Clinical Records Policy

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

This policy should be used in conjunction with:

- 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 – Process Requests for Access to Health Records Procedure
- CORP/REC 4 – Requesting, Locating and Tracking Patients 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

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Date revised	June 2024
Approved by (Committee/Group)	Policy Approval and Compliance Group
Date Approved	June 2024
Date Issued	September 2024
Next Review Date	June 2027
Target audience:	Trust-wide

Amendment Form

Brief details of the changes made:

Version	Date	Brief Summary of Changes	Author
Version 6	June 2024	**Major changes made – PLEASE READ IN FULL** • New Introduction • Definitions – Additions and amendments • Roles and Responsibilities – Updated and amended	Judy Lane Sonya Granby
Version 5	2019	• Updated from CaMIS casenote tracking module to iFIT • Documentation Officer changed to IPOC coordinator	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	Christine Coates Julie Robinson Tracy Evans-Philips

		• Reference to non-site specific casenotes and single virtual casenote library. • Monitoring compliance and effectiveness processes clarified. • Other more minor changes.	
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

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. High standards of record keeping underpin the delivery of high quality evidence based healthcare and many other key service deliverables.

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 purposes.

It is therefore important that the Trust ensures health records are efficiently managed and that the appropriate policy, procedures audit and management accountability provides a robust governance framework for ensuring continued high quality health records management.

Records Management is the process by which an organisation manages all the aspects of records whether internally or externally generated and in any format or media type, from their creation, all the way through their life cycle to their eventual disposal.

This policy has been developed in line with the Records Management Code of Practice 2023 that has been published by NHS England as a guide to the required standards of practice in the management of records for those who work within or under contract to NHS organisations in England. It is 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.PURPOSE AND SCOPE

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.

This document defines a structure to ensure that health records are managed and controlled effectively, and at best value, commensurate with legal, operational and information needs.

Our organisation's health records are a core part of our corporate memory, providing evidence of actions and decisions and representing a vital asset to support our daily functions and operations. They provide the foundation for policy formation and clinical and managerial decision-making. They support consistency, continuity, efficiency and productivity and help us deliver our services in consistent and equitable ways.

The Trust requires accurate contemporaneous record-keeping in all formats regardless of which media they are held.

Through the proper control of the content, quality, storage and volume of records, Health Records Management reduces vulnerability to legal challenge or financial loss and promotes best value in terms of human and space resources through greater coordination of information and storage systems.

It is the responsibility of all staff, including those on temporary or honorary contracts and students, to comply with this policy. 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.

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

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

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

This policy covers all aspects of health records management including (but not limited to):

- Creation
- Content
- Data Quality
- Maintenance & Preservation
- Storage
- Tracking
- Access, Sharing & Disclosure
- Archiving
- Retention
- Destruction

3.DEFINITIONS & ABBREVIATIONS

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.

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.

Abbreviations

DPO	Data Protection Officer
GDPR	General Data Protection Regulation
GP	General Practitioner
ID	Identification
IG	Information Governance
IICSA	Independent Inquiry into Child Sexual Abuse
NHS	National Health Service
RA	Registration Authority
SIRO	Senior Information Risk Owner

4. ROLES AND RESPONSIBILITES

Records management should be recognised as a specific corporate responsibility within every organisation. It should provide a managerial focus for records of all types, in all formats throughout their lifecycle, from creation through to ultimate disposal. The records management function should have clear responsibilities and objectives and be adequately resourced to achieve them.
A designated member of staff of appropriate seniority, ideally with suitable records management qualifications, should have lead responsibility for records management within the organisation. This lead role should be formally acknowledged, included in relevant job descriptions and communicated throughout the organisation. It is essential that the manager(s) responsible for the records management function is directly accountable to or works in close association with the manager(s) responsible for other information governance work areas. When new IT projects or upgrades are introduced, the person responsible for records management should be closely involved.

