Public – To be published on the Trust external website

Records management - unified records

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Contents

1 Introduction

The electronic record is the complete care record and must contain a complete record of all relevant interventions with the service user. However, there are still paper records and assessments that cannot be input to Paris so must be held in paper form. A relevant summary must be included on Paris so that the correct clinical decisions can be made and the integrity of the complete care record is maintained.

The unified record procedure brings together all relevant information relating to the service user to help inform involved professional carers to better co-ordinate the care of that individual. The other procedures detailed in this document will help to ensure that the clinical record is a source of comprehensive, accurate and reliable information.

This procedure is critical to the delivery of to Our Journey To Change (OJTC) and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism. It helps us deliver our strategic goals as follows:

- This procedure supports the trust to co-create a great experience for all patients, carers and families from its diverse population by ensuring the information held allows access to the care which is right for the patient
- This procedure supports the trust to co-create a great experience for our colleagues by working innovatively across organisational boundaries to improve services.

2 Purpose

Following this procedure will help the Trust to:

- Ensure systems and processes within the organisation to support a unified clinical record are understood
- Demonstrate an understanding of the principles of a single service user record and processes to be followed within all speciality services to:
    - Demonstrate and maintain a unified clinical record
    - Ensure availability of comprehensive, accurate and timely information to clinicians.
- Identify the correct processes for filing, volumising (splitting records) and clinical document control within paper-based records.

3 Who this procedure applies to

This procedure applies to all employees of Tees, Esk and Wear Valleys NHS Foundation Trust including temporary, agency and contracting colleagues.

4 Related documents

This procedure describes what you need to do to implement section:

- 4.3 Managing and Storing paper and digital records
- 4.9 Sharing records and information

of the Records Management Policy.

The Records Management Policy defines Trust and staff responsibilities for records management which you must read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to:

- Minimum Standards for Clinical Record Keeping Procedure

5 Unified clinical record

5.1 Primary care record

Many mental health and learning disability service users have a range of needs that cannot be met by a single treatment, service or agency. Effective communication between professionals, services and agencies involved in an individual's care has been shown to be vital to the care and treatment of the individual.

- All clinical information must be input into the electronic record (Paris/CITO or IAPTUS).
- The electronic record is always the primary record and must contain a complete record of all relevant interventions with the service user.

5.2 Information on shared drives

- It is a legal requirement that the Trust knows and can tell the patient about how we hold their information and why. This includes information that is held on shared drives.

Information about service users which is held on shared drives must also be signposted from the electronic care record even if it is also on the Paris or supplementary paper record. This is so that we can understand where we hold information about a person should they make a subject access request and also to enable retention times to be assigned.

5.3 Supplementary paper records

Paris allows users to input information for a comprehensive single assessment but it will not allow users to record details of some profession or service specific assessments. You may record a full profession or service specific assessment in a supplementary paper record but you must provide a summary of this assessment in the electronic record.

Until Paris offers full functionality, a system of paper records is still required to support the aims of the unified record procedure. The key mechanism to facilitate the unified approach is the completion of the 'Additional Clinical Information/Notes' panel on the front of the paper care record folder. Summaries from all professions involved must be filed in the unified service user record in the absence of an electronic record. Correspondence from external agencies and organisations should be filed in a casenote folder until the facility to scan, digitise and store incoming correspondence electronically becomes available.

When using Paris, follow the instructions and guidance documented in the Paris procedure, user guides and support materials.

1. To facilitate the unified approach, health professionals not part of that care team but who are providing clinical input into the case must be noted on the box provided on the front of all current case note folders (see Appendix 2).

2. Upon opening a new unified record, check to see if the service user is known to any other services within the Trust – fill in the additional clinical information panel on the case note folder to indicate that other professions and or services are involved. Tick an appropriate box and write the type (e.g., psychology, physiotherapy, liaison psychiatry) and the location of additional records.

3. The panel should be left blank if no other services are involved with the service user or if all input with the service user is included within the unified clinical record.

4. On identifying the involvement of another professional and or service area, the relevant clinician will then be required to provide regular summary reports of their interventions into the unified record.

5. On discharge the unified clinical record and casenote folders from other professions/services involved must be collated and stored together at the Trust's external storage facility. Contact the records service for more information (email : tewv.archiverequests@nhs.net)

6 Filing

Under the Public Records Act 1958 all NHS employees are responsible for any records that they create or use in the course of their duties. An element of some job roles within the Trust are specifically designed to ensure that paper clinical records are maintained by accurately filing correspondence, investigation results, care plans and other associated documentation.

Although ward clerks, medical secretaries and clinical team administrators may have these functions specified within their job descriptions, **all** staff, including healthcare professionals who use records must take responsibility for maintaining them. Prior to creating a new paper file you should interrogate Paris and seek support from the Records Team tewv.archiverequests@nhs.net to ensure that duplicate records are not created. The Records Team will assist with locating and if appropriate obtaining the paper file for update.

