NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Records Management Policy – Practice Guidance Notes Record Keeping Standards – V03		
V03 Date issued **Issue 1 – May 16** **Issue 2 – Sep 17**	**Planned review** **May 2019**	**RM-PGN-02** Part of NTW(O)09 Management of Records
Author/Designation	**Angela Faill - Head of Information Governance and Medico Legal**	
Responsible Officer / Designation	**Darren McKenna – Director of Informatics**	

Contents

Appendices				
Appendix No:	**Description**	**Issue**	**Issue Date**	**Review Date**
Appendix 1	Relevant Policies	2	Sep 17	May 19
Appendix 2	Key Standards and the RiO support file	2	Sep 17	May 19
Appendix 3	Shredding documents that have been scanned	2	Sep 17	May 19
Appendix 4	Scanning Guide	2	Sep 17	May 19
Appendix 5	Importance of contracting monitoring and performance reporting	2	Sep 17	May 19

1 INTRODUCTION

1.1 This practice guidance note (PGN) has been produced for all staff who record in healthcare/clinical care records within and out of hours.

1.2 This practice guidance note summarises over-arching strands of guidance and sets Northumberland, Tyne and Wear NHS Foundation Trust (the Trust/NTW) record keeping standards within this context. This practice guidance note should be viewed as informing best practice and as a contribution to the continuing development of Trust policy in this area and may be supplemented by additional guidance in relation to locally agreed protocols and relevant CQUIN requirements as they occur.

2 GUIDELINES FOR RECORDS AND RECORD KEEPING

2.1 Professional standards/Guidelines for Records and Record Keeping should be regarded as providing the core guidance for professionals on this area. All healthcare professionals should possess and be familiar with the content of their professional bodies' standards

2.2 It is neither feasible nor desirable to attempt a summary of the detailed guidance contained within all of the separate professionals' standards, therefore this PGN is designed to be compatible with the General Medical Council (GMC), Nursing Midwifery Council (NMC), Health Care Professions Council (HCPC) and The British Psychological Society guidelines and should be viewed in conjunction with them.

2.3 All Professionals must exercise their professional responsibility with regard to record keeping. This is the case whether they are keeping paper or electronic formats or using both in parallel.

2.4 Health records are legal documents recording what is the intended and actual care and treatment of a service user. Record keeping is an integral part of practice and good record keeping is the mark of a safe and skilled practitioner.

- **"Poor records mean poor defence, no records means no defence"**

- Also refer to **NTW(O)09 – Records Management Policy** and associated PGNs

2.5 Health records are created to ensure that information is available within the Trust to support:

- the care process and continuity of care
- day to day business which underpins delivery of care
- evidence-based practice
- sound administrative and managerial decision-making
- improvements in clinical effectiveness through research

- whenever, and wherever there is a justified need for information, and in whatever media it is required

2.6 In addition to ensuring continuity of care, complete, accurate and timely records allow a clear picture of events to be obtained which is imperative for managing claims and complaints, and for auditing practice and remaining proactive.

2.7 Records are valuable because of the information they contain. Information is only usable if it is correctly and legibly recorded in the first place, is then kept up to date, and is easily accessible when required.

2.8 It is the responsibility of all Managers/Clinical Staff within the Trust to ensure that staff within their remit who have any involvement with healthcare/clinical care records are made aware of and fully understand the content of the records management policy and Practice Guidance notes.

2.9 **General healthcare/clinical care record keeping standards – 'one patient, one multidisciplinary record'**

2.9.1 The purpose of a clinical record is to facilitate the care, treatment and support of a particular service user. Service user records should:

- Be factual, consistent and accurate
- Be contemporaneous - written as soon as possible after an event has occurred, providing current information on the care and treatment of the service user (if the date and time of the event differs from that when the records are written up, this must be clearly noted under the signature, printed name and position/grade) - **Please see** Minimum Standards for Electronic Clinical Record Keeping, page 5
- Provide evidence of clinical assessment and formulation, care planned, implementation and evaluation of the care delivered and information shared
- Be relevant and useful
- Identify any problems that have arisen and the action taken to rectify them
- Be consecutive, with no gaps in the text
- Be written, wherever possible, with the involvement of the service user or carer and in terms that the service user or carer will be able to understand
- Provide evidence of actions agreed with the service user (including consent to treatment and/or consent to share information)

- Be accurately dated, timed and signed along with the author's printed name (not just signature). These details must be entered underneath each record entry in the paper case records. N.B. When using the electronic record the entry will be attributed to the login therefore the name and designation of the person making the entry will be stamped onto the electronic record and validation of the entry is the equivalent of a 'sign off '/signature. The date entered must be the date of the clinical activity

- The use of abbreviations in clinical records must be avoided however if absolutely necessary then the first use should be followed by the full word/ term in brackets

