journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

Creating and Retrieving Supplementary Clinical Records Procedure

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Status: Approved
Document type: Procedure
Overarching Policy: Records Management Policy

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1 Purpose

The care records held on both the Electronic Patient Record (EPR) and in the supplementary paper record are a complete status of the patient's treatment and care, past, present and current. It should hold a complete picture of the decisions made, risk and treatment plans identified and views from all involved people including the patient.

This procedure relates to the creation of supplementary paper records. It aims to ensure that records are created in a uniform manner so that:

- They can easily be retrieved,
- Their structure enables the quick review of relevant information so that clinically safe and effective decisions can be made.

Following this procedure also minimises the likelihood of creating a duplicate paper record.

A duplicate paper record could introduce risk to the patient due to the people involved in their care not having all relevant information available to them when they need it.

A duplicate electronic patient record increases the risk further due to the potential for relevant information not being visible on the record that is being viewed, for example allergies or risk history.

Duplicate records also increase the likelihood of not making a full disclosure in response to a subject access request.

2 Related documents

The Records Management Policy defines responsibility for creating and retrieving clinical records which you must read and understand before carrying out the procedures described in this document.

Refer to the Minimum Standards for Clinical Record Keeping if the record is known to relate to a Trans patient.

The Records Management Policy describes how records management supports Our Journey To Change and fits with Trust values and behaviours.

This procedure also refers to:

- EPR Procedures and guidance
- Information Governance Framework
- Information Governance Policy

- Minimum Standards for Clinical Record Keeping

3 Procedure

Paper patient records are only needed for those documents that are received into the Trust in paper format for example letters, test results etc.

Any documents that are received electronically can be uploaded in PDF format into the EPR. Documents received electronically should not be printed and put into a paper record. This is duplication and an unnecessary use of resource. The electronic version remains the primary record.

3.1 Step-by-step instructions for setting up a paper case note folder

Step	Who	Task
1.	IAA – Administrators	On receiving a referral, follow the guidance for creating a record in the Paris element of the EPR. This is vital so that duplicate records are not created on the electronic system If the patient is new to Paris, carry out a search to find out if any paper records exist: • Refer to legacy lookup in the IIC for older systems not now used • Contact medical records via the generic email tewv.archiverequests@nhs.net who will search all other storage facilities
2.	IAA – Administrators	When it is certain that no paper record exists, consider which type of case note folder is required: • Supplementary case note folder – Patient accepted into service, and a number of paper-based letters and assessments are expected to be needed over time. • Green Envelope – Not very much paper-based information will be generated.
3.	IAA - Administrators	Contact tewv.archiverequests@nhs.net if stocks of case note folders or Green envelope are required.

4.	IAA – Administrators	Set up the case note folder following the Trust standard filing structure within the case note folder: • Clinical Documentation (not on EPR) • Temporary Clinical Notes (typically used for times when EPR might be offline or if the electronic patient record cannot be accessed but a record needs to be made. Records made in this section must always be transferred to EPR as soon as possible. • Mental Health Act and Consent • Test Results including Mount sheets • External Correspondence
5.	IAA – Administrators	• Record written details on the front cover only where indicated. Both corner sections need to be completed together with a start date. Volume numbers should be written on the folder. • Patient information other than that allowed for should not be printed on the front of the folder • Do not re-use folders. • For deceased persons, record their date of death on the front of the file.
6	Compliance and Records staff	Provide guidance on the use of case note folders and hold supplies of folders for distribution across the Trust.

3.2 Step-by-step instructions for retrieving records

Step	Who	Task
1.	Clinical or administrative staff	Identify the need to retrieve records and establish 'need to know' for records retrieval
2.	IAA – Administrators	Interrogate the EPR to identify the last person to be in contact with patient. Teams must conduct their own thorough searches prior to contacting Medical Records. This may involve using break glass functionality. Choose appropriate option depending upon reason for retrieving records (audit reason would be indirect care but patient re referred would be direct care)
3.	IAA – Administrators	If previous owner cannot be located contact tewv.archiverequests@nhs.net who will conduct a wider search on your behalf following their standard processes.

4.	IAA – Administrators	Regardless of whether you are receiving or lending, records must be tracked and traced throughout their journey so that their status and location can always be identified.
5.	IAA – Administrators	On receipt of records, always complete and return the acknowledgement form. Telephone the lender when you receive records so that they can close their records tracing system to show your receipt. You can now open a log to show the records being located in the receiving department.
6.	All involved staff	Transport records by following the mailing procedure. Plastic mailer envelopes must be used and are available to order from Cardea (medium WYO2771 and large WHH225). The yellow confidential record labels are for internal use only All records sent using external post should be sent by signed for delivery.

4 Definitions

Term	Definition
EPR	• Electronic Patient Record. This refers to the electronic patient record system and includes both Paris and Cito.

5 How this procedure will be implemented

- This procedure will be published on both the staff intranet and, Trust website.
- The Policy Coordinator will disseminate this procedure to all Trust employees through monthly all-staff briefing.

5.1 Implementation action plan

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
N/A				

5.2 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
N/A			

6 How the implementation of this procedure will be monitored

See Records Management Policy

7 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	30 April 2024
Next review date	30 April 2026 (n.b. a 2 year review required by NHSX CoP 2021)
This document replaces	CORP-0026-0004-v1 Records Management - Creating and retrieving clinical records procedure
This document was approved by	Information Governance Group
This document was approved	17 April 2024
This document was ratified by	Digital and Data Management Meeting
This document was ratified	30 April 2024
An equality analysis was completed on this policy on	26 April 2024
Document type	Public

Change record

Version	Date	Amendment details	Status
1	13 Nov 2019	Full revision with minor amendments. Reference number amended to reflect that this procedure 'sits under' the Records Management Policy	Withdrawn
1	12 Apr 2021	Review date extended to 13 May 2023	Withdrawn
2	30 Apr 2024	Full revision with minor amendments to job titles and system names	Published

Appendix 1 - Equality Impact Assessment Screening Form

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

Section 1	Scope
Name of service area/directorate/department	Digital and Data Services
Title	Records Management – Creating and retrieving clinical records
Type	Procedure/guidance
Geographical area covered	Trustwide
Aims and objectives	To ensure that paper patient records are created in a uniform manner so that they can be easily retrieved and their structure enables the quick review of relevant information so that clinically safe and effective decisions can be made.
Start date of Equality Analysis Screening	May 2023
End date of Equality Analysis Screening	28 March 2024

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	All patients, their families and carers, and the staff involved in their care
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **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 / people who are breastfeeding, women / people accessing perinatal services, women / people 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** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	None
Describe any positive impacts / Human Rights Implications	The procedure impacts positively on patients as it ensures that information relating to their diagnoses and care that is not held on the EPR is recorded and available when needed.

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.)	NHSX Records Management Code of Practice 2021
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	No
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	N/A – the current procedure will remain in place until such time as all new patient records created electronically only and supplementary paper notes are digitised into the EPR

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	
Describe any training needs for patients	
Describe any training needs for contractors or other outside agencies	

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

Appendix 2 – Approval checklist

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?	Yes	
Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
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	
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	
9. Approval		
Does the document identify which committee/group will approve it?	Yes	
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	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Yes	
Do all pictures and tables have meaningful alternative text?	Yes	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Not applicable	