The Minimum Standards for Clinical Record Keeping Procedure provides guidelines for the filing of documentation associated with the clinical record.

7 Volumising

The current unified care record folder has a concertina type spine, designed to expand as the internal plastic document holders are populated with paper. Filling the folders with documentation beyond the point of capacity must be avoided. When the plastic spines become over-populated with paper, the holes punched in the paper documents tear and sheets may easily become dislodged from the folder and lost. This situation can be avoided by limiting the thickness of paperwork filed in the folder. The loss of documentation from the paper record will be minimised by following the volumising procedure detailed below.

1. Split clinical records that are in excess of 7cm into separate volumes.

2. Split records on a chronological basis with the most recent documentation in the latest volume. Check meticulously for current episodes of care as both an in-patient and an out-patient or community service user.

3. The newly created volume must contain the notes from at least one out-patient attendance or community contact and any associated diagnostic tests and correspondence.

4. Bind all relevant documentation relating to the last in-patient episode for each consultant associated with the patient in the new folder. As a minimum, relevant information should include the following:

   - Current risk assessment
   - Current care plan
   - Current risk alert sheet
   - Known allergies
   - Known major medical problems
   - Used medicine cards

   Note – the transfer of relevant documentation from a former volume to a new volume must be based on clinical judgment and considered on an individual basis. Documentation must be transferred that limits any risk to the service user, staff, and the public and allows for the continued provision of high quality care.

5. Check the 'old' clinical/care records for loose filing and secure all documents to the binding clips in the correct section.

6. Clearly mark the volumes "Volume 1", "Volume 2" on the outside front cover and the start and end date of Volume 1 and the start date of Volume 2 being clearly recorded on the outside front cover of the clinical/care records.

7. Cross through older volumes and write "Volume Closed" written clearly on the front cover. Do not file current documents into closed volumes.

8. Update patient administration systems if possible to indicate that there are multiple volumes in existence.

9. Record requests for older volumes of clinical records by noting the volume number, the requesting clinician and the date of request in the lender's and borrower's tracing and tracking system. Keep all volumes together at all times while the clinical/care records are in circulation.

10. Clinicians to provide a summary when records are split from the previous volume/volumes of information that may be relevant to the current care of the patient. This may be a simple statement to the effect that the previous volumes contain relevant and important information to the current care.

8 Clinical document control

The Trust Board, through the Digital Performance and Assurance Group, recognises the need to standardise and regulate the development, implementation and review of all clinical documentation in use within the Trust.

The Department of Health's publication HSC 1999/065 Clinical Governance in the new NHS, lists four components of clinical governance. One of these components is a comprehensive programme of quality improvement activities which includes *'effective monitoring of clinical care with high quality systems for clinical record keeping and the collection of relevant information'.*

The Trust has therefore recognised that a key component in maintaining standards within the case note folder is to ensure that the documentation being used is authorised as Trust approved documentation and that it clearly identifies the purpose for which it is being used.

It is therefore essential to ensure that all clinical documentation is maintained through the Trust documentation library and that all staff are made aware of the most current versions. Failure to achieve this undermines clinical effectiveness and potentially exposes the Trust to future investigation and litigation.

Clinical document control will ensure:

- Documentation is developed and ratified by the appropriate groups.
- Systems for document evaluation and review are in place
- Documentation is accessible and its use understood by all staff
- The overall quality of the record is improved through appropriate use of standard documentation
- The development of templates for use is co-ordinated as the Trust continues to improve Paris functionality
- To protect the Trust, as far as possible, against the potential of litigation due to poor record keeping standards

The responsibilities of specific members of staff must be understood before considering the procedure:

Responsibilities of the document control co-ordinator. The head of information governance and records management acts as the coordinator and is responsible for:

- Allocating a unique Identity number to the document
- Ensuring archive of 'dead' documents and amended pages

- Ensuring that the document library is available on the Intranet
- Ensuring circulation ordering procedures for documents
- Reminding appropriate persons when documents are due for review

Responsibility of professional heads and senior managers. Professional heads and senior managers have responsibility for ensuring that assurance mechanisms are in place and ensuring the implications of 'documents' are explicit and managed within and across services.

Responsibility of directorate and departmental managers. Clinical directors, head nurses and service managers are responsible for ensuring that all documents are developed in accordance with this policy. In addition, they are responsible for providing a contact point for the control and co-ordination of this policy within their services to liaise with the head of information governance and records service.

Responsibility of author/originator. The author/originator is responsible for ensuring the document is developed and authorised in line with the key stages outlined in the following process. Specifically:

- Ensuring the appropriate opinion and endorsement is sought during the preparation and drafting of the document
- The document complies with the agreed Trust formats
- Final versions of the document have been submitted to the groups and the evaluation document completed prior to submission to the records management group

9 Process

1. Develop all new Trust documents and existing documents in accordance with the following procedural steps:

2. **Identify the need** for the clinical documentation.

