made throughout to reflect the changeover from total care PAS to CaMIS PAS. • Updated to Medical Records Manager/Patient Services Manager throughout. • Format updated. • Changed appendices from A, B, C to 1, 2, 3.	Judy Lane, Charles Harrison, Julie Robinson
Version 3	March 2012	**Major changes made – PLEASE READ IN FULL** • Standards for records keeping in full have been removed – Now separate policy CORP/REC 6 - Policy for Record Keeping Standards • Clarification of roles and responsibilities of all casenote users, handlers and line managers added. • Responsibility for training identified • Reference to single treatment number and single casenote folder added. Health Records Department local procedural documents added. • Web page – link to documents added. • Reference to other procedural documents within the Trust updated. • Clarification on use of 'Return To' labels on casenotes. • Duplicate PAS registration and duplicate casenote merge procedure added. • Reference to revised order of filing • Reference to non site specific casenotes and single virtual casenote library. • Monitoring compliance and effectiveness processes clarified. • Other more minor changes.	Christine Coates Julie Robinson Tracy Evans-Philips
Version 2	July 2009	• New Introduction - Former introduction incorporated into Policy Statement • Definitions – Additions and amendments • Legal Obligations and Good Practice – Additions and amendments • Roles and Responsibilities – Updated and amended • Training – Availability and responsibility updated • Clinical Audit – Now separate policy CORP/COMM 15 - Clinical Audit Procedure for NHS-LA and CNST Casenote Audit • The Casenotes - Minor updates throughout section • CORP/REC 5.v.2 - Cross referenced throughout to other relevant Trust Policies • Bassetlaw Hospital Baby notes – see page 17 for clarification • Appendices re-numbered	Christine Coates

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1. KEY PRINCIPLES OF THE POLICY

1.1 Introduction

Medical Records are an integral part of effective patient care, their principal purpose is to record and communicate information about patients and their care. They are also used as a source of data for hospital service activity reporting, supporting contracting and commissioning, monitoring the performance of hospitals and for audit and research.

Generic record keeping standards contribute to maximising patient safety and providing quality care, supports professional best practice and assists compliance with Information Governance.

The Healthcare Commission inspections and (NHS Resolutions), NHS Litigation Authority Risk Management Standards which superseded and combined the Clinical Negligence Scheme for Trusts (CNST) standards include requirements for medical records keeping and for structure and content. The Royal College of Physicians Approved 'Generic Medical Record Keeping Standards' define good practice for medical records and address the broad requirements that apply to all clinical note keeping.

Medical Records Management is the process by which the organisation manages medical records generated in any format or media type, all the way through their lifecycle to their eventual disposal. The Records Management Code of Practice published by the Department of Health is the guide to the required standard of practice for the management of medical records, based on current legal requirements and professional best practice.

This document sets out a framework within which staff responsible for managing the Trust's medical records develop specific policy and procedural documents to ensure they are managed and controlled effectively, commensurate with legal, operational and informational needs to ensure that they support consistency, continuity and efficiency, protect the rights of patients and staff and protect the interests of the Trust.

2. POLICY STATEMENT

This policy in conjunction with other associated Trust procedural documents, aims to direct and control the creation and volume control, the distribution, filing, retention, storage and disposal of medical records, whilst serving the operational needs of the Trust. To ensure the awareness of all health care professionals and staff involved in the handling of paper and electronic records of their responsibilities.

2.1 Medical records must be managed according to current legislation, standards and the Trust's Information Records Management – Code of Practice **CORP/ICT 14.**

2.2 Medical Records must be appropriately managed to support the day to day activities of the Trust, including patient care, continuity of care, fulfilment of legal requirements to supporting decision making, and to assist clinical and other audits.

2.3 Misuse of medical records or breaches of this policy are reportable to the Information Governance Manager, which may result in disciplinary action.

2.4 Medical records users have a responsibility for maintaining good record-keeping practice. Staff must be aware of, and comply with the requirements of the Policy for Record Keeping Standards **CORP/REC 6**, and **CORP/COMM 17**.

2.5 The Medical Records Departments manage the Legal Retention and Destruction of Hospital Patient Medical Records **CORP/REC 8,** and maintain the integrity, confidentiality, security and availability of the records.

2.6 The Medical Records Department's aim to ensure that patients complete and comprehensive medical records are available at the point of consultation.

2.7 Service delivery is monitored for outpatient and inpatient activity to ensure targets and standards are maintained.

2.8 The Clinical Records Committee is responsible for approving the format and content of the health record (Terms of Reference – Appendix 1).

2.9 Alterations updates, and/or replacement of clinical documents must be approved by the Committee, before typesetting, piloting or implementing. (Process for obtaining new/revised casenote documentation – Appendix 2/3).

3. DEFINITIONS

3.1 Casenote Folder

A Trust folder holding a health record.

3.2 Health Record

A health record is anything containing information (in any media) which has been created or gathered as a result of any work of NHS employees. It must be a reliable reconstruction of activities or events that have taken place, so that the content can be interpreted; who created or added to the record, during which process, and how the record relates to other records.

3.3 Record-keeping

The process of recording information in any form, on treatment, conversations etc. as a record of evidence that the action has taken place. The recording of accurate timely and complete information by the clinician of patient activity is essential for clinical coding and the recovery of income from commissioners.