Roles	Responsibilities
Chief Executive	Has overall responsibility for the maintenance and implementation of the policy.
Data Controller	The Senior Information Risk Owner (SIRO) is the Trust's Data Controller and has an overarching duty to make arrangements for the safety and integrity of the Trust's health records.
Caldicott Guardian	The Medical Director is the Caldicott Guardian and has responsibility for matters relating to patient confidentiality.
Data Protection Officer	The Head of Information Governance is the Trust's registered Data Protection Officer (DPO) and has responsibility for ensuring health records meet statutory requirements
Service Manager - Patient Access	The Service Manager for Patient Access is responsible for implementation of this policy. In conjunction with General Managers agree a named individual Health Records Manager for each division who will ensure staff within the division receive appropriate clinical records training and that records held within the division services are managed appropriately, ensuring adherence to national and local standards and delivery of action plans.
All staff	All staff must be aware of and comply with the principles of this policy to ensure confidentiality, integrity, accuracy and appropriate availability of records and report any instances of non-compliance. All staff are personally responsible for the records they create, use or handle. This responsibility is also incorporated into professional Codes of Conduct, Information Governance Policy, and Policy on the Use and Protection of Patient Information. All staff must ensure that all requests for access to health records are referred to the centralised Access to Health Records team to ensure that requests are processed in accordance with statutory time limits and legislative data protection requirements.
Line Managers	All ward, team or service managers, supported by guidance from the Patient Access Service Manager, are responsible for ensuring the principles set out in this policy are followed together with any local supporting procedures.

	All line managers and supervisors must ensure that their staff, whether administrative or clinical, are adequately trained on the relevant policies and procedures in relation to the management of health records and apply the appropriate guidelines. This includes training in IT applications and Standard Operating Procedures relevant to the creation, content, data quality, tracking, access, storage, retention and destruction of health records.
Clinicians	Clinicians must ensure they adhere to the records management standards of their professional body in addition to the requirements of this policy. Clinicians must ensure before each appointment and before taking action relating to a service user's care that the clinical record is checked for any new documentation added since the previous appointment or action.
Health Records Staff	Health records staff will: Maintain safe and structured records management, applying a consistent approach to records management. Ensure retrieval, tracking, filing, archiving, storage and destruction of records is undertaken in a controlled manner in accordance with Records Management NHS Code of Practice. Organise the safe transportation of records from one location to another.

5. THE CASENOTES

Casenote Creation, Content, Structure, Maintenance, Security and Data Quality

Creation

Each patient must have a personalised record. Where no previous record exists a new record must be created.
All patients registered on the Patient Administration System (CaMIS) 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. D1234567.v2.

Local Procedural Documents are held within Medical Records.

Babies are registered on CaMIS with a District number at birth. If they are recorded 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.

Content/Structure

Ensure that that every piece of paper is secured within the casenote folder and they are bound and stored so that loss of documentation is minimised.
Ensure that every document has the patient's name, date of birth, identification number and NHS number.
All documents must be approved and have a WPR number
All entries must be dated.
Records **must** demonstrate the chronology of events and all significant consultations, conversations, assessments, observations, decisions, interventions and outcomes contemporaneously.
Separate health records **must not** be kept

All electronic records are subject to the same legislation and guidance as paper records. Only Trust approved electronic systems must be used for health records. These must at a minimum be password protected and only accessible by authorised users who have a legitimate reason to access the records.

Where records are held electronically, staff must follow additional guidance in relation to information security as described in the Trust's Information Governance Policy and its associated documents.

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.**

Maintenance

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.

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

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 dividers, a patient ID sheet and patient ID labels and a RFID tag ensuring that the tag is associated to the patients' notes on the IFIT system.

Casenotes must be returned to the appropriate Medical Records Library as soon as they are no longer required.

Security and transportation

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~~**

Health records must not be left unattended or unsecured in public areas (i.e. Corridors/ wards/clinics).

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.

Data Quality

In existing casenotes any change to a patient's demographic details must be updated on CaMIS, the ID labels and the 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.

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.

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 3.

Adopted Persons Records

When patients are adopted they are registered with a new NHS number. See Appendix 1

Transgender Persons Records

Patients may request to change gender on their patient record at any time and do not need to have undergone any form of gender reassignment treatment in order to do so. When a patient changes gender, the current process on NHS systems requires that they are given a new NHS number by their GP and registered as a new patient at their GP practice. Once a new NHS number has been issued by their GP, a patient can request that their hospital records are similarly updated. It is important to discuss with the patient what records are moved into the new record.