- Be written clearly, legibly and in such a manner that they cannot be erased

- Be readable on any photocopies and/or scanned copies on the electronic record

- Be written in legible **black** ink only if using paper documents

- Erasers, liquid paper, or any other obliterating agents must not be used to cancel errors on paper documents. A single line must be used to cross out and cancel mistakes or errors and this must be signed and dated by the person who has made the amendment. In the electronic patient record (RiO) this is achieved using the **entered in error** functionality in progress notes

- Be bound and stored so that loss of documents when using a paper records is prevented (poly pockets are **not** permitted. Snopake Polyfile ring binder wallets stock requisition code WXH165 and secure store envelopes may be used)

and include

- Medical observations: examinations, tests, diagnoses

- Prognoses, medication prescribed, any other treatments

- Relevant disclosures by the service user – pertinent to understanding cause or affecting cure/treatment

- Relevant information from carers / family members

- Facts presented to the service user

- Correspondence from the service user or other parties including minutes and reports from professionals or other parties in relation to safeguarding and MAPPA arrangements

2.10 **These standards are used when clinical records are audited**

2.11 **Service user records must not include**

- Unnecessary abbreviations, jargon, meaningless phrases, irrelevant speculation and subjective statements. Teams need to be aware that shorthand phases that are understood within the team are often meaningless or open to different interpretations by other clinicians. Examples of these are
    - "Able to guarantee own safety"
    - "Has been very settled this am"
    - "Low threshold for admission"
- Latin abbreviations such as od, bd, tds, qds must be avoided. Frequency of medication dosing should be written in full plain English (e.g. twice daily)
- Personal opinions regarding the service user/client (restrict to professional judgments on clinical matters)
- The name(s) of third parties involved in a serious incident. Such names must be included when completing the electronic incident report for cross-referencing. (The 3rd party should be referred to in the records by use of the Trust/NHS number)
- Correspondence generated from legal papers, complaints and claims and incidents
- Email correspondence between clinicians not directly related to the patient's care and treatment e.g. arranging meetings, asking a clinician to call another professional.

3 MINIMUM STANDARDS FOR ELECTRONIC CLINICAL RECORD KEEPING

3.1 **In Community/Outpatient Settings (see flow chart)**

- Entries in the electronic patient record (RiO) should be made as soon as possible, but in the event RIO cannot be accessed, a handwritten aide memoire must be written on the same day as the patient is seen. This entry must then be transferred into the electronic patient record (RIO) NO LATER than three working days UNLESS:
- Any instance of risk or concern, in which case the entry should be made as soon as practicable and on the same day as the patient is seen and consideration should be given to use the urgent entry process

3.2 In Inpatient /Crisis team Setting

- Entries into the electronic patient record (RiO) should be made as soon as possible, NO LATER than the end of shift UNLESS:

- Any instance of risk or concern, in which case the entry should be made as soon as practicable **but** no later than the minimum standard stated above and consideration should be given to use the urgent entry process

3.3 Urgent Entry to RiO

- Where clinical judgment indicates that there is the need to update the record urgently and where there is no immediate access to RiO available, entry must be made by another member of NTW staff in an un-validated progress note with originator on the note changed as appropriate. Each team must ensure this facility is in place within their team, e.g. through duty system or administrator arrangements. These entries must be made immediately onto the electronic patient record (RiO)

3.4 Unvalidated Progress Notes

- When an entry is made on RiO, it should be validated in the timescales described for each area of service delivery

