POLICY TITLE: Healthcare Records

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Policy Owner:	Adrian Cree, Executive Medical Director
Ratified by:	Paul Cowans, Specialist Director
Responsible Signatory:	Colin Quick, Chief Quality Officer
Outcome:	This policy: • Aims to ensure that patients are assured that their health records are clear records of their treatment and are handled, stored and accessed appropriately. • Provides guidance on access to Health records. • Provides a matrix for periods of retention.

Cross Reference:	H11	Consent
	H35	Clinical Risk Assessment and Management
	H47	Observation and Engagement
	H108	Outpatient Referrals to Priory Therapy Services and Priory Wellbeing Centres
	HR01.3	Practising Privileges for Independent Self Employed Doctors
	IT02	IT Security
	LE03	Data Protection
	LE03.1	Document and Data Retention
	LE06	Confidentiality
	OP04	Incident Management, Reporting and Investigation
	OP05	Mental Capacity

EQUALITY AND DIVERSITY STATEMENT

Priory is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics (age, disability, gender identity and expression, marriage or civil partnership, pregnancy or maternity, race, religion or beliefs, sex, sexual orientation), and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email LegalandComplianceHelpdesk@priorygroup.com.

HEALTHCARE RECORDS

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1 INTRODUCTION

1.1 A comprehensive health record is maintained for every patient. However, there will be some differences in some of the arrangements for inpatients and day patients. Where there are variations, a local procedure will be in place as agreed by the hospital's Clinical Governance committee.

1.2 Priory Healthcare is committed to moving towards a fully comprehensive and complete electronic health record, thereby minimising paper records to eliminate duplication and to ensure that colleagues from all disciplines across a hospital and within the compliance and central management team can access records at all times. It is also essential that Agency Registered Nurses are able to access the electronic Health Record and further details on this are provided in Appendix 4 - CareNotes Agency Login Protocol. It is the responsibility of the Hospital Director to assess their local requirements to achieve this and to ensure that a high standard of Health Records are maintained.

1.3 At Healthcare sites where CareNotes has been installed, the primary source of patient information is via this electronic patient record system. Any paper records, kept whilst the patient is admitted, are scanned into the relevant section of the patient's Health Record on CareNotes during admission or upon discharge.

1.3.1 On sites where CareNotes is not installed, a comprehensive paper folder is kept in accordance with professional e.g. NMC and GMC guidelines and in accordance with H Form: 98A - Healthcare Records Dividers Template.

1.3.2 Any forms used in the Health Record must either be corporate documentation, or local documents that have been ratified via the local Clinical Governance process and the Clinical Network Professional Lead consulted for ratification and advice on whether it needs to be taken to the Clinical Network.

1.4 Whether the Health Record is electronic or on paper there is:

(a) A summary in the record that contains all the patient's demographic details and all administrative details relevant to the admission.
(b) The record has a unique patient number and the number is recorded on each part of the record.
(c) Space is provided to record the patient's first language, where their first language is not English.
(d) There is a system of allergy 'alert' notation in place.
(e) An up to date and chronological account of the patient's care.

1.5 Consultants may use paper records for outpatients, and they may carry clinical notes with them to facilitate the consultation at their own risk and under their own registration with the Information Commissioner's Office (ICO), but must under no circumstances keep them away from Priory premises for longer than absolutely necessary. When outside Priory premises the notes must be stored securely at all times. The notes need to be scanned & uploaded to CareNotes.

1.6 Patient confidentiality must be maintained at all times - refer to LE06 Confidentiality, IT02 IT Security, and LE03 Data Protection.

1.7 For standards in relation to the recording of Outpatient Patient records, please refer to H108 - Outpatient Referrals to Priory Therapy Services and Priory Well Being Centres.

2 HEALTH RECORD CONTENTS

2.1 Health records must contain the following minimum data set:

(a) The patient's name in full on each part of the record.
(b) The patient's home address, postcode and telephone number.
(c) The patient's date of birth and gender.
(d) Contact details for the patient's general practitioner.
(e) The patient's NHS number.
(f) The name of the responsible clinician/consultant in charge.
(g) The date of patient admission as an inpatient, and the date of discharge or transfer if appropriate.
(h) Details of the patient's property held on admission.
(i) Information about the patient's religion (if applicable).
(j) Contact details for the next-of-kin or other person to be notified in an emergency, including a telephone number.
(k) The source of referral and a referral letter/report.
(l) A clinical reason for admission/referral and the date and time of the initial consultation
(m) An initial patient history.
(n) The clinical risk assessment undertaken for the patient on admission (refer to H35 Clinical Risk Assessment and Management).
(o) A dated MDT care and treatment plan drawn up for the patient. The care plans will be discussed with the patient and the outcome of that discussion recorded. A copy of the Care Plans will be offered to the patient.
(p) The daily care and progress notes, observations, consultation reports and care programme approach meeting notes made by all health professionals involved in the patient's care.
(q) Medication records that include the name of the medicine, the dose, the route of administration and the frequency and time for administering. Medication records are to be signed by the prescriber.
(r) All relevant Consent forms signed by the patient.
(s) A cross reference to the Incident number from the Datix Incident Reporting system of any Incident Reports involving the patient.
(t) Details of any transfer of the patient to another hospital, the date of transfer, the reason for transfer and the name of the receiving hospital.
(u) A discharge or transfer summary completed by the consultant, specialty doctor or responsible clinician. This includes (as a minimum): diagnosis of the patient's condition, medication prescribed, the programme of treatment and care given and the patient's response to the treatment, a note of any aggressive incidents and an assessment of the risk of harm to self or others.