3.4 Contemporaneous

A record made at the same time as the event you are recording.

3.5 Integrated Pathway of Care

An explicitly agreed route through health and social care services, the structure content and standard of recording based on professional consensus that reflect best practice. A record of agreement between the multidisciplinary professionals involved in the care, typically covering the type of care and treatment, involvement, level of skills and location of the care.

3.6 Clinical Audit

"Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes"

New Principles of Best Practice in Clinical Audit
HQIP January 2011

3.7 Multidisciplinary

Multidisciplinary refers to professionals from multiple disciplines working together e.g. social work, nursing, physiotherapy.

4. LEGAL OBLIGATIONS AND GOOD PRACTICE

4.1 Public Records Act 1958

Under the terms of the Public Records Act 1958 sections (1) – (3) all NHS records are public records. The Secretary of State for Health and all NHS bodies have a statutory duty to make arrangements for the safekeeping and eventual disposal of their records.

The Chief Executive, Directors and Senior Managers are personally accountable for the quality of records management within the Trust.

Line managers are required to ensure that their staff, whether clinical or administrative are adequately trained and apply the appropriate guidelines to maintain the integrity of information through security and control of unauthorised access and disclosure.

4.2 Confidentiality Code of Practice

The NHS and all persons working within the NHS have a common law duty of confidence to patients. The duty of confidence extends after the patient's death or an employee has left the Trust. See Policy for Confidentiality - Code of Conduct - **CORP/ICT 10.**

4.3 Data Protection

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2016.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/uk-data-protection-legislation-eu-general-data-protection-regulation-gdpr/

4.4. Access to Health Records Act 1990

Governs access to the Medical records of a deceased person.

4.5 Freedom of Information Act 2000

Gives extended rights of access in certain circumstances, to information which is not held on a computer or in a relevant filing system.

4.6 Access to Medical Reports Act 1988

An employer or insurance company cannot seek a medical report on an individual for employment or insurance purposes from the doctor responsible without the individual's knowledge and consent.

4.7 Access to Personal Files Act 1988

Gives individuals the right of access to records not held on computer held by local authorities and local social services.

4.8 Department of Health Records Management Code of Practice (Updated 2009)

A guide to the required standards of practice in the management of records for those who work within or under contract to the NHS organisations in England. It is based on current legal best practice.

5. ROLES AND RESPONSIBILITIES

5.1 Caldicott Guardian/ Senior Risk Information Officer

The Caldicott Guardian / SIRO has overall responsibility to the Trust Board of Directors for reflecting patient's interests regarding the use of patient identifiable information.

5.2 Clinical Records Committee (CRC)

The CRC is an expert strategic group, who work objectively without individual interests, to oversee good quality clinical records – See Appendix 1 for Terms of Reference.

5.3 Medical Records Manager/Patient Services Manager

The Medical Records Manager/Patient Services Manager is responsible**:**

- to the Clinical Records Committee for ensuring that medical records management systems and processes are developed, co-ordinated and monitored.
- for presenting medical records policies and procedures for approval, and raising awareness of medical records issues currently affecting the Trust at both local and national level.
- for monitoring compliance against standards for medical records management, implementing changes and driving forward new initiatives, developments and plans for improvement that are approved by the Clinical Records Committee.
- providing an administrative/secretarial service to the Clinical Records Committee.

5.4 IPOC Coordinator

The IPOC Coordinator's role is to facilitate and co-ordinate the development of multi-disciplinary, integrated documentation and other clinical documentation to ensure uniformity with the ultimate aim of ensuring all clinical documentation is digitised, completed and stored electronically. This work is done in co-operation with the Clinical Records Committee**.**

5.5 Line Managers, Users and Handlers of Patient Medical Records

Under the duty of care all line managers and users and handlers of patient medical records have a responsibility for ensuring compliance with this policy and the related policies outlined in this document.

6. TRAINING

Staff must be advised through local induction that training for members of staff who handle casenotes is mandatory. Individual managers are responsible for training their staff; training materials are available from the Medical Records Manager/Patient Services Manager. Training is in line with the SET learning needs analysis

7. THE CASENOTES

7.1 Casenote Structure

Properly structured and well maintained records will:

- Ensure that records are bound and stored so that loss of documents is minimised.
- Ensure that every piece of paper is secured within the casenote folder
- ensure that every document bears the patient's name, date of birth, identification number and NHS number.
- Ensure alerts and sensitivities are recorded on the Alert/Hazard Notification within the casenotes. All entries must be dated.
- Records must demonstrate the chronology of events and all significant consultations, conversations, assessments, observations, decisions, interventions and outcomes contemporaneously.

7.2 Integrated records/Integrated Pathway of Care (IPOCs)

7.2.1 The Audit Commission (1995) found patients were suffering as a result of poor communication between professionals, even within the same area of practice and/or ward/base. Records were frequently treated as the personal property of a practitioner instead of as a care team asset to promote quality care. As a response to this, the Trust is committed to promoting integrated patient records to support safe and effective care.

7.2.2 The main aim of an IPOC is to improve the quality of patient care by decreasing variation in practice and increasing communication between practitioners. This is achieved by utilising a single record of care alongside multidisciplinary, contemporaneous record keeping. All IPOCs developed within the Trust are based on guidelines, evidence and best-practice. IPOCs provide a continuous cycle of evaluation and improvement in clinical practice and can demonstrate the inclusion of clinical effectiveness and clinical governance into routine patient care.