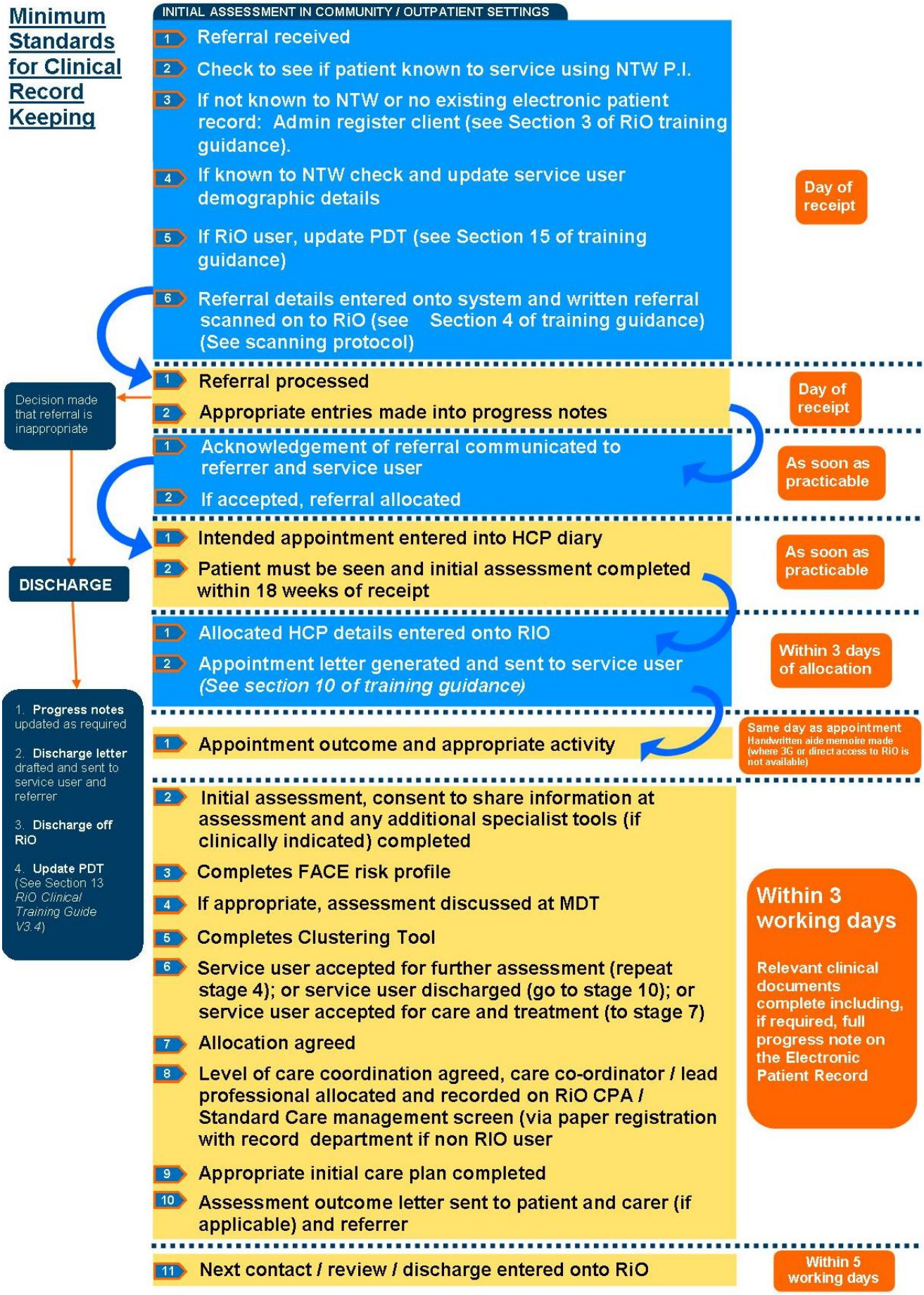
- It is a professional responsibility to ensure all progress notes are validated, including entries made by unqualified staff as soon as practicable **but** no later than the minimum standard stated for each area of service delivery

- Validation is the electronic signature that indicates the entry is appropriate

3.5 Dates and Times on RiO Entries

- When entering into progress notes or clinical forms, the date entered should be the date of the activity or contact, NOT the date of entry to RiO which is automatically done by the system

Minimum Standards for Clinical Record Keeping



4 CREATING AN ELECTRONIC PATIENT RECORD

4.1 The NTW Patient Index and Patient Document Tracking (PDT) must be searched for any previous history/previous health records. This has information from RiO and all legacy/Trust related systems.

4.2 Historic/previous paper records must be retrieved.

4.3 The NHS defines the following fields as mandatory in creating a new electronic record

- Name
- Date of Birth
- Ethnicity
- Postcode
- NHS Number
- GP
- Marital Status

4.4 Either on referral to the service, when the referral is uploaded, or on the first clinical entry for each patient on RiO, PDT will automatically record that there is an electronic file for the patient

4.5 The principle of the electronic record is that the progress notes are the place where all activity/recording in relation to a patients care are documented. This often will be a brief entry that references a document or another section of RiO has been completed or that Mental Health Act or Mental Capacity Act forms have been completed.

4.6 For further guidance please see **MR-PGN-03** – Tracking and Tracing, which sits with NTW(O)09 – Records Management Policy.

5 ADDING A REFERRAL

5.1 When recording a referral on RiO, the referral date is the date recorded on the referral, not the date entered on RiO or the date received

6 REGISTERING AN ADMISSION

6.1 The admission date and time should be recorded as the date and time the service user was admitted to the ward, and not clicked as the date and time the admission was entered on RiO

7 ENTERING INTO PROGRESS NOTES

7.1 Progress Notes must be used by all Health Care Professional as a record of all activities/interventions in relation to the service user's care and treatment. The date and time of the event must be entered, not the date and time of the entry of this information in the electronic record

7.2 If entering information into the electronic patient record **(**RiO) on behalf of someone else, their name must be entered into the Originator box (for further information see RiO training materials)

7.3 The spellchecker is recommended to be used prior to Validation.

7.4 The outcome of discussions about individual patients at team meetings should go into their electronic record (RiO) as a progress note.

7.5 It is an organisational requirement that all clinical staff who are working with a child (or their family) who has a Child Protection Plan receive a minimum of 6 monthly safeguarding supervision. The clinician is to record in the service user's health records that safeguarding supervision has taken place, including the name of the supervisor.