6. CASENOTE LOCATION, ACCESS, STORAGE, TRACKING AND RETRIEVAL

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 in 2017 there is a mixture of terminal digit and location based filing.

Casenotes are stored in the following areas:

- Bassetlaw - Main Library
- Bassetlaw - New Library
- Bassetlaw - Post Grad
- Bassetlaw - Manual Handling Room
- Bassetlaw – BLA, BLB & BLC
- 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 and at a cost please contact Medical Records. A full inventory of what is held is off site is available

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.

ALL health records must be stored securely and safely in compliance with IG standards requirements as outlined in the Trust's Information Governance Policy.

ALL health records must be stored in such a manner that will allow them to be easily located, retrieved and accurately re-filed.

ALL health records must be retained in line with legislative retention period for health records. The length of the retention period for health records depends upon the type of record. See Records Management NHS Code of Practice.

The following standards apply with respect to Health Records Storage at all times:

- Patient records should not be removed from Trust hospital premises, see **CORP/REC 2**. In exceptional situations where casenotes are transferred with a patient, **must at all times and in all circumstances be tracked** to their current location on iFIT
- Records identified as lost must be considered as a risk and must be reported immediately and marked on IFIT as ‘Cannot Find’
- Appropriate physical security measures must be in place to control access to work areas where health records are stored or used.

Health Records must be available to access on a 24 hour/7 day a week basis.

Contaminated Casenotes

In the event that records become contaminated (e.g. by spillage, fire, and flood):

- Records Department to submit Datix incident report
- If possible wearing suitable PPE photocopy any casenotes. If not possible create a duplicate medical record reproducing where possible all relevant patient clinical history (e.g. GP correspondence, reports, medical history from other treating clinicians both within and out of the organisation)
- If possible store the contaminated record in a specific secure area and track on iFIT.

Archiving & Retention

Health records in any media (electronic or paper) must be retained according to the Trust’s Record Retention Guidance This is based on the NHS Records Management Code of Practice.

However the following inquiries overrides the normal retention periods for all documents; therefore all records affected by the inquiries must, at this time, be retained indefinitely until further notice. See **CORP/REC 8**

- IICSA (Independent Inquiry into Child Sexual Abuse)
- The Infected Blood Inquiry – further information about the records required can be found on their website
- The COVID-19 Inquiry – The Transformation Directorate of NHS England has produced some guidance and FAQs on this Inquiry

All health records which have crossed the minimum retention period must be assessed and if appropriate destroyed.

Records requiring extended retention must be easily identified with a ‘Do not destroy’ marker if they meet the following criteria:

The Health Records Management team will ensure records marked with ‘Do not destroy’ labels are appropriately archived in line with the required retention periods.

Destruction

Any records eligible for destruction see **CORP/REC 8** – Legal Retention and Destruction of Hospital Patient Medical Records will be done in house by fully trained medical records staff. All health records must be destroyed in a secure manner.

The Trust has adopted the NHS Code of Practice disposal schedule. For guidance refer to **CORP/ICT 14** – Information Records Management – Code of Practice.

Use of Health Records for Audit, Research and Teaching Purposes

Access to records for audit purposes must only be undertaken for projects that have been registered and approved through the Trust's audit registration process. Collection of data must comply with the Data Protection Act 2018 (GDPR). In particular, clinical audit reports must be anonymised to preserve service user confidentiality. If the patient (service user) is involved in a research study, please refer to and adopt the principles outlined CORP-COMM-17-v-4-Recording-of-Research-Info-in-Patient-Paper-Casenotes-Final.pdf (dbth.nhs.uk)

If health records are to be used for teaching purposes outside of the clinical team then the records must be made completely anonymous. Where it is not possible to completely anonymise records (i.e. photographic records from which a service user may be identifiable), consent from the service user must be obtained.