7.2.3 Where possible, practitioners should use or develop records that other professionals and the patient / carer / relatives are able to use to promote continuous effective care for the patient i.e. IPOCs. The agreed shared record / IPOC should be used by all practitioners during any interventions.

7.3 Casenote Identification

The District Number
All patients registered on the CaMIS Patient Administration System have a unique District number, the District number appears on all patient identification labels and on the patient identification sheet inside the casenotes. This is the single treatment number which is used within the Trust

Maternity casenote folders are specialty specific

Multiple folders must be relabelled as separate volumes of the District number e.g. D123456.v2

Local Procedural Documents are held within Medical Records

Babies are registered on CaMIS with a District number at birth. If they are recorded on CaMIS as a 'Well Baby', a casenote folder is not created unless the child is either admitted or attends as an Outpatient. The baby notes are filed within the mother maternity casenotes. Baby notes can be identified from the patient tracking location history on iFIT

7.4 Requesting, Locating and Tracking Patient Records

For full guidance please refer to the Policy for Requesting, Locating and Tracking Patients Records - **CORP/REC 4.**

7.5 Casenote Folders and Care of Casenotes

Replacing damaged casenote folders is the responsibility of all wards and departments
To replace a Trust casenote folder, refer to the Policy for the Order of Filing in Hospital Casenotes **CORP/REC 1.**

Do not write confidential information on the front cover of casenote folders.

Wards, departments and medical secretaries are responsible for filing their own documents. Do not return casenotes to the medical records libraries containing loose filing.

'Alert Notifications' must be recorded on the Alert / Hazard Notification in the front of the casenotes, the information must be recorded in all volumes referring the user back to the original alert / hazard. See **CORP/REC 1** Order of Filing in Hospital Casenotes Policy

Do not use staples on casenote folders.

Stocks of casenote folders and casenote dividers are available on request from Medical Records Department's. All casenote folders must have a current 'Year Sticker' and a District numbered patient ID barcode label. The folder must contain appropriate specialty dividers, a CaMIS patient ID sheet and patient ID labels and RFID labelling and association

In existing casenotes any change to a patient's demographic details must be updated on CaMIS , the ID labels and ID sheet must be replaced in the casenotes. The old versions must be destroyed as confidential waste. All users share the responsibility for updating demographics on CaMIS .

Individual history sections must not be removed from a casenote folder unless for the purpose of splitting thick folders to create a further volume.

Casenotes must not be removed from, or be kept outside of the hospital premises i.e. car boot, home, hospital residences. See Policy for Safeguarding Patient Records Held Separately from Medical Records Libraries and in Transit **CORP/REC 2.**

All documentation must be securely filed within the correct section of the folder and be kept tidy; broken plastic fasteners must be replaced before casenotes are returned to file. See Policy for the Order of Filing in Hospital Casenotes Policy **CORP/REC 1.** Supplies are available from all medical records departments.

The medical records departments must be notified of a patient death at the earliest opportunity, to enable CaMIS to be updated. This will automatically cancel future appointments, admissions and transport arrangements. Write the date of death clearly on the front of the folder.

7.6 Duplicate patient registrations and Duplicate Casenotes

Duplicate patient registrations on CaMIS must be notified to a medical records department for the patient details to be merged and for any resulting duplicate casenotes to be merged. See the procedure for merging duplicate Registrations and Duplicate Casenotes Appendix 4.

7.7 Order of filing

The order of filing is printed in the casenotes, please also refer to the Policy for the Order of Filing in Hospital Casenotes Policy **CORP/REC 1.**

8. CASENOTE LIBRARIES

The aim is to create a single virtual library across all hospital sites. Patients' casenotes will be filed at the current or most recent site attended.

All libraries are archived and culled, with the implementation of iFIT there is a mixture of terminal digit and location based filing.

Casenotes are stored in the following areas:

- Bassetlaw - Main Library
- Bassetlaw - New Library – Post Grad
- Bassetlaw - Post Grad
- Doncaster Royal Infirmary – General Records 1

- Doncaster Royal Infirmary – General Records 2
- Doncaster Royal Infirmary – Fracture Records plus annexe
- Doncaster Royal Infirmary – Maternity Records 2 separate rooms
- Doncaster Royal Infirmary – Old Laundry
- Montagu – General Records plus archive area

Deceased and archived maternity patients' casenotes are stored in an offsite facility, these can be retrieved if necessary with notice please contact Medical Records.

Access to the Medical Records Departments and Casenote Libraries is restricted to authorised staff. Access to the security door codes will be disclosed by medical records department supervisors to designated staff groups only. Door security codes which must be signed for and must not be publicly displayed or disclosed to colleagues. The Trust is working towards closed libraries in all areas.

9. CASENOTE LOCATION AND RETRIEVAL

- Patient records should not be removed from Trust hospital premises, see **CORP/REC 2**. In exceptional situations where casenotes transfer with a patient, they must at all times, in all circumstances be tracked to their current location on iFIT.
- For guidance refer to the Policy for Requesting, Locating and Tracking Patients Records Policy **CORP/REC 4** and policy for Safeguarding Patient Records Held Separately from Medical Records Libraries, and in Transit **CORP/REC 2.**
- Authorised Trust transport is the secure method of transporting patient records. Casenotes must be secured and sealed within an envelope, or in sealed tote box, and clearly named and marked with the destination address.
- Casenotes must be returned to the appropriate Medical Records Library as soon as they are no longer required.