   This is a core function within local governance committees, management teams and service areas. It is based upon an evaluation of the requirements of the service and may result from an incident occurring, new legislation or new evidence on clinical practice. A lead person will be identified to see the process of design through to its conclusion.

3. **Confirm** that the need for the clinical documentation is not already met within the Trust or is already in design.

   If the need for new documentation is confirmed within the service area, the lead person should contact the head of information governance and records management to confirm that the need is not already met elsewhere. This will enable

the service to understand whether their documentation need is service driven or Trust wide. The head of information governance and records management will confirm authority to proceed to development stage.

4. **Develop** the documentation. The lead person will consult with a range of people. They must consider:

    - the relevance to the service and organisation
    - readability and usability
    - consulting relevant people, including patients and the public where appropriate
    - conformity to Trust guidelines and format
    - identification of methods of dissemination and a planned supportive educational and training programme
    - the service, via its governance group and sign off the document
    - that the development stage has been properly documented
    - that the sign off and development document are forwarded to the information governance and records management group via the head of information governance and records management.

5. **Ratify** the documents. The lead person must ensure the clinical documents are ratified by the information governance and records management group. This group will:

    - Ratify the document and confirm its existence either as a Trust wide or service specific document
    - Ensure that the document library is updated
    - Communicate the existence of the document to all other service areas

6. **Storage** is the responsibility of the head of information governance and records management. The manager will:

    - Assign the document a unique number
    - Mark the document as controlled
    - If the document has been copied or requires a licence ensure that the proper procedures are adopted
    - Place the document within the document library within the correct classification
    - Place a review date on the document and alert authors when review date approaches

7. **Dissemination** is the responsibility of the head of information governance and records management. The manager will:

    - Alert staff via e-mail when the document is available to order
    - Co-ordinate training for Trust wide implementation

10 Terms and definitions

Term	Definition
Unified record	• The brining together of every record about a service user in any format e.g., electronic care record, supplementary paper record(s) and information on shared drives

11 How this procedure will be implemented

• This procedure will be published on the Trust's intranet and external website.
• Line managers will disseminate this procedure to all Trust employees through a line management briefing.

11.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All staff	Records management workshop	0.5 day	Annually

12 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Clinical record keeping audit	Annually	Digital Performance and Assurance Group

13 References

- UK GDPR
- Records Management Code of Practice 2021 guidance

14 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	24 January 2023
Next review date	24 January 2026
This document replaces	CORP-0026-006-v1
This document was approved by	Information Governance Group
This document was approved	18 January 2023
This document was ratified by	Digital and Data Management Meeting
This document was ratified	24 January 2023
An equality analysis was completed on this policy on	18 October 2022
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
1	03 Oct 2018	Reference number changed to reflect that this procedure sits under the Records Management Policy Updated in line with GDPR and current organisation structure	Withdrawn
1	12 Apr 2021	Review date extended to 03 April 2022	Withdrawn
1	13 April 2022	Review date extended to 31 July 2022	Withdrawn
1.1	24 Jan 2023	Updated in line with the Records Management Code of Practice 2021 guidance Updated email address and additional information to minimise duplicate paper records being created	Published

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Information Department – Digital and Data Services
Title	Records Management – Unified Records Procedure
Type	Procedure
Geographical area covered	Trust-wide

Aims and objectives	This procedure:
	• Describes the systems and processes within the organisation to support a unified clinical record;
	• Covers the principles of a single service user record and processes to be followed within all speciality services to:
	  ○ Demonstrate and maintain a unified clinical record
	  ○ Ensure availability of comprehensive, accurate and timely information to clinicians.
	Includes processes for filing, volumising (splitting records) and clinical document control within paper-based records.

Start date of Equality Analysis Screening	18 Oct 2022
End date of Equality Analysis Screening	18 Oct 2022

Section 2	Impacts

Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Patients Other clinicians
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.)**NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO**
Describe any negative impacts	
Describe any positive impacts	Many mental health and learning disability service users have a range of needs that cannot be met by a single treatment, service or agency. This procedure supports effective communication between professionals, services and agencies involved in an individual's care which is vital to the care and treatment of the individual.

Section 3	**Research and involvement**

What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	UK GDPR Record Management Code of Practice 2021 guidance
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	**Training needs**
As part of this equality analysis have any training needs/service needs been identified?	Yes
Describe any training needs for Trust staff	Annual ½ day Records management workshop
Describe any training needs for patients	n/a
Describe any training needs for contractors or other outside agencies	Annual ½ day Records management workshop

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes / No / Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?		
	Have any related documents or documents that are impacted by this change been identified and updated?	N/A	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	
	Are training needs included in the document?	Yes	

	Title of document being reviewed:	Yes / No / Not applicable	Comments
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	Approved by E&D 8/12/2022
9.	**Approval**		
	Does the document identify which committee/group will approve it?	yes	IGG, DDMM
10.	**Publication**		
	Has the policy been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	