2.2 Levels of observation are noted in the patient's health records. The handwritten Nursing Observation sheets will be kept in the patient folder. Where CareNotes is installed, the observation sheets will be kept in the folder until discharge. Upon discharge, it is good practice for them to be scanned into CareNotes if it is a short admission or if a longer admission with large volumes of paper, the paper copies need to archived as per due process for archiving clinical records. (Refer to H47 Observation and Engagement).

2.3 The discharge summary of the patient's health record must be sent to the patient's GP, or to the patient's care co-ordinator in the Community Mental Health Team (as appropriate), within a locally agreed timescale (but no later than two weeks after discharge). In case of transfer the summary is sent at the time of the transfer of care to the receiving responsible clinician or consultant.

2.4 Where a patient is known to have died while in our care, the Health Record must contain copies of the notification of death to the GP and the regulatory body (e.g. CQC, HIW, HIS etc).

2.4.1 The records should demonstrate:

(a) A link between any risks that have been identified, incidents and/or problems that have arisen and the action(s) taken to rectify them (where applicable). The patient's risk assessment and care plan must be promptly reviewed and updated as required in response to any incident or near miss.
(b) Clear communication between colleagues
(c) Effective communication with a patient's family, in particular they should be informed after significant incidents and this communication should be recorded
(d) The assessment and clinical decision making process and the resulting intervention.

2.5 All nursing entries into Health Records should be made in line with 'Record keeping: Guidance for Nurses and Midwives, NMC 2015 which can be found at http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Record-Keeping-Guidance.pdf

2.6 It is recognised that certain units use handover notes/shift planners as an aide memoir to ensure that relevant information is exchanged and acted upon at shift handover and during the shift. Where handover notes/shift planners are used these should not be a unique case record but instead should be a copy of and/or reflect the contents of the patient's existing case records. Local systems should be adopted to retain the handover notes/shift planners for example scanning the documents and placing them on a shared drive. The handover notes/shift planners should be retained for a minimum period of two years

3 DATA PROTECTION

3.2 Colleagues must ensure that they comply with the principles of the Data Protection Act when performing their duties and when making entries into a Health Record. Further information on obligations under the Data Protection Act can be found in LE03 Data Protection.

3.3 The Data Protection Act 2018 gives everyone the right to apply for access to his or her personal data which is held within their health records. (Refer to section 7 - Access to Health Records)

4 LOCATION OF DOCUMENTS AND STORAGE

4.1 The primary location for Health record storage is on the electronic record system, CareNotes, where it is installed.

4.1.1 On sites where CareNotes **is installed**, although this is the primary source for all patient records, a patient folder can be set up to retain only the paper documents deemed necessary by the hospital's Clinical Governance committee. However, paper documents must be kept to a minimum and only the **latest** version must be kept in the patient folder.

4.1.2 Any documents kept on paper must be filed securely in a patient folder in sections according to the dividers, which will have been agreed by the hospital's Clinical Governance committee and used consistently across a site. (The divider template is available from the Intranet **H Form: 98A**). See **Appendix 2** for Guidance.

4.2 Where CareNotes **is not installed**, any documents will be filed securely in a patient folder in sections according to the dividers, which will have been agreed by the hospital's Clinical

Governance committee and used consistently across a site. Sites must use the agreed forms for Health Records which can be found on the Intranet.

4.3 Where CareNotes is in use all documents will be scanned into CareNotes on discharge or during the episode of care according to local procedure in accordance with a process agreed by the hospital's Clinical Governance committee. Paper records must be disposed of as confidential waste once they have been scanned into CareNotes.

4.4 All emails sent and received relating to a patient's care and treatment, to include any external referrals made, and transfer and discharge planning through to completion, are to be copied and entered contemporaneously into the patients clinical notes section of CareNotes.

4.5 The filing system for paper-held records must ensure rapid retrieval of records and prevent misfiling. It must also incorporate an effective tracing system.

4.6 All patient folders must be kept in secure controlled locations, locked rooms, locked cabinets or security protected computer systems. Areas used for the storage of paper health records must be fitted with smoke alarms.

4.7 Authorised colleagues must have 24-hour access to health records.

4.8 Electronic records must not be copied onto any other media such as CDs or memory sticks.

4.9 Each unit must identify a contingency plan for accessing electronic documents in the event of an emergency power or system failure.

4.10 **Retention Periods for Health Records -** Healthcare records should be retained for the correct periods of time according the type of patient and type of record (see **Appendix 3**). Full details of retention periods for all documents and data collected during the provision of our services are set out in LE03.1 Document and Data Retention. Please also refer to LE Form: 05 for further details.

4.11 Currently the electronic information will be held indefinitely.

5 MENTAL HEALTH ACT REQUIREMENTS

5.1 Health records for patients detained under the Mental Health Act must contain details of any legal orders, application or directions to which the patient is subject:

(a) Section papers, Renewals, Authority to Transfer, Community Treatment Orders (CTO) Recall and Revocation (if revoked), Court Orders and Restriction Orders, Guardianship and Guardianship Orders, including permission for transfer from the Secretary of State for Justice.
(b) Explanation of Patient Rights Section 132 & 130D (MHA Form: 05).
(c) Patient Record of Capacity and Consent to Treatment Interview form (MHA Form: 11).
(d) Urgent Treatment Section 62(1) and 62(2) Continuation of Treatment (MHA Forms: 06 and 07).
(e) Consent to Treatment Certificates issued by Responsible Clinician (RC) or Second Opinion Appointed Doctor (SOAD), including documentation of communication between SOAD, RC and or Professional.
(f) Review of Treatment forms Section 61 Care Quality Commission (CQC) England, Healthcare Inspectorate for Wales (HIW).
(g) Section 17 Leave of Absence from Hospital forms, including Recall from Leave where applicable, any leave granted by the Ministry of Justice.
(h) Reports and Decisions from Mental Health Tribunals and Associate Mental Health Act Managers.
(i) Absolute and Conditional Discharge in relation to Restricted Patients from the Ministry of Justice or by a Mental Health tribunal.