7.6 In addition to acting as a record of ongoing care and treatment, the progress notes should also be an index of all information entered into all parts of RiO. A short note should be made on RiO to reference when other documents are entered or edited for example:

- Assessments
- Consent to share information forms
- Risk Assessments
- Care Plans
- Reviews/MDT Reviews
- Any specialist assessments or tools
- Medication updates/changes

7.7 This note should, as a minimum, comprise of the standard entry

- Please see <form name> entered <date> in <appropriate folder> or Medication changes made on <date> - please see <medication name> OR on Kardex held in <file details>

7.8 A hyperlink has been added to the bottom of all RiO forms to enable faster access to enter progress notes

7.9 To add a Progress Note to the Risk History

- If you add a note as a risk item (using the risk event tick box on progress notes screen), consider if the risk assessment should be reviewed and amended

7.10 To add a Progress Note as a Significant Event

7.10.1 A significant event should be agreed by the clinical team – this should be agreed by the care team as a significance of the entry is dependant on each individual service user

7.10.2 You add a note as a significant event using the significant event tick box on progress notes screen

7.10.3 If information on a progress note has been entered and validated in error:

- Click 'amend'
- Select 'entered in error' (at the bottom left hand corner). A red line will go through the content but it will remain visible on screen. No information is deleted from the system
- Create new entry to explain error and add correct information

8 GUIDELINES FOR VALIDATION

8.1 Validation is confirmation that an entry is of an appropriate quality and standard, consistently fulfilling the Trusts and legislative bodies' requirements.

8.2 Validation is the equivalent of a signature. Any clinical entry in a record is a vital source of information and it is imperative that recording of the information is **accurate, relevant, complete and contemporaneous**.

8.3 Where validation is carried out by someone other than the person who made the entry, it is an indication that the validator was eligible to delegate the work. Validation in this instance is **not** an indication that the content is accurate but confirms that the entry has been checked and is of an appropriate standard.

8.4 Clinical entries should be validated by a registered member of staff or by unregistered staff that have had a clinical task delegated to them.

8.5 When delegating tasks to an unregistered member of staff, the supervisor/ responsible clinician must ensure competency of the individual to both carry out the task and make a clinical entry in the record in line with professional regulatory bodies requirements.

8.6 Registered staff refers to all employees who are required to be registered with any of the following regulatory bodies to practice:

- The General Medical Council (GMC)

- Nursing and Midwifery Council (NMC)
- Health Care Professions Council (HCPC)
- The General Pharmaceutical Council (GPhC)
- In line with NTW(HR)03 – Professional Registration Policy

8.7 It is neither feasible nor desirable to attempt a summary of the detailed guidance contained within all the separate professional standards. This standard is designed to be compatible with the regulatory bodies listed above and should be viewed in conjunction with them.

8.8 All staff whether registered and/or unregistered should work within their scope of competence. Where work has been delegated to someone who is both competent to carry out the work and competent to write it up, validation of the clinical entry is not necessary. This will be monitored, reviewed and documented against both Trust and professional standards where appropriate. This will be done at least annually through the KSF Core Dimension 1 Communication as well as through clinical supervision, observation and audit.

8.9 Staff who are registered/unregistered are deemed competent to validate notes. Where this is not the case either due to professional requirements or identified poor practice then IT should be contacted and the right to validate notes removed for that named individual.

8.10 Unregistered staff on inpatient wards must have their entry validated this is equivalent to a counter signature as required by NMC.

8.11 All staff are accountable for their own practice but also to their operational line manager and ultimately the Trust; whether the member of staff is “Registered” or not, accountability remains the same.

8.12 Administrative staff have validation rights as they make non clinical entries in accordance with Trust’s NTW(O)09 – Records Management policy.

8.13 **Where an entry is made on behalf of a clinician in the notes, the clinician should be noted as the originator and the notes should be validated in line with the Clinical Standards for Record keeping timescales.**

8.14 Where an entry is made on behalf of the clinical team e.g. administrator recording MDT/review this should be validated by an agreed member of the clinical team.

8.15 Staff who are not working within or are not supervised by a regulated professional have validation rights but are required to make entries in accordance with Trust’s NTW(O)09 - Records Management Policy, and adherence to these standards should be monitored through line management routes outlined above.

8.16 **Staff without Validation Rights**

8.16.1 Staff who do NOT have validation rights

- Students

- Unregistered staff on inpatient wards
- Staff with an agreed professional action plan/order fitness to practice
- Staff on HCPC return to practice

8.17 Validation of notes written by these individuals will be the responsibility of the qualified member of staff who delegated the task/supervisor/line manager.

8.18 **NB** Where validation of an entry is required; the notes should be validated in line with the Clinical Standards for Record keeping timescales. Validation timescales within Community services should be as soon as possible but within the timescales identified within Trust's, NTW(C)31 - Clinical Supervision and Peer Review Policy, within one calendar month.

8.19 Prior to validating the notes, the content must be checked to ensure that it meets the both professional and Trust record keeping standards.