10. RETENTION AND DESTRUCTION

The Trust has adopted the NHS Code of Practice disposal schedule. For guidance refer to **CORP/ICT 14** – Information Records Management – Code of Practice. See also **CORP/REC 8** – Legal Retention and Destruction of Hospital Patient Medical Records.

11. CONFIDENTIALITY AND DISCLOSURE

For full guidance refer to **CORP/ICT 10** - Confidentiality - Code of Conduct **CORP/ICT 7** Data Protection Policy.

In the event of uncertainty contact a Medical Records Manager/Patient Services Manager or the Information Governance Manager for advice.

12. MONITORING COMPLIANCE AND EFFECTIVENESS

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Quality of casenote preparation Quality of casenote condition	Patient Services Manager, Assistant Medical Records Managers and Medical Records Supervisors	Weekly	Update provided to CRC monthly Feedback given to staff re quality Exceptions are reported through Datix

12.1 Standards for Record-Keeping and Clinical Audit

CORP/REC 6 - Record Keeping Standards and clinical audit aims to ensure that all staff within Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust understand their individual responsibility for standards of records keeping practice. The process for ensuring that Record Keeping Standards are maintained, is outlined in this policy.

12.2 Casenote Structure, Filing and Tracking

CORP/REC 1 - Order of Filing in Hospital Casenote Policy and **CORP/REC 4 -** Requesting, Locating and Tracking Patients Records, requires that casenotes will be audited for compliance with these policies.

12.3 Key Performance Indicators

12.3.1 Medical Records Departments report on the following identified KPI's

- Duplicate Registrations identified and managed
- Total number of temporary sets of casenotes in circulation
- Casenotes prepared correctly for outpatient clinics weekly
- Emergency Casenotes retrieved in a specified time period
- Accuracy of Filing in libraries using shelf audits and invalid track logs.

13. 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 7).

14. OTHER ASSOCIATED DOCUMENTS

CORP/REC 1 - Order of Filing in Hospital Casenotes Policy
CORP/REC 2 - Safeguarding Patient Records held Separately from Medical Records Libraries and in Transit Policy
CORP/REC 3 – Processing Requests for Access to Health Records Procedure
CORP/REC 4 - Requesting, Locating and Tracking Patient Records Policy
CORP/REC 6 - Record Keeping Standards
CORP/REC 8 - Legal Retention and Destruction of Hospital Patient Medical Records
CORP/ICT 7 - Data Protection Policy
CORP/ICT 10 – Confidentiality - Code of Conduct
CORP/ICT 14 – Information Records Management – Code of Practice
CORP/COMM – 17 – Recording of Research Information in Patient Casenotes
CORP/EMP 4 – Fair Treatment for All Policy
CORP/EMP 27 – Equality Analysis Policy.

15. REFERENCES

- Academy of Medical Royal Colleges, A Clinicians Guide to Records Keeping Standards 2008.
- Generic Record Keeping Standards, Royal College of Physicians, 2008
- NHS-Litigation Authority Risk Management Standards for Acute Trusts, NHSLA, Apr 2007
- Records Management Code of Practice 2009
- The Audit Commission, 2008 PbR data Assurance Framework 2008
- Public Records Act 1958
- Data Protection Act 1998 and GDPR 2018
- Access to Health Records Act 1990
- Freedom of Information Act 2000
- Access to Medical Reports Act 1988
- Access to Personal Files Act 1988
- Dept. of Health Records Management (2009)
- The Audit Commission 1995

