Order of Filing in Hospital Casenotes Policy

This procedural document supersedes: Policy for the Order of Filing in Hospital Casenotes - CORP/REC 1 v.5

This policy should be used in conjunction with:

- **CORP/REC 5 - Clinical Records Policy**
- **CORP/REC 6 – Record Keeping Standards**
- **PAT/EC 8 – Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Policy**

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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):	Rebecca Joyce – Chief Operating Officer
Name and Title of Author/Reviewer	Judy Lane
Date Revised	August 2021
Approved by (Committee/Group)	Clinical Records Committee
Ratified by	Policy Approval and Compliance Group
Date Ratified	30 September 2021
Date issued	October 2021
Next Review date	August 2024
Target audience:	Trust-wide

Amendment Form

Brief details of the changes made:

Version	Date Issued	Brief Summary of Changes	Author
Version 6	28 October 2021	• Minor changes made throughout historical practice removed as no longer relevant	Judy Lane
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 Case notes • 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 case notes and for the filing of patient care documentation within the case notes.

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

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

- Clinical Governance
- Information Governance Framework
- Department of Health 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

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified

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

When patients are newly registered on the Patient Administration System (PAS) and require new case notes to be created these are labelled with district numbered barcode labels and tagged with an RFID tag.

Pre-existing case notes must be tagged with an RFID tag; multiple folders must be relabelled as separate volumes and tagged with an RFID tag and then individually tracked.

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

Medical records departments will not file case notes containing loose filing, the case notes will be returned to the sender along with the loose documents.

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.

4 ORDER OF FILING

The case note 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) ReSPECT form including 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 consultant's 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

4.1 Supplementary Instructions for Filing Recommended Summary Plan for Emergency Care and Treatment 'ReSPECT' including 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) Directives

Also refer to PAT/EC 8 – ReSPECT Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).

The policy stipulates that:-

- DNACPR decisions must be documented on the ReSPECT form. A copy of the ReSPECT form on the front of the front spine, behind the patient identification sheet and the patient identification labels.
- Whilst the patient is in hospital the ReSPECT form must remain in the case notes, behind the identification documents.
- The most recent ReSPECT form must be filed on top.
- Cancelled forms which are no longer valid, must remain filed in the case notes, 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 on the ReSPECT form and maintained by the clinician responsible, on the ALERT page in the case notes.

4.2 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 only official IPOC continuation sheets 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 case note 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 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.

5 EDUCATION AND TRAINING

It is mandatory requirement for all staff to complete SET training and attend a Trust Induction included in these sessions is a section on case note management and Information Governance

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

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. (Appendix 1)

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.
(See Appendix 2)

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.

7 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- CORP/REC 5 - Clinical Records Policy
- CORP/REC 6 – Record Keeping Standards
- PAT/EC 8 – Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Policy
- CORP/EMP 4 – Fair Treatment for All Policy
- CORP/EMP 27 – Equality Analysis Policy

8 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 UK General Data Protection Regulation (GDPR) 2021.

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/information-governance/

9 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 – CASENOTE REVIEW AUDIT

2017 Casenote
Review Audit - Data (

APPENDIX 2 – CLINIC PREPARATION AUDIT SHEET

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Clinic Preparation Audit Sheet

Clinic Date	Patient Number	Clinic	F/Sheet & Labels	Section	Recon Slip	Merging/Amalgamating	Relevant Volume	Tagged/ Tracked	Specialty	Temp	Comments
01/01/1900	B123456	ABC123	✓	✓	✓	✓	✓	✓	✓	X	N/A
01/01/1900	D1234567	ABC123	✓	✓	✓	X	✓	✓	✓	X	Didn't merge all sets

APPENDIX 3 – 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
Order of Filing in Hospital Casenotes – CORP/REC 1 v.6	Performance	Judy Lane	Existing policy	27 08 2021

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: August 2024

Checked by: Karen McAlpine **Date: 27 08 2021**