The principles of access and confidentiality remain the same regardless of intent and therefore the right of the patient to refuse access to their records for the purposes of research, audit or teaching purposes must be respected and documented in their notes.

7. IMPLEMENTATION AND TRAINING PLAN

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. Training is in line with the SET learning needs analysis.

The responsibility for implementing this policy lies with the Health Records Department. The Health Records Department are responsible for ensuring that all relevant areas within the Trust are made of aware of any changes required in the policy.

The implementation process will commence upon approval of this policy by the Trust Policy Ratification Group. It is the responsibility of Matrons/Heads of Departments/Service to ensure that new staff receives information about this policy and it should be part of any local inductions. They must also ensure that any changes to this policy are effectively communicated within their areas of responsibility. It is the responsibility of Matrons/Head of Departments to maintain evidence that all staff have received information about this policy and any updates to it.

Health Records Policy is a core subject area that all staff must be aware of and be compliant with. New staff must be made aware of the policy at the earliest opportunity. The Health Records Team will work with individual departments to ensure departments are equipped to undertake this training, and where applicable, local assistance will be provided.

The Health Records team will take responsibility for raising the level of Health Records Policy awareness and training throughout the Trust.

- The Trust Health Records Policy will be introduced to new starters via the Corporate Induction.
- The Health Records Team will raise Trust wide awareness of Health Records issues, common themes in incident reporting, training opportunities and progress etc. via appropriate communications methods.
- The Health Records Team will develop Health Records communications materials to inform and advise service users and staff on Health Records issues.

What	How	Associated action	Lead	Timeframe
Reporting of any suspected Health Records Policy Breaches based on Health Records Policy knowledge gained from Health Records Training.	Trust's Incident Reporting System	All Staff who will report any suspected incidents/ breaches to a senior member of staff.	As and when incidents occur	Health Records Incidents Reported
Health Records Tracking	Audit	Medical Records		
Health Records Quality Audit	Audit	Medical Records		

Key Performance Indicators

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 monthly
- Total number of casenotes destroyed
- Total number of casenotes filed
- Total number of casenotes pulled
- Emergency casenotes retrieved in a specified time period
- Accuracy of Filing in libraries using shelf audits and invalid track logs.

8. 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

9. 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).

10. OTHER ASSOCIATED DOCUMENTS – NEED TO CHECK THESE

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.

11. REFERENCES

- Generic Record Keeping Standards, Royal College of Physicians, 2015
- Records Management Code of Practice 2023
- Public Records Act 1958 and Local Government Act 1972
- Data Protection Act 1998 and GDPR 2018 (www.legislation.gov.uk)
- Access to Health Records Act 1990 (www.legislation.gov.uk)
- Freedom of Information Act 2000 (www.legislation.gov.uk)
- Access to Medical Reports Act 1988 (www.legislation.gov.uk)
- Access to Personal Files Act 1987 (www.legislation.gov.uk)
- Health and Social Care Act 2008

APPENDIX 1 – ADOPTED PERSONS RECORDS

1. On receipt of information that a patient has been adopted please get as much information as possible about the patient's old and new demographic details

2. Check the Care Records Service (spine) to ensure all details are correct making a note of the new NHS number

3. Check that the patient has not been double registered

4. On CaMIS amend all details on CaMIS, ensuring that previous name is not kept and deleting all addresses (except the one assigned to the patient's date of birth, which has to be kept)

5. Ensure that the new NHS number is recorded and that the address, GP, NOK and patient's telephone number is updated

6. Retrieve all volumes of notes relating to the child and photocopy the casenotes of the patient and put the copies in a folder with original name and district number, marking folder 'Adopted, now (new name and any new associated numbers)'

7. These copies are filed in a filing cabinet in Medical Records Laundry store. Track the casenotes on IFIT to 'GREC ADOPT'

8. Using the original documents create second volume of casenotes replace ID sheet and cover up all previous details, replacing with new name, address, GP etc.