APPENDIX 1 – CLINCIAL RECORDS COMMITTEE – TERMS OF REFERENCE

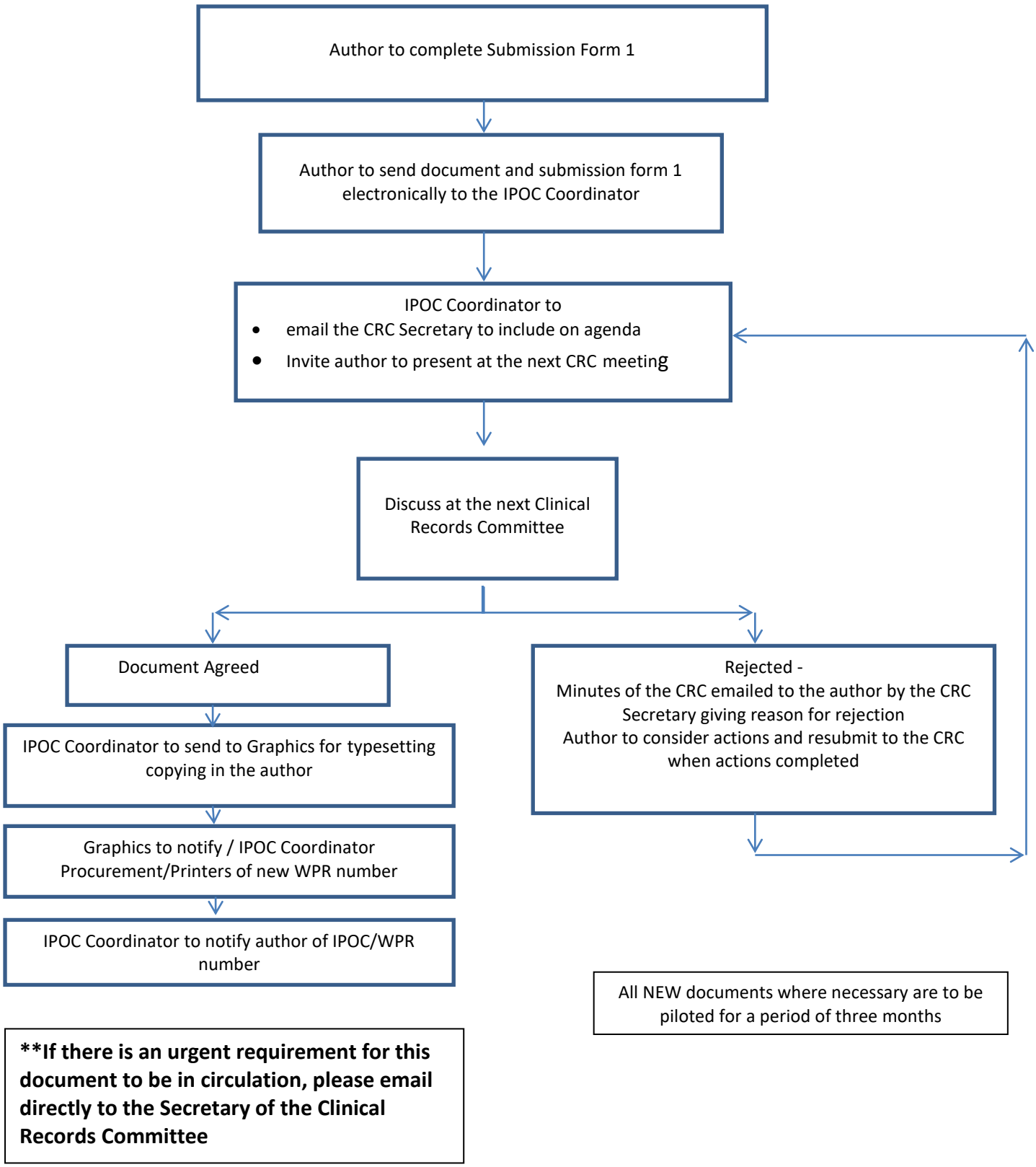
Clinical Records Committee

Terms of Reference

Name	Clinical Records Committee
Purpose	This committee is constituted as a sub-committee of the Clinical Governance Process and reports to it via the Patient Safety Review Group.
Responsible to	• Patient Safety Review Group • Information Governance Group
Duties and work programme	• To recommend and support that all patients have a written multi-disciplinary record that conforms to all current standards agreed nationally and locally. • To endeavour that systems are in place to make all relevant written clinical records available to healthcare professionals at the point of contact with the patient. • To ensure that all clinical records within the Trust are uniform in terms of documentation, layout and format. • To ensure mechanisms are in place for the security and confidentiality of clinical records. To drive the department of clinical records as they evolve from the written hard copy into electronic format.
Chair	Dr Gillian Payne, Consultant Cardiologist.
Membership	Five members of the committee must be present for the meeting to be quorate, including the chair person or nominated deputy. The members present should represent both clinical and non-clinical settings.
In attendance	Authors of any new documentation to be approved.
Secretary	Judy Lane Patient Services Manager – Medical Records
Quorum	Chair plus four other members.
Attendance Requirements	Committee members must attend 75% of meetings. Members unable to attend should notify the group administrator three days in advance of the meeting and attempt to arrange a deputy to attend.
Frequency of meetings	Monthly – approximately two hour meeting.
Papers	Papers will be distributed five days in advance of the meeting.
Circulation of minutes	• Group members, consultation members and authors of proposed documentation being put forward for approval. • Chair of the Patient Safety Review Group
Agreed by the Clinical Records Committee:	31.10.2019
Next Review:	31.10.2021

APPENDIX 2 - PROCESS FOR REQUESTS FOR NEW CLINICAL DOCUMENTATION

Process for requests for **New** Clinical Documentation for use within Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust



Submission form 1 - Request for New Clinical Documentation

The Clinical Records Committee has been created to recommend and support that all patients have a written multi-disciplinary record which conforms to all current standards agreed nationally and locally. This Committee ensures that all requests received to either change or create clinical documentation which will be seen and/or used by patients and clinical staff will ensure high-quality publications, safeguarding against duplication, aiming for economies of scale and making sure that language and style are consistent with the Trust's corporate style.

This request form should be completed and sent, together with your proposed text and illustrations via email to: dbth.ipoc@nhs.net. All proposed text and illustrations must be typed, handwritten documents will be returned to the author. In addition, the author must support the submission of the new document at the Clinical Records Committee. Any documents submitted without the presence of the author will not be discussed.

The final draft and publication

To be completed by the person creating the document

Proposed name of publication:

Description (e.g. leaflet, information film, display board):

Name of author(s):

Job title:

Department: Division:

Ext. No: Email address:

Date publication required:

Reason/Background: (i.e. new service, new evidence (e.g. NICE)

Have you researched to detect if there are any other documents within the Trust of a similar nature?