5.2 Notification of death of a person detained under the Mental Health Act is to be faxed or sent by secure e-mail to the regulatory body within 24 hours of death and the appropriate incident reporting process followed as per OP04 Incident Management, Investigation and Reporting.

5.3 For services working with patients detained under the Mental Health Act, all colleagues working with health records will receive specific training. For information on training availability and requirements colleagues should contact People Development, at the Central People Team.

5.4 Where services choose to scan Mental Health Act documentation into CareNotes, the originals must be kept in accordance with Appendix 3 as part of the health record. Old section 17 leave forms must be crossed through if they are no longer in date.

6 DATA ENTRY

6.1 All disciplines involved in the patient's care are required to make entries in the Health Record. On sites where CareNotes is in use all disciplines must make their entries into it. (Any handwritten documentation will be in black ink).

6.2 All entries, whether on CareNotes or on paper, will be accurate and contemporaneous (as soon as possible but within 24 hours), giving a clear account of events and the patient's treatment and must be completed in accordance with relevant professional standards.

6.3 All records are legal documents and as such professionals must use non-judgemental and non-offensive language and substantiate any remarks with supportive evidence.

6.4 Authors need to be mindful that patients are entitled to have access to their records and that (wherever possible) the language that is used should be clearly understandable to the patient. The use of jargon and abbreviations should be avoided.

6.5 CareNotes forms are set up to ensure that all entries are dated, timed and have an identifiable author. Any paper records must also have a time, a date and show the designation and initials of the author.

6.6 In CareNotes the act of 'confirming' an entry constitutes signing the entry. The author is clearly identifiable by the login used. Any records written by staff with non-confirmation access (often non-qualified staff) will be carefully checked for accuracy and countersigned on paper, or 'confirmed' on CareNotes by the professional who is responsible for supervising that person during the shift to which the note pertains. (Notes will auto highlight spelling anomalies for correction, and these should be spell checked before any clinical note is "confirmed").

6.7 Registered and 'accredited' colleagues (Nurses, Doctors, Occupational Therapists, Psychologists, Therapists etc.) are responsible for all activities they have delegated to non-registered/accredited colleague (Students, Healthcare Assistants, OT Assistants, Psychology Assistants, Gym Assistants etc.). Handwritten notes and entries into CareNotes by non-registered/accredited colleagues constitute a delegated activity and must be countersigned/confirmed on CareNotes accordingly by the qualified/accredited member of staff who delegated this activity.

6.8 As an exception to 6.6, in rehabilitation units that are staffed by non-registered staff, a clear local procedure on the process for confirming or countersigning notes must be in place, which has been approved by the overarching hospital's Clinical Governance committee and the Hospital Director of that site.

6.9 Each page or form in the record, whether hard copy or electronic, will have the patient's name clearly written on it.

6.10 **Invalid entries** - Inaccurate or incorrect notes should only be made 'Invalid' by the author. If this is not possible, the person doing so must leave an entry as to why this has happened.

6.10.1 On paper this is done by striking through the entry with a single line, so that it remains clearly visible and a note made of why it is being made 'Invalid'.

6.10.2 Caution must be exercised if a patient asks for access to their notes if third party information is visible within any 'invalid' entries. Paper copies must always be redacted (words or phrases blacked out, so they cannot be read) and checked before passing to the patient or their representative, this applies to both photocopies of paper notes and printed copies from CareNotes (refer to section 7). If information on another patient is shared by mistake, then this is an information governance breach and must be reported as an incident (Refer to OP04 Incident Management, Investigation and Reporting)

6.9.3 **NB** - Third party information such as names or initials of other patients, visitors or carers should not routinely be recorded in Health records unless there is a specific identified need to do so.

6.11 Entries in CareNotes, on paper Health Records or in reports which draws heavily on the content of another professional's work must contain an acknowledgement to the original author. The source of the information must be clearly identified including the date it was produced and for what original purpose.

6.12 Any notes about a patient, including e-mails, informal handwritten notes, and notes made at meetings, are regarded as part of a patient's record regardless of where they are kept.

6.13 Reports and forms which are attached to a patient record in CareNotes will be produced using agreed templates only. If a corporately agreed template does not exist, a local one may be used, but must be agreed by the hospital's Clinical Governance committee and the Clinical Network Professional Lead consulted to ratify or take to the wider service line Clinical Network.

6.14 Any clinical notes made on behalf of a clinician by a medical secretary must be checked and confirmed by the author. Only the original author may edit unconfirmed records in Carenotes.

6.14 Any patient attending therapy intervention at sessions or groups will require a therapy clinical note. Therapy clinical notes can be per group attendance or a summary of the day's attendance, but should be at a minimum of once per day of the patient's attendance. (For sites using CareNotes, the Clinical Note 'Category', Type' (selected from the drop down list) and 'Summary' must be completed to identify that the clinical note relates to a therapy session. If the clinical note is related to a group, the group details would be added into the Summary for example selecting Category =Therapist, Type= Therapist Group and 'Summary' free text would be entered as **Art Group Attendance**

6.15 Each therapy entry must be of high quality and sufficient detail to reflect the patient's presentation. (For example the wording 'Attended group' only is not acceptable, as this is not sufficiently informative on the patient's response to the therapy intervention).

6.16 Any urgent feedback from a patient's attendance to a therapy intervention must be documented and also verbally handed over as soon as possible to the relevant MDT members. The clinical note entry must **not** be the only method of communication in a matter of high risk or urgency.