9. Redact all references to previous name ensure birth mother's details and number are covered on the patient's notes

10. Where patient name is typed (e.g. correspondence to/from GP), cover with black marker

11. Ensure that all labels with previous name/address are removed from the notes and destroyed

12. The redacted notes are now the notes to be used for the patient

APPENDIX 2 – 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 CaMIS 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 2) to the relevant Medical Records Department Supervisor

CaMIS duplications must only be merged by a trained Medical Records Manager or Supervisor

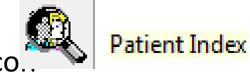
CaMIS duplicate registration and flagged duplicate registration reports, will be routinely produced and actioned by all Medical Records Departments.

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 (spine)
- 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 CaMIS

- Select Patient Index Ico..

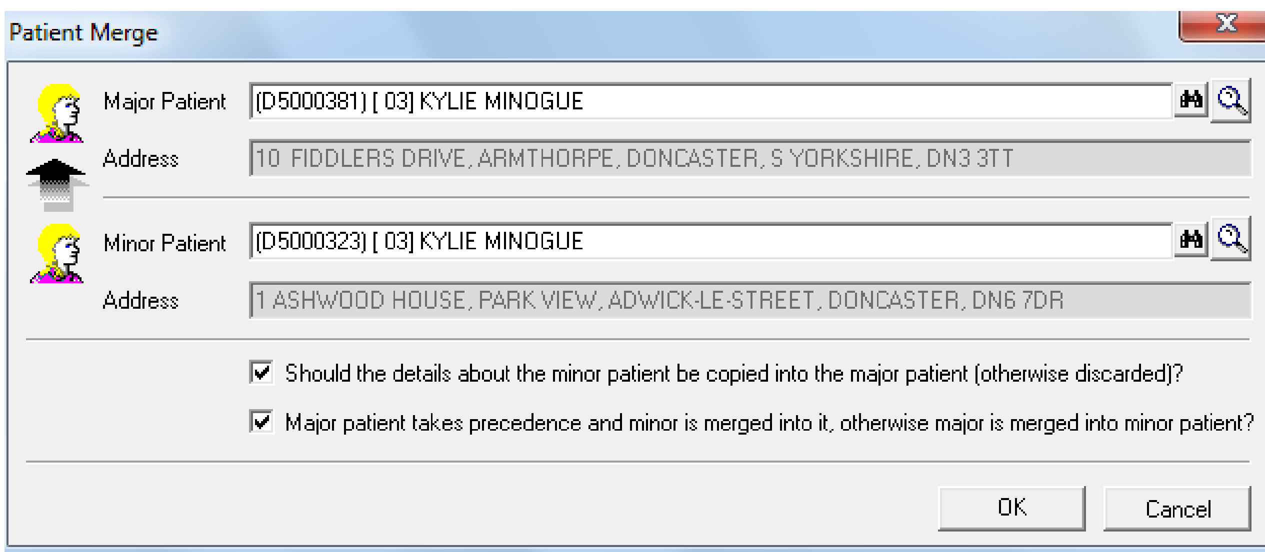


- Select Patient Merge from options
- Patient Merge screen will display
- At **Major Patient** search using the binoculars and select the patient you want to keep

Patient Details...
Patient Merge...
Patient Death...
Patient Inactive...
Patient Browse...

- 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 3 – 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	**Incorrect Patient ID Number**
________________________	________________________
Correct Patient Details	**Incorrect Patient Details**
Name____________________	Name ____________________
Address	Address
D.O.B. _______________	D.O.B. ________________
GP ___________________	GP ____________________

Name of staff making notification ____________________________

Department ____________________________

Ext No ____________________________

APPENDIX 4 – PROCEDURE FOR RECORDING NOTIFICATION OF DECEASED

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 PAS, 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.

APPENDIX 4 NOTIFICATION OF DEATH

NOTIFICATION OF DEATH

- **ID Number (i.e. District or NHS No.)** ____________________________________
- **Date of Death** ____________________________________
- **Patient Name** ____________________________________
- **Date of Birth** ____________________________________
- **Place of Death (If known)** ____________________________________
- **Person notifying death** ____________________________________

Name of staff ____________________________ Date ____________________

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

APPENDIX 5 – 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	June 2024

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 ?

Date for next review: June 2027

Checked by: Patient Access Manager **Date: June 2024**