Is there another department that uses, or may need, a similar publication?
If 'Yes', state which:

Have you liaised with Pharmacy about this document?

Have you researched nationally any standards which should be considered?

What is the target audience?

Is it a Trust-wide publication?

Has the document been through the required approval process i.e?

- **Local Clinical Governance**
- **Patient Safety Group, Divisional Clinical Director**
- **Divisional General Manager**

If so, please provide their name, details and date approved:

Has the development/review of this publication involved service users (e.g. patients, carers)?
If so, please enclose evidence showing how you have done this i.e. Information for Services Users Group.

Special Instructions: (e.g. size, colour, material – paper, card or carbonated paper)

Estimated Usage (monthly/yearly)

Cost

Please be aware that if you are requesting your document to be carbonated or be printed on colour paper, the cost of printing will be increased on average by 25%.

As part of the Trust's contract the printers can hold up to three months' stock on their shelves of a document. This means that each time a document is replaced/removed/ altered or changed; this will incur a cost to destroy any stock which has already been printed.

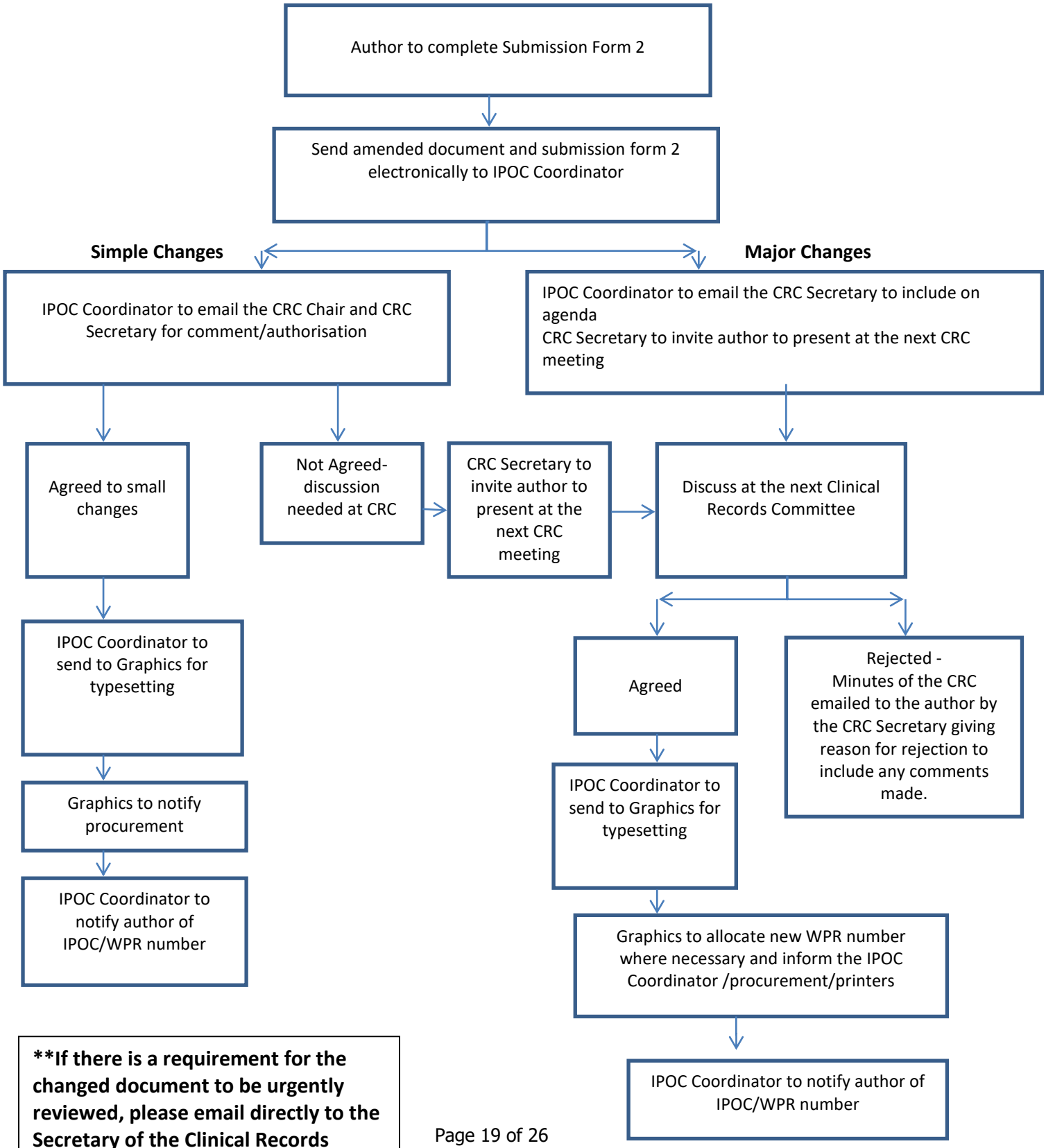
WPR number

Any piece of clinical documentation that is filed in a patient's casenotes **MUST** be registered and officially approved, officially typeset and allocated a WPR number. The WPR number is a unique identifier. Every time a document is updated the WPR number will go up by a digit for version control. This number can be in the left hand margin of the document.