7 ACCESS TO HEALTH RECORDS

7.1 The Data Protection Act 2018 (DPA) governs an individual's right to access documents and data which an organisation holds about them. Requests for access to the records of a deceased individual are governed by the Access to the Health Records Act 1990 (AHRA). The Freedom of Information Act 2000 (FOIA) only applies to public authorities: Priory is not considered to be a public authority so is not subject to the requirements of the FOIA.

7.2 Detailed information in relation to the DPA and access to Health Records and other documents and data by adults and children can be found in LE03 Data Protection.

7.2.1 However, where an application is made under the AHRA for the records of a deceased individual, and all the notes requested were made within the 40 days preceding the request, the timetable period for giving access will be 21 days from the date of the request. The charge for this is £10 plus printing costs. Where an application is made by an individual's personal representative or executor under this Act, access need not be granted to records created before 1st November 1991. Such notes may, however, be disclosed if access to them is necessary in order to make any part of a record which has been disclosed accessible.

7.3 All requests for access to medical records (whether made under the DPA or the AHRA) should be forwarded to the Hospital Director or the person nominated by the Hospital Director, as soon as they are received regardless of whether this is in writing or verbally. All such requests must then be notified to the central Data Protection team so that they can be logged and advice and guidance given.

8 AUDIT

8.1 CareNotes content is regularly audited remotely and a report sent to all units. The standards to be maintained for all Service Lines are as follows:

(a) Every episode must have a consultant and an ICD10 code.
(b) Every episode must have relevant outcomes measures at admission, discharge, and the appropriate interim periods.
(c) All clinical notes and confirmable documents must be confirmed by a qualified member of staff.
(d) Health records contain evidence of Physical Health monitoring.

8.1.1 **For Acute, ED and CAMHS Services:**

(a) All patients must have a minimum of two clinical notes per day (at least one per shift, day and night).
(b) All patients must have a risk assessment which is updated every seven days or more often.
(c) All patients must be offered the relevant Patient Survey on discharge.
(d) Day-patients must have one clinical note per day of attendance pertaining to therapy interventions.

8.1.2 **For Forensic Services and Rehabilitation & Recovery:**

(a) A All patients must have at least two clinical notes per day
(b) All patients in Specialist DBT Personality Disorder Services must have at least one risk assessment per month, but more often if indicated.
(c) All patients in Medium and Low Secure Forensic must have their Risk Assessment updated at least every two weeks, but more if indicated.
(d) All patients in Rehabilitation & Recovery must have their Risk Assessment updated at least every three months, but more often if indicated.

8.2 H Form 108E Documentation Quality Walk Round should be used to audit in-patient health records on a monthly basis, in addition to any locally agreed audits that may be carried out.

Arrangements should also be made at site, to audit the quality and consistency of therapy documentation across in and day patient records.

8.3 For a Health record to be used for auditing purposes, it must include written consent from the patient. (**H Form: 34 -** Consent on First Contact with Priory Services (Inpatient) **H Form: 34A -** Consent on First Contact with Priory Services - Outpatient or Day-patient)

8.4 The results of all audits will be considered by the hospital's Clinical Governance committee and learnings or actions for improvement shared with staff and progress monitored.

9 REFERENCES

9.1 Data Protection Act 2018
Health and Social Care Act 2008

9.2 CQC (2015) Specialist Mental Health Services: Provider handbook
IGA (2016) Records Management Code of Practice for Health and Social Care 2016
NMC (2015) The Code: Professional standards of practice and behaviour for nurses and midwives (updated 2018)
Scottish Government Records Management: NHS Code of Practice 2012
Welsh Assembly Government (2010) Doing Well, Doing Better: Standards for Health Services in Wales
Welsh Health Circular (2000) 71: For the Record - Managing Records in the NHS Trusts and Health Authorities

Associated forms:

H Form: 34 - Consent on First Contact with Priory Services (Inpatient)
H Form: 34A - Consent on First Contact with Priory Services (Outpatient or Daypatient)
H Form: 63 - Specimen Signature sheet
H Form: 72 - Access to Healthcare Records - Authority from Patient
H Form: 73 - Authority from responsible clinician or Consultant
H Form: 95 - Dietary Requirements
H Form 108E – Documentation Quality Walk Round
H Form: 98A - Healthcare Records Dividers Template
H Form: 121 - CareNotes Agency Username and Password
H Form: 121A - CareNotes Agency Registered Nurse Logins Record

Appendix 1 - Guidance on the use of CareNotes
Appendix 2 - Guidance on the use of Patient folders and Dividers
Appendix 3 - Retention periods for Records on Healthcare sites
Appendix 4 - CareNotes Agency Logins protocol
Appendix 5 – Good Record Keeping (May 2022)

Appendix 1

GUIDANCE ON THE USE OF HEALTHCARE CARENOTES

INTRODUCTION

There are clear instructions on the Intranet in the form of CareNotes User Guides. Sites should also have a CareNotes Champion for on-going induction and training, advice and information. Local arrangements for training new colleagues on the use of CareNotes is the responsibility of the site CareNotes Champion. Carenotes Champion/Superuser Training can also be requested via ITtraining@priorygroup.com

Carenotes eLearning video for new starters (available from April 2020) "An Introduction to Carenotes" video is available and should be published to all new starters who require access to Carenotes as part of their role. The eLearning videos can be assigned to individuals by Site Learning Administrators.

All clinical data about patients will be entered into the individual electronic patient record (EPR) on CareNotes.

Each patient may also have a folder for hard copies of certain documents which either are required to be signed by the patient or are deemed to be vital documents which could be required in an a emergency or in the event that Carenotes is unavailable. Examples would be the latest Care Plans, Missing Patient care/management plans, Advance Decisions to Refuse Life Sustaining Treatment, signed Consent forms. This list is not exhaustive.