8.20 The qualified member of staff/supervisor/line manager who validates the entry is accountable for the content of the progress note.

8.21 Notes that have not been validated must only be changed/amended by the originator, i.e. where a qualified/supervisor/line manager has concerns regarding an entry they must ensure that the originator amends the information prior to validating it.

9 RECORDING OF MESSAGES THAT ADMINISTRATORS TAKE FOR CLINICIANS

9.1 If the telephone contact with the service users or carer relates to simple message needing to be passed to a clinician, e.g. cancelling/rearranging an appointment, this should be communicated to the clinician via an email or message on mobile phone and not recorded on RiO progress notes. Administrators of course can update the appointment screen as required.

9.2 If the telephone contact with the service users or carer relates to the service user's current presentation/situation then administrators should enter the information provided and by whom into RiO progress notes, and also communicate to the clinician via an email or message on mobile phone that a significant call relating to the patient has been entered.

9.3 An entry into RiO does not equal communication.

10 MEDICATION

10.1 The purpose of the medication page is to have one page on the electronic patient record (RiO) to give a list of medication at key points in in the patient's care and treatment in one easily accessible place.

10.2 Once past initial assessment/first contact, it is the responsibility of any NTW prescriber to ensure this is kept up to date at key time points. These are:

- assessment
- admission to an inpatient unit
- discharge from an inpatient unit
- Care Co-ordination review
- transfer between NTW services
- discharge from all NTW services

10.3 This is not a prescription; this is a record of the medication. If prescriber is non-NTW, then it would be Care Coordinator's/Lead Professional's responsibility to keep up to date when information is available (even if info is scant).

10.4 Medication at inpatient discharge (transfer) needs to be completed by medical staff/pharmacy/nurse prescriber. Nurses/other therapists are not allowed to transcribe medication information from the Kardex unless by local agreement.

10.5 The general principle applies that when an entry is made into the medication page of RiO, an accompanying progress note is made to describe when and where information has been updated. All medication changes at key points should be documented using the following format in progress notes. Medication changes made on date - please see medication page.

10.6 The link to the medication form within the care co-ordination assessment document should be used to record a complete list of all medication taken at the time of assessment.

10.7 When admitting to an inpatient area, the details should be entered in the medication page and this referenced in progress notes. Medicines reconciliation guidelines should be followed when detailing a patient's medication upon admission.

10.8 For inpatients, the Kardex will be amended to reflect medication changes.

10.9 At the point of discharge, what medication the patient was discharged on must be recorded on the medication page, so as to make determining changes to treatment made during the admission easier. This will also serve as a reference for outpatient teams taking over the care in the community and will reduce the risk of errors being made in prescribing discontinued treatment post-discharge.

10.10 Ensuring this information is entered in the medication page and this referenced in progress notes in a contemporaneous manner will enable clinicians to establish when medication changes took place.

10.11 The joint GPC and Consultant Committee statement on hospital test results has been updated and a statement on **Duty of care regarding drugs recommended from out-patient clinics** has also been published – as per below and on the BMA website.

10.12 Duty of care regarding communication of investigation results

10.12.1 We are aware that in some areas, some hospital doctors have been instructing GPs to find out the test results which the hospital had ordered. Both the General Practitioner Committee and the Consultants Committee of the BMA agree this practice is potentially unsafe, and that the ultimate responsibility for ensuring that results are acted upon, rests with the person requesting the test.

10.12.2 That responsibility can only be delegated to someone else if they accept by prior agreement.

10.12.3 Handover of responsibility has to be a joint consensual decision between hospital team and GP. If the GP hasn't accepted that role, the person requesting the test must retain responsibility.

10.12.4 This advice is in line with both National Patient Safety Agency guidance and the Ionising Radiation (Medical Exposure) Regulations.

10.13 Duty of care regarding drugs recommended from outpatients

10.13.1 Communication of prescribing recommendations from out-patient clinics to patients and their GPs is a complex area where patient safety can be compromised.

10.13.2 As recommend by British Medical Association this PGN incorporates the following general principles:

- Drugs required for urgent administration should be prescribed by the hospital doctor, and if appropriate dispensed by the hospital
- Responsibility for the provision of a prescription for non-urgent medications should be determined and agreed locally, but must recognise that delegation of responsibility for prescribing from hospital to GP can only take place with the explicit agreement of the GP concerned
- All communications should be in writing with the responsible doctor identified
- Where communications are sent via the patient, there should be clear instructions to the patient regarding the time scale for completion of the prescription, and this should be in addition to and not instead of a formal communication
- The doctor recommending a prescription should ensure that the prescription is appropriate, including carrying out any tests required to ensure safety

- The doctor recommending a prescription should provide counselling for the patient about important side effects and precautions, including any need for ongoing monitoring, which if needed should be agreed between primary and secondary care clinicians

- Recommendations should be in line with any agreed local formularies. Individual judgements should be made about the desirability of recommending a particular drug as opposed to a therapeutic class

- Where a GP feels that a prescription recommendation is inappropriate, the secondary care clinician should be informed

- Notwithstanding any of the above, all prescribers must be aware that the ultimate responsibility for the prescription lies with the prescribing doctor and cannot be delegated

11 ALLERGY RECORDING

11.1 All allergies and sensitivities including Drug Allergies and Adverse Drug Reactions must **only** be recorded on the medication page on RiO.