Any document that has been created within a department/ward which has not gone through the above process is **STRICTLY PROHIBITED**. This also includes photocopied forms

APPENDIX 3 – PROCESS FOR REQUESTS TO AMEND/ALTER EXISTING CLINICAL DOCUMENTATION

Process for requests to **amend/alter** existing clinical documentation for use within Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust



****If there is a requirement for the changed document to be urgently reviewed, please email directly to the Secretary of the Clinical Records Committee**

Submission Form 2 - Request to Amend/Alter Existing Clinical

The Clinical Records Committee has been created to recommend and support that all patients have a written multi-disciplinary record which conforms to all current standards agreed nationally and locally. This Committee ensures that all requests received to either change or create clinical documentation which will be seen and/or used by patients and clinical staff will ensure high-quality publications, safeguarding against duplication, aiming for economies of scale and making sure that language and style are consistent with the Trust's corporate style.
This request form should be completed and sent, together with your proposed text and illustrations via email to: dbth.ipoc@nhs.net. All proposed text and illustrations must be typed, handwritten documents will be returned to the author. In addition, the author must support the submission of the proposed changed document at the Clinical Records Committee. Any documents submitted without the presence of the author will not be discussed, unless the change is not requiring adding or removing any text. i.e. Adding a signature or date box.
The final draft and publication of the document must be signed off by the author who then has the sole responsibility of the document.

To be completed by the person creating the document

Proposed name of publication:

Description (e.g. leaflet, information film, display board):

Name of author(s):

Job title:

Department: Division:

Ext. No: Email address:

Date publication required:

Have you researched to detect if there are any other documents within the Trust of a similar nature?

Is there another department that uses, or may need, a similar publication?
If 'Yes', state which:

Have you researched nationally any standards which should be considered?

What is the target audience?

Is it a Trust-wide publication?

Has the development/review of this publication involved service users (e.g. patients, carers)?
If so, please enclose evidence showing how you have done this.

Have the changes been agreed with the Divisional Clinical Governance group and/or service lead? If so, please provide their name, details and date approved with the Division:

APPENDIX 4 – PROCEDURE FOR MERGING DUPLICATE REGISTRATIONS AND DUPLICATE CASENOTES

Duplicate registrations can occur for a variety of reasons for example:

- Incomplete or inaccurate information provided by referrers
- Inaccurate spelling of names by data inputters
- Inaccurate date of birth
- Patients use of middle name or abbreviated form of name
- Staff not searching the Patient Master Index adequately.

Immediately it is established that a patient has been registered more than once on CaMIS and /or duplicate casenotes are discovered for a patient, it is the responsibility of the person discovering the error to initiate the merge process by:

- Telephoning the appropriate Medical Records Supervisor
- Completing and forwarding a form of notification (see appendix 5) to the relevant Medical Records Department Supervisor

Duplications must only be merged by a trained Medical Records Manager, Assistant Medical Record Managers, Supervisors or Patient Services, Service Manager or Team Leaders.

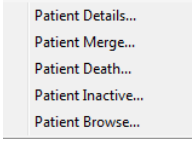
CaMIS duplicate registration and flagged duplicate registration reports, will be routinely produced and actioned by all Medical Records Departments.

1. Before undertaking a merge on the CaMIS:

- Exhaust all available avenues to ensure that the district numbers relate to the same patient
- Pay particular attention to the recorded date/s of birth and NHS numbers.
- If more than one unique NHS number that has been verified undertake further checks through the Care Records Service
- Obtain all of the casenotes under all of the patients numbers
- Ensure that the contents of all of the casenotes relate to the same patient. It may be necessary to verify the patient's details with the registered GP.