Each patient's hard copy folder will also contain copies of statutory documents, which relate to their original detention, Ministry of Justice letters (where relevant), documents relating to treatment and Section 17 leave, and copies of relevant court/care/access orders.

NB: Looked After Children - An **Alert** must be entered onto CareNotes for any 'Looked After Children' and a copy of the Court Order (Access) is kept in the Mental Health Act administrator's office. Colleagues who are caring for the child must be aware of the conditions within the Court Order Documents relating to a change of name whilst in our care will also be scanned into CareNotes.

All referral reports/letters will be available in the electronic record added as Attachments under the Correspondence tab in Healthcare Carenotes. These will be scanned into the record as soon as it has been set up, prior to admission whenever possible.

INFORMATION ON CARENOTES

CareNotes contains:

Accurate demographic information for each patient - This is found in the 'Patient Information' tab. Also in 'Patient Information' tab are the details of all individuals who are connected with the patient's care i.e. their Team Members and Contacts. Contacts such as NOK, Nearest Relative, Care Managers/Co-ordinators etc. all should have current contact numbers, emails and addresses. This should be updated as changes occur in a timely fashion.

Outcomes Information - examples are HoNOS. These are contained in the 'Outcomes tab' in Healthcare Carenotes

Clinical Notes - these are the contemporaneous running records, to which all disciplines must contribute. In order to retrieve information and to perform audit, the Categories and Types from the look up lists should be selected by author's role and the type of entry being made. The 'Summary' field which is free text entries, must be agreed locally at each site by hospital's Clinical Governance committee and monitored to ensure compliance. These are contained in the 'Clinical Notes tab' in Healthcare Carenotes.

Risk assessments tools - All patients must have a completed Risk Screening (Traffic Light) completed on admission, at agreed intervals and when their risk changes. Some services use additional and agreed Risk Assessment tools (such as HCR20 and START). Sites have agreed standards and timescales for completion of these which are in line with commissioning requirements. These are contained in the 'Risk tab' in Healthcare Carenotes

Care Plans - These include plans for physical, mental and emotional and social issues or any others identified by the patient or their clinical team using the 4 domain headings of Keeping Healthy, Keeping Safe, Keeping Well and Keeping Connected. These are contained in the 'Care Plan tab'.

Healthcare CareNotes allows for attachments of any kind, which are relevant to the patient's record. Attachments can be added into Carenotes under the following specific tabs: **Legal tab** using the form 'Attachment Legal', under '**Assessments tab'** using Physical Health Attachment (for things such as Pathology results), **MDT tab** using 'MDT and CPA attachment', **Care Plan tab** using 'CarePlan Attachment' and **Correspondence tab** using 'Correspondence Attachment'. Attachments need to be filed in a way that allows for easy data retrieval using an appropriate title for the file uploaded and using the specific attachment under the relevant tab. Each site must have a system for titling attachments agreed via the hospital's Clinical Governance committee, which will be monitored.
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CareNotes contains standard assessment forms such as the Doctor and Nursing Assessments and Current Physical Health, which must be completed on admission. It also contains Therapy Assessments. These are located in the 'Assessment' tab-

Each site will agree locally (through the hospital's Clinical Governance committee) when documents will be scanned, either at intervals throughout the episode or on discharge. Scanned documents must be easily retrievable, so using the specific attachments under the tabs and titling them will be agreed at each site.

All electronically produced records/reports, which have not been produced within CareNotes, are saved as attachments in CareNotes using the specific Attachments form under the tabs. These reports are protected/confirmed to avoid tampering.

Carenotes is constantly being developed so over time more forms will be included within Healthcare CareNotes rather than as attachments. As changes are made this will be communicated to site Champions and Healthcare Carenotes user guides updated on the intranet as appropriate.

Site superusers and the CareNotes Champions are the first port of call for colleagues with CareNotes queries. Communications regarding any changes are sent out from IT Systems Specialist to the CareNotes Champions to cascade to users on their sites.

Appendix 2

GUIDANCE ON THE USE OF PATIENT FOLDERS AND DIVIDERS

For sites without CareNotes installed:

All documents must be filed securely in one robust folder, and the folders kept in a locked location.

The Dividers (see Table A) can be tailored for each site by adding details into the list of example documents. The list of what is necessary to keep in hard copy must be agreed by the hospital's Clinical Governance committee and the dividers amended accordingly.

For sites with CareNotes installed:

The **primary** source of Patient Information is CareNotes; therefore a **minimum** of paperwork is to be kept in hard copy in the Patient folder.

Only documents as agreed by the hospital's Clinical Governance committee should be kept in hard copy. Best practice is for documents to be scanned into CareNotes as quickly as possible, so that they are available to all colleagues across the hospital at the same time.

Documents must be scanned into CareNotes, following a procedure agreed by the hospital's Clinical Governance committee.

The Dividers (see Table A) can be tailored for each site by adding details into the list of documents. This list must be agreed as necessary to keep in hard copy by the hospital's Clinical Governance committee.

Table A below is a list of documents that sites may consider to keep in hard copy and in which section.

Only **one** version of a document should be kept in the patient folder and that MUST be the latest version. Once an updated version is placed in the folder, the old version must be disposed of as confidential waste. Old Section 17 leave forms must be crossed through if they are no longer in date.

Once a document has been scanned into CareNotes and the paper version must immediately be disposed of as confidential waste.

External regulatory inspectors must be accompanied when viewing patient's records on CareNotes, not only so that they can be assisted with finding their way round the record, but also to ensure confidentiality.