12 MEDICAL INTEROPERABILITY GATEWAY (MIG)

12.1 The Trust is working with GP practices to enable identified NTW staff to access the GP records for Service Users. This information will be available through a link on the electronic patient record (RiO) case record screen titled 'View Primary Care Record'. It will give users real time access to GP data improving delivery of patient care, patient and staff safety and reduce administrative / clinical resources required to source GP information.

12.2 Explicit consent must be gained from the service user and recorded via the electronic patient record (RiO) consent status screen (unless emergency access is required). Emergency access to the MIG can be used when consent cannot be gained, however there must be an urgent clinical reason and in the service user's best interest to view their GP data. Access to the service user's Primary Care Record via the MIG must be referenced within the service user's clinical note (progress note), including rationale for emergency access. In addition, any relevant clinical documents should also be updated to reflect information gained from the Primary Care Record.

12.3 Detailed User Guides and Quick Guides can also be found on the RiO log in screen by clicking the link to the RiO User Guide Site:-

http://nww1.ntw.nhs.uk/services/?id=4178&p=2780&sp=2824

13 ALERTS

13.1 Alerts should be used for any information that needs to be flagged to all staff. The current alert descriptions are:

- Advanced Statement
- Advanced Decision in Place
- Allergy
- Check Client GP
- Client Deceased Reported – Awaiting Verification via NSTS
- Diabetic
- Epileptic
- Guest
- Jehovah's Witness
- Limits on Information Sharing
- Not Suitable for Day Patient Detox
- Open referral on IAPTus
- Participant in research
- Patient on Register
- Previous treatment episode in IAPT
- Risk Issues/ Concerns
- See Social Worker
- Service Users File Note
- Significant Risk Issues
- Unified Health Record
- URGENT – Risk to Staff

13.2 As well as entering key information into alerts – all staff should ensure that they check for new alerts on each access of service user records.

13.3 The comment box should be used to provide a brief description to support the alert and if appropriate signpost to relevant section of the record.

13.4 When information is reassessed and there is a need to update/change any RiO form, use the CREATE NEW button. The EDIT button should ONLY be used when amending your own entry.

13.5 Alerts can be deleted when no longer relevant (but these will remain in alert history)

14 CORE ASSESSMENT

14.1 All Health Care Professionals involved in a service user's care can contribute to the completion of the Core (Care Coordination) Assessment.

14.2 The minimum requirements for consideration at an initial/first assessment are shown in red on the assessment screen. These sections are not mandatory and clinical judgment will continue to be used based on the presentation of the service user.

14.3 Other sections of the Core assessment can be used as clinically appropriate at initial/first assessment.

14.4 Health Care Professionals will only contribute to the sections of the assessment which are relevant to their input.

14.5 The Health Care Professional leading/ undertaking the assessment is responsible for ensuring the overall content of the assessment is comprehensive, meaningful and leads to the formulation of the service user's care and treatment plan.

14.6 The need for further Specialist Assessments to be carried out will be identified in the initial/first Core (Care Coordination Assessment) and recorded in the further action section of the assessment as an action to be carried out.

14.7 In some Directorates, the care co-ordination and specialist assessments are the same document.

14.8 Information should be entered in the same timescales described in section 3

14.9 All information should be entered into the appropriate assessment screen sections.

14.10 The only exception to this standard is for **On Call Medics/Liaison Psychiatry** who can enter information into the assessment, using the **Formulation/Summary of Assessment and Plan** sections of the assessment only. This can be by the uploading of a paper document if no direct access to RiO is possible. The paper assessment once scanned, can be uploaded and associated into the Core Assessment. This can then be directly viewed from the assessment and also via document view.

14.11 The standards for entry as described in Section 2 should be followed.

14.12 The Trust Physical Health monitoring form should be completed as clinically appropriate to the assessment, as set out in the Trust policy, NTW(C)29, Trust Standard for the Assessment and Management of Physical Health.

14.13 Having completed initial/first assessment, all service users who go on for care and treatment must have their CPA status and allocated care coordinator or Lead Professional entered into RiO, regardless of additional recording systems also in place. This must be kept up to date with any changes and review information.