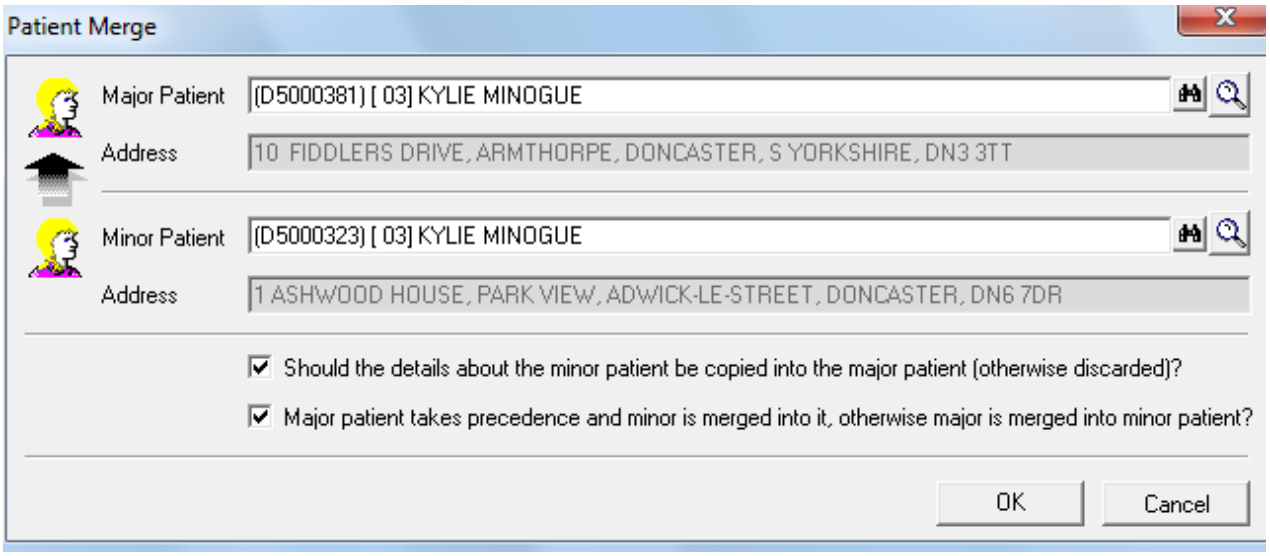
2. Merging the Patient Records on PAS

- Select Patient Index Icon  Patient Index
- Select Patient Merge from options



- Patient Merge screen will display
- At **Major Patient** search using the binoculars and select the patient you want to keep
- At **Minor Patient** search using the binoculars and select the patient that is the duplicate that you want to merge

NOTE: THE MAJOR PATIENT WILL STAY ON CAMIS WITH THE HOSPITAL NUMBER. THE MINOR PATIENT WILL NO LONGER EXIST



- If you want to save the minor patient's details you **MUST** put a tick in the box - **Should the details about the minor patient be copied into the major patient (Otherwise discarded)?**
- If you want the Major patient to have all the information merged into it put a tick in the box – **Major patient takes precedence and minor is merged into it, otherwise major is merged into minor patient?**
- Click **OK**
- The merge is complete and the screen will go blank
- If you search for the patient using the old Hospital Number it will find the Major Patient

APPENDIX 5 – POSSIBLE DUPLICATE REGISTRATION ON CAMIS NOTIFICATION FORM

POSSIBLE DUPLICATE REGISTRATION ON CaMIS

This form should be sent promptly to the appropriate Medical Records Department when duplicate registrations have been confirmed

Patient ID Number _____ Patient ID Number _____

Correct Patient Details

Name _____

Address

D.O.B. _____

GP _____

Incorrect Patient Details

Name_____

Address

D.O.B. _____

GP _____

Sender Name/Department/Ext No _____

Date _____

POSSIBLE DUPLICATE REGISTRATION ON CaMIS

This form should be sent promptly to the appropriate Medical Records Department when duplicate registrations have been confirmed

Patient ID Number _____ Patient ID Number _____

Correct Patient Details

Name _____

Address

D.O.B. _____

GP _____

Incorrect Patient Details

Name_____

Address

D.O.B. _____

GP _____

Sender Name/Department/Ext No _____

Date _____

APPENDIX 6 – PROCEDURE FOR RECORDING NOTIFICATION OF DECEASED PATIENTS

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Notification of deaths can be received in a number of ways;

- Weekly returns from the registrar's office, Reports from Information Department, BID reports
- Messages from GP's, patient's relative's etc
- Casenotes returned to Medical Records Libraries

Deaths notified via the registrar/Report from Information Department/BID report

Look up the patient on CaMIS. Against each patient on the report, tick when each has been up-dated as follows:

If registered and the patient is recorded as 'deceased' on CaMIS, then tick across to confirm no further action is needed on CaMIS. If the patient is not marked as 'deceased', update the system via CaMIS Patient Death icon, entering the date and place of death as per the report

Deaths Notified Via Message

When we receive verbal notification of a patient death we will check the following information and when we are convinced that the information is accurate we will decease the patient on CaMIS by checking the following
Patient Identifiable Number
Patients full name
Patients address
Patients Date of Birth

Casenotes returned to the libraries marked as deceased

Any casenotes returned to the libraries which are marked deceased should be checked against CaMIS to confirm the patient is deceased. If the patient is not deceased on CaMIS, then checks will need to be made.

Check inside the casenotes for any certification of death. If there are none then further checks are required via the Summary Care Record system, alternatively contact the patients GP to verify.
If you gain verification from either inside the casenotes or the GP, update the system via CaMIS Patient Death icon, entering the date and place of death.

Written: *October 2010*
Reviewed: *September 2019*
Review Date: *September 2021*

NOTIFICATION OF DEATH

***You must confirm at least 4 out of the 6 identifying pieces of information from the person notifying you before marking a patient as deceased on the system**.

1. ID Number (ie.District No) _____
2. Patient Name _____
3. Patient Address _____

   _____

   _____
4. Date of Birth ------ / ------- / ----------
5. Telephone Number _____
6. GP _____

Date of Death _____

Place of Death (If known) _____

Person notifying death _____

Name of staff _____Date _____

CaMIS updated? **Yes** **No**

APPENDIX 7 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Clinical Records Policy CORP/REC 5	Corporate - Performance	Judy Lane	Existing	September 2019

1) Who is responsible for this policy? Name of Division/Directorate: Performance

2) Describe the purpose of the service / function / policy / project/ strategy? The casenotes are utilised and managed within local and national guidelines

3) Are there any associated objectives? National and local guidelines and standards

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** [e.g. Monitoring, consultation]

6) Is there any scope for new measures which would promote equality? [any actions to be taken]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: September 2022

Checked by: Karen McAlpine Date: September 2019