Table A - Examples of Contents for Patient Folders sections:

	Sites **WITH** CareNotes	Sites **WITHOUT** CareNotes
Section 1 - Admission/ Assessments	Admission Checklist Specimen Signature sheet (H Form: 63) **Patient Data sheet (printed from CareNotes) needs adding to new Healthcare CareNotes** Signed Property list Signed consent forms	Pre-Admission Assessments Admission Assessments Financial Assessment My Life Story Patient Choice information: E.g. Food Preferences If I Am Sick and I die Advance Directive for dealing with Challenging Behaviour Dates that are Important to me
Section 2 - Legal Documents	Copies of MHA documentation (Originals should be in the MHA office) Copy of Court Order (access, parental responsibility etc.) Section 17 Leave (MHA Form:01) Evidence of being advised of Rights (MHA Form:05) Any relevant Ministry of Justice documents DoLs Authorisations	Copies of MHA documentation (Originals should be in the MHA office) Copy of Court Order (access, parental responsibility etc.) Section 17 Leave (MHA Form:01) Evidence of being advised of Rights (MHA Form:05) Any relevant Ministry of Justice documents DoLs Authorisations
Section 3 - Correspondence	Referral letter Pre-admission report, GP letters Letters from solicitors External appointments e.g. Dentist, Physiotherapist	Voting Arrangements Any Non-clinical Correspondence
Section 4 - Care & Risk Planning	Latest active Care Plans Advance Directives (OP Form: 03) Standard Menus and Menu plans NG Feeding charts and associated checklists Personal Emergency Evacuation plan (H&S Form: 70)	Care Plans Care Plan Evaluations Risk Assessments/Management plans Activity Timetables Latest MDT reviews Latest CPA reviews
Section 5 - Medical Investigations/ Physical Health	Any test results – Bloods, Pathology, Psychotropic monitoring Completed MAR sheets Assessments that are not on CareNotes e.g. Becks, GAF	Results of any tests Annual Health Check reports Epilepsy plan of care Outcomes of External appointments
Section 6 - Observation / Clinical Notes	Copies of Nursing Observation sheets (H Form: 99A,99B, & 99C) Seclusion Reviews (H Forms:74A,74B & 74C)	Observation Sheets Clinical/Progress Notes

Appendix 3

RETENTION PERIODS FOR RECORDS ON HEALTHCARE SITES

RECORD	APPLIES TO	RETENTION PERIOD	ACTION REQUIRED AT THE END OF THE ADMINISTRATIVE LIFE OF THE RECORD	SOURCE
Admission books (where they exist in paper format)	England	8 years after the last entry	Likely to have archival value	DH, Records Management NHS Code of Practice, 2009
	Scotland	8 years after the last entry	Likely to have archival value	Scottish Government, Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012
	Wales	Local decisions should be made with regard to the permanent preservation of these records, in consultation with relevant health professionals and places of deposit		WHC (2000) 71: For the Record - Managing Records in the NHS Trusts and Health Authorities
Adults - Mental Health Records (Records of Mentally disordered persons within the meaning of the Mental Health Act)	England	20 years after the date of last contact between patient and any health/care professional employed by the mental health provider, or 8 years after the death of the patient if sooner The records of all mentally disordered persons (within the meaning of the MH Act) are to be retained for a minimum of 20 years irrespective of discipline e.g. Occupational Therapy, Speech & Language Therapy, Physiotherapy, etc. Social services records are retained for a longer period.	When the records come to the end of their retention period, they must be reviewed and not automatically destroyed. Such a review should take into account any genetic implications of the patient's illness. If it is decided to retain the records, they should be subject to regular review	Mental Health Act 1983 and its successors Royal College of Psychiatrists DH, Records Management NHS Code of Practice, 2009
	Wales	20 years after no further treatment considered necessary; or 8 years after the patient's death if patient died while still receiving treatment.	Destroy under confidential conditions	WHC (2000) 71: For the Record - Managing Records in the NHS Trusts and Health Authorities
	Scotland	20 years after date of last contact between the patient and any health/care professional employed by the mental health provider, or 3 years after the death of the patient if sooner and the patient died while in the care of the organisation.	When the records come to the end of their retention period, they must be reviewed and not automatically destroyed. Such a review should take into account any genetic implications of the patient's illness. If it is decided to retain the records, they should be subject to regular review	Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012
Child & Adolescent - Mental Health Records	England	20 years from the date of last contact, or until their 25th/26th birthday, whichever is the longer period. Retention period for records of deceased persons is 8 years after death.	Destroy under confidential conditions	DH, Records Management NHS Code of Practice, 2009

RECORD	APPLIES TO	RETENTION PERIOD	ACTION REQUIRED AT THE END OF THE ADMINISTRATIVE LIFE OF THE RECORD	SOURCE
(includes clinical psychology records)	Wales	Until the patient's 25th birthday, or 26th if young person was 17 at conclusion of treatment; or 8 years after patient's death if death occurred before 18th birthday.	Destroy under confidential conditions	WHC (2000) 71: For the Record - Managing Records in the NHS Trusts and Health Authorities
	Scotland	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 3 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain for a longer period.	Destroy under confidential conditions	Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012
Records relating to the Safeguarding/Child Protection Register	England	Retain until the patient's 26th birthday or 8 years after the patient's death if patient died while in the care of the organisation	Destroy under confidential conditions	DH, Records Management NHS Code of Practice, 2009
	Scotland	Retain until the patient's 26th birthday.	Destroy under confidential conditions	Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012
Clinical audit records	England and Wales	5 years	Destroy under confidential conditions	DH, Records Management NHS Code of Practice, 2009
	Scotland	5 years	Destroy under confidential conditions	Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012
Controlled drug documentation	England	Requisitions – 2 years Registers and CDRBs – 2 years from last entry Extemporaneous preparation worksheets – 13 years Aseptic worksheets (adult) – 13 years Aseptic worksheets (paediatric) – 26 years External orders and delivery notes – 2 years Prescriptions (inpatients) – 2 years Prescriptions (outpatients) – 2 years Clinical trials 5 years minimum (may be longer for some trials) Destruction of CDs – 7 years	Destroy under confidential conditions	Misuse of Drugs Act 1971 Misuse of Drugs Regulations 2001 DH, Safer management of controlled drugs: a guide to good practice in secondary care (England), 2007 DH, Records Management NHS Code of Practice, 2009
Death – Cause of, Certificate counterfoils	England and Wales	2 years	Destroy under confidential conditions	DH, Records Management NHS Code of Practice, 2009
	Scotland	2 years	Destroy under confidential conditions	Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012
Death registers – i.e. register of deaths kept by the hospital, where they exist in paper format	England	Lists sent to GRO on a monthly basis. Retain for 2 years. Death registers prior to lists sent to GRO – offer to Place of Deposit.	Likely to have archival value	DH, Records Management NHS Code of Practice, 2009