14.14 Assessment and formulation should be ongoing as clinically indicated.

14.14.1 Once assessment has been made regarding the person's strengths and needs and a formulation reached which guides the provision of care and treatment it should be validated. Clinical judgment will need to be applied as to when there is the need to update the assessment and formulation However, admission to a **ward** will always require a reassessment of need. The use of the '**create new button'** on RiO ensures that the previous assessment information is available to populate subsequent assessment. Reassessment should include checking the accuracy of information held and updating / adding to, as appropriate. This will, in particular, facilitate the development of an accurate personal history over time

15 FACE RISK PROFILE

15.1 Within the Trust the minimum approved Risk Assessment framework to record the outcome of the assessment of risk for service users is either the FACE Risk Profile or the narrative risk tool.

15.2 Liaison Psychiatry incorporate the narrative risk tool in the Formulation/Summary of Assessment and Plan sections of the assessment. This can be by the uploading of a paper document if no direct access to RiO is possible. The paper assessment once scanned, can be uploaded and associated into the Core Assessment. This can then be directly viewed from the assessment and also via document view.

15.3 Risk assessment, formulation of risk and risk management planning are a Multi-Disciplinary responsibility and are required:

- As part of initial assessment (using the narrative risk tool or using the approved FACE risk profile tool if this is supportive to clinical practice)
- When admitting and discharging from hospital (documented as a minimum on a FACE risk profile risk) and as part of planning and agreeing leave
- Risk should be reassessed as part of review considerations
    - For service users with enhanced needs if there is no change to assessed risk as recorded by the risk indicators / level of risk / risk formulation on the FACE risk profile then this profile remains current providing there is clear recording of no change via the Care Coordination review form within current assessment of risk and the requirement for a new FACE risk profile radial button is set at No
    - For service users who do not have enhanced needs enhanced needs if there is no change to assessed risk as recorded by the narrative risk tool then this remains current providing there is clear recording of no change in the electronic care record using the lead professional care / review screen ensuring the record meets the Trust's standards (Appendix 2). This also enables the population of a clinical letter (put in the name of the letter) from the electronic care record

- Risk should also be reassessed:
    - When there are major changes to presentation / personal circumstances or following an incident
    - When alerted by Carers
    - When alerted by other members of the care team about major changes to presentation / personal circumstances / an incident

- For service users with enhanced needs if there is no change to assessed risk as recorded by the risk indicators / level of risk / risk formulation on the FACE risk profile then this profile remains current providing there is clear recording of no change in the electronic care record progress note that records the incident / presentation / information from Carers

- For service users who do not have enhanced needs enhanced needs if there is no change to assessed risk as recorded by the narrative risk tool then this remains current providing there is clear recording of no change in the electronic care record progress note that records the incident / presentation / information.

- When referring / transferring service users to other teams/service providers this should be supported by a current assessment of risk recorded in the risk tool appropriate to the service user's level of need

15.4 Where there is joint work across services shared assessment of risk is critical and this can be facilitated by an agreement as to how this is best recorded, i.e. where FACE is being used, which of the FACE risk profiles is most appropriate to record the assessment of risk, e.g. Adult or Addictions. Once the decision is made then it is important that the risk profile not being used references where the assessment of risk is recorded.

15.5 Where there is shared care between EIP and Children and Young people's teams the CYPS FACE risk profile is used for all young people with enhanced needs up to the age of 18.

15.6 For young people with enhanced needs who remain in service with NTW post 18 at their next care co-ordination review (which would include a ward discharge review) the Adult FACE risk profile will be completed unless they are transitioning out of NTW services when clinical judgement will be used to determine when (or indeed if) a different FACE risk profile should be used.

15.7 Risk Management Plans are an integral part of the Care Plan.

15.8 A Consultant Psychiatrist should be directly involved in formulating risk assessments and management plans for all service users who express delusional beliefs involving children or might harm a child as part of a suicide plan (including Safeguarding Processes where applicable). This involvement should be whenever risk assessment is required and should be formally documented using the FACE Risk Profile.

15.9 Risk Assessments may be carried out in Partnership with other organisations, using frameworks other than FACE Risk Profile. In these cases, where FACE is in use, NTW staff must complete the FACE Risk Profile scoring sections in RiO as a minimum, and refer to the location of a scanned copy of the Partnership assessment carried out for full details of the assessment. If the narrative risk tool is being used it should be completed as a minimum to refer to the location of a scanned copy of the Partnership assessment carried out for full details of the assessment

16 MENTAL HEALTH CLUSTER (where appropriate)

16.1 Assessment is an ongoing process however, when sufficient information regarding risks and needs has been gathered via one or more of the tools described in this document, this information should be summarised and presented in a standardised format.

16.2 This should be undertaken by scoring the Mental Health Clustering Tool (MHCT) as they become available in each service area and allocating the patient to the most appropriate Care Cluster.

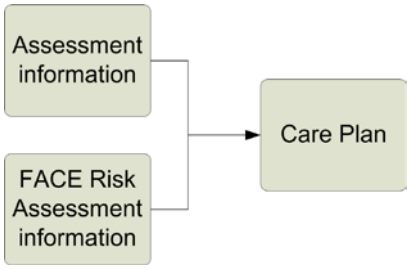
16.3 This process should be completed as soon as sufficient information has been gathered, but no later than 2 contacts.