RECORD	APPLIES TO	RETENTION PERIOD	ACTION REQUIRED AT THE END OF THE ADMINISTRATIVE LIFE OF THE RECORD	SOURCE
	Wales	Local decisions should be made with regard to the permanent preservation of these records, in consultation with the relevant health professionals and places of deposit		WHC (2000) 71: For the Record - Managing Records in the NHS Trusts and Health Authorities
	Scotland	2 years	Likely to have archival value	Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012
Discharge books (where they exist in paper format)	England	8 years after the last entry	Likely to have archival value	DH, Records Management NHS Code of Practice, 2009
	Scotland	8 years after the last entry	Likely to have archival value	Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012
	Wales	Local decisions should be made with regard to the permanent preservation of these records, in consultation with relevant health professionals and places of deposit.		WHC (2000) 71: For the Record - Managing Records in the NHS Trusts and Health Authorities
Duty rosters	England	4 years after the year to which they relate	Destroy under confidential conditions	CQC Essential Standards of Quality and Safety 2010
	Wales	2 years	Destroy under confidential conditions	WHC (2000) 71: For the Record - Managing Records in the NHS Trusts and Health Authorities
General operating procedures	England	Retain the current version and previous version for three years		CQC Essential Standards of Quality and Safety 2010
Handover Notes or Shift Planners if used	England, Wales and Scotland	Local systems should be adopted to retain the handover notes/shift planners for a minimum period of two years	Destroy under confidential conditions	Priory
Homicide/'serious incident' records	England	30 years	Destroy under confidential conditions	DH, Records Management NHS Code of Practice, 2009
	Scotland	30 years	Destroy under confidential conditions	Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012
	Wales	The documents must be considered for permanent preservation and the advice of the chief archivist of an appropriate place of deposit obtained.		WHC (2000) 71: For the Record - Managing Records in the NHS Trusts and Health Authorities
Hospital records (i.e. other non-specific, secondary care records that are not listed elsewhere in this schedule)	England	8 years after conclusion of treatment or death.	Destroy under confidential conditions	DH, Records Management NHS Code of Practice, 2009

RECORD	APPLIES TO	RETENTION PERIOD	ACTION REQUIRED AT THE END OF THE ADMINISTRATIVE LIFE OF THE RECORD	SOURCE
Incidents, events or occurrences that require notification to the Care Quality Commission	England	3 years	Destroy under confidential conditions	CQC Essential Standards of Quality and Safety 2010
Psychology records	England	20 years or 8 years after death if patient died while in the care of the organisation.	Destroy under confidential conditions	DH, Records Management NHS Code of Practice, 2009
	Scotland	30 years	Destroy under confidential conditions	Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012
	Wales	20 years or 8 years after death if patient died while in the care of the organisation.	Destroy under confidential conditions	DH, Records Management NHS Code of Practice, 2009
Psychotherapy Records	England	20 years or 8 years after the patient's death if patient died while in the care of the organisation.	Destroy under confidential conditions	Guidance for best practice: the employment of counsellors and psychotherapists in the NHS, British Association for Counselling and Psychotherapy (BACP) 2004 DH, Records Management NHS Code of Practice, 2009
Record of patients Money or valuables deposited for safe keeping	England	3 years	Destroy under confidential conditions	CQC Essential Standards of Quality and Safety 2010
Records of destruction of individual health records (case notes) and other health related records contained in this retention schedule (in manual or computer format)	England	Permanently		BS ISO 15489 (section 9.10)
	Scotland	Permanently		Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012
Records/documents related to any litigation	England	As advised by the organisation's legal advisor. All records to be reviewed. Normal review 10 years after the file is closed.	Destroy under confidential conditions	DH, Records Management NHS Code of Practice, 2009
	Scotland	As advised by the organisation's legal advisor. All records to be reviewed.	Destroy under confidential conditions	Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012

RECORD	APPLIES TO	RETENTION PERIOD	ACTION REQUIRED AT THE END OF THE ADMINISTRATIVE LIFE OF THE RECORD	SOURCE
Suicide – notes of patients having committed suicide	England	10 years	Destroy under confidential conditions	DH, Records Management NHS Code of Practice, 2009
Video records/voice recordings (clinician to patient)	Scotland	6 years subject to the following exceptions: Children and Young People: records must be kept until the patient's 25th birthday, if the patient was 17 at the conclusion of treatment until their 26th birthday, or until 3 years after the patient's death if sooner. Mentally disordered persons: records should be kept for 20 years after the date of last contact between patient and any healthcare professional or 3 years after the patient's death if sooner.	Destroy under confidential conditions	Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012
	England and Wales	8 years subject to the following exceptions or where there is a specific statutory obligation to retain records for longer periods.	The teaching and historical value of such recordings should be considered, especially where innovative procedures or unusual conditions are involved. Video/video-conferencing records should be either permanently archived or permanently destroyed by shredding or incineration(having due regard to the need to maintain patient confidentiality)	DH, Records Management NHS Code of Practice, 2009
Ward registers, including daily bed returns (where they exist in paper format)	England	2 years after the year to which they relate.	Likely to have archival value	DH, Records Management NHS Code of Practice, 2009
	Scotland	2 years after the year to which they relate.	Likely to have archival value	Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012
	Wales	Local decisions should be made with regard to the permanent preservation of these records, in consultation with relevant health professionals and places of deposit.		WHC (2000) 71: For the Record - Managing Records in the NHS Trusts and Health Authorities

NB: Whilst the Independent Inquiry into Child Sexual Abuse (IICSA) is ongoing, examining the extent to which institutions and organisations in England and Wales have taken seriously their responsibility to protect children, Priory will comply with the chairperson's request for organisations not to destroy any historical patient records in case they are required as evidence by the inquiry. However, the correct retention period should still be included in the information for the external Archive provider.

Appendix 4

CARENOTES AGENCY LOGINS PROTOCOL

1 BACKGROUND

1.1 Priory's use of agency colleagues on the wards requires the temporary registered nursing colleagues to have access to CareNotes to enable note entry, review existing risk assessments/care plans and other functions to ensure that colleagues on duty are able to have access to the patient record so they can fulfil their duties in terms of knowing information about the patient and being able to record new information about the patient. This is to ensure professional accountability, good governance and continuity of care.

2 FORMAT AND PRODUCTION OF PASSWORDS AND USER ACCOUNTS

2.1 The IT department will be responsible for the production of the user accounts and passwords.

2.2 (a) Naming Convention
(i) CCCONF1 - Confirmation Level for Registered Nurses
(ii) CCCONF2 - Confirmation Level for Registered Nurses
(CC is the site name abbreviation)
(b) Usernames and passwords for these accounts will be sent to the site to distribute via a spreadsheet in a secure network folder.
(c) Passwords will be reset and an email sent to the site HD and CSM every 2 weeks to advise this has been done.
(d) Agency Registered Nurses will log on to the computer with a new restricted access network account with the username and password being the same as detailed above.

3 HOSPITAL PROCEDURE

3.1 (a) The site will confirm to the Help Desk who requires access to the network folder.
(b) The site will be responsible for monitoring the accounts, including who has been issued with the login details and capturing the dates and times. The CareNotes Agency Registered Nurse Login Tracker needs to be used for this as an overarching overview and saved in a shared folder. It must be available for audit purposes.
(c) The agency registered nurse should acknowledge receipt of the login details by signing the CareNotes Agency Username and Password form. These forms should be retained in a designated folder.
(d) All logins are confidential and remain the responsibility of the agency registered nurse that they are allocated to. The login details should be returned to the nurse in charge at the end of the shift and destroyed unless a block booked/locum nurse. Safe return of these details should be noted on the CareNotes Agency Username and Password form.
(e) Agency registered nurses should add their name to any entries made on CareNotes.

4 INFORMATION SECURITY AND AUDITING

4.1 (a) The ultimate responsibility for the security of the information lies with the site and the site needs to be satisfied that the logins are not being used inappropriately. This may be achieved by use of walk rounds, monitoring compliance with the IT Security Policy etc.
(b) Reports are available to enable cross checking of the logins and should be used as part of a regular usage audit.

4.2 **The reports are available by copying the links below into the Citrix Priory Reports address bar or they can be found in the CareNotes folder.**
(a) Report to show individual logins by date range
http://sql-phc-cl/reports/report/Carenotes/Agency%20User%20Account%20Logons
(b) Report to show total usage by login, and date of last password change
http://sql-phc-cl/reports/report/Carenotes/Agency%20User%20Account%20Summary

The Help Desk will arrange access as required.

Appendix 5

Accurate and Timely Record Keeping

Record-keeping is an integral part of our practice and is essential to the provision of safe and effective care.

Records are a way of demonstrating that we are working co-operatively with our patients, that we are taking into account their needs and addressing risk. High quality daily records, risk assessments and care plans are evidence of compassionate care based on the patient's needs. They also help us to deliver care consistently which then reduces the risk of incidents and complaints.

Remember …
Records are usually called as evidence as part of:

- Coroners' inquests and criminal proceedings
- Hearings conducted by professional organisations e.g. the Nursing and Midwifery Council
- An internal investigation into an incident or complaint
- Staff disciplinary investigations

Good record keeping shows how decisions related to care were made while poor record keeping increases the risk of harm when making decisions. Good record keeping provides evidence if the standard of your care is ever questioned.

Accurate and Timely Record Keeping: The 12 Must Do's

1. All entries in a record must be recorded, wherever possible, with the **involvement** of the patient and written in **clear** and **understandable** language.
2. Records must be **accurate** and written in such a way that the meaning is **clear**.
3. Records must demonstrate a **full account** of the intervention and the care planned and provided and the actions taken including information shared with others.
4. The content of the daily care record **must correspond** with the content of the handover record. This will ensure consistency and reduce uncertainty.
5. All entries in a record must be **dated** (to include date/month/year), **timed** accurately and **clearly signed**.
6. All entries in a record must be recorded **as soon as possible** after an event has occurred, providing current information on the care and condition of the patient.
7. Records must outline any **risks** identified and/or **problems** that have arisen and the **action** taken to rectify them. Be mindful that the patient's risk assessment and care plan must be promptly updated in response to any incident or near miss.
8. Double-check you're saving notes into the correct patient record, especially when there's another patient with the same surname.
9. **Abbreviations, jargon, meaningless phrases** or **offensive statements** must not be included in any records.
10. Records must **never** be falsified.
11. Cutting and pasting from other records (another patient's records or the patient's own records) is not permitted.
12. You have a **duty** to keep up to date with, and adhere to, relevant legislation, case law and national and local policies relating to information and record keeping.