17 CARE PLAN

17.1 The Care Plan is the overall record of the service user's assessed needs, bio-psycho-social formulation, interventions to be carried out, outcome of interventions and evaluation of effectiveness.

17.2 The content of the Care Plan is derived from needs identified in the Care Coordination Assessment and any Specialist Assessments which have been carried out.

17.3 The Care Plan is the overarching record of care which detail specific actions and staff interventions.



17.4 For more detailed information, refer to Trust's policies and practice guidance notes, NTW(C)20 Care Co-ordination (including CPA) and NTW(C)48, Care Coordination, and CPA for Children and Young People.

17.5 As with other kinds of plans and reviews, an entry should also be made in progress notes, referring to this document.

18 STANDARDS FOR LEAD PROFESSIONAL CARE PLAN

18.1 All letters should be written using language/terms that the service user and their family/carer (if appropriate) are able to understand as much as is practicable.

18.2 The care plan letter, as a minimum, should clearly contain:

- The date of contact/clinic/visit
- The current plan of intervention/care/treatment agreed with the person and their carer (if appropriate), the rationale for this (based on assessment and formulation) and who is providing this
- Indicate the circumstances in which the service user may need extra help and the associated crisis arrangements
- The outcome of the assessment of Risk (consideration **must** be given to any keeping children safe assessment) and if appropriate the agreed plans to manage the identified risk.
- Date of next appointment/visit

18.3 If medication is part of the care plan the medication, dosage and prescriber should be specified including arrangements for future prescriptions.

19 CARE PLANNING AND WINTER / SUMMER EMERGENCY PLANNING

19.1 The care planning sections of Rio have been updated to:

- Enable the identification of service users who are in high risk groups that should have the flu vaccine
- Enable the identification of service users who are in high risk groups should alerts be issued in relation to Winter or Heatwave preparedness

19.2 The help screens provide details of high risk groups.

19.3 The Inpatient Care plan library has care plans relating to each level of alerts in relation to Winter or Heatwave preparedness that can be personalised.

19.4 The lead professional and care co-ordination care plans have a link to care plan content relating to each level of alerts in relation to Winter or Heatwave preparedness that can be copied and pasted into the care plan and personalised.

20 REVIEW

20.1 When the clinical Review information has been completed, it must be also be recorded on the CPA Management screen in RiO.

20.2 If a review is undertaken by a MDT, the Chair of the MDT is responsible (this task can be delegated) for ensuring that the current assessment and formulation, assessment, formulation and management of risk and changes to Care Plan accurately reflects the discussion that took place at the MDT meeting and is completed at or shortly after the MDT meeting (within one working day).

21 STANDARDS FOR LEAD PROFESSIONAL REVIEW CLINICAL LETTER

21.1 If the letter is the review record this needs, to be clearly specified, e.g. when we met on day/date we reviewed your current plan of care and agreed that..

And as a minimum should clearly contain:

- Plan of intervention/care/treatment agreed with the service user/and their family/carer (if appropriate), the rationale for this based on review of assessment and formulation and progress made, and who is providing this
- The circumstances in which the person may need extra help and the associated crisis arrangements
- The outcome of the reassessment of Risk, (consideration **must** be given to any keeping children safe assessment) including if there is no change and if appropriate the agreed plans to manage the identified risk
- Date of next appointment/visit
- If medication is part of the care plan the medication, dosage and prescriber should be specified including arrangements for future prescriptions.

21.2 This letter can be produced form RiO using the GP letter options IF the lead professional care plan screen is completed.

22 APPOINTMENTS WITH SERVICE USERS IN SETTINGS WHERE RIO IS NOT AVAILABLE

22.1 Where Health Care Professionals are seeing service users in venues where RiO is not available, it is the responsibility of the service to facilitate the Health Care Professional to print off any necessary information/documentation from RiO for the appointment.

22.2 The printed information may be temporarily held within the RiO support file for the duration of the appointment unless it is considered clinically relevant for all appointments and if so, it should be retained in the final section of the file.

22.3 The printed information not considered clinically relevant for all appointments must be securely disposed of after the appointment.

22.4 The Health Care Professional is responsible for the security of the information held in the RiO Support File (see MR-PGN-01 Operational Guidance for creating, retrieving and maintaining a health record and associated MR-PGN-06 Taking Clinical Records off Trust Premises).

22.5 Health Care Professionals may continue with the practice of making handwritten /audio aide memoires' at outpatient/community appointments from which Medical Secretaries/administrators will input information onto RiO where available.

22.6 Where this is the case, Health Care Professionals **must** validate information put into RiO by Medical Secretaries/administrators into progress notes by using the validate button. Once validated the aide memoire may be securely destroyed.

22.7 Where information has been entered into clinical forms the professional must use the Edit Current button to check, edit and save the information

22.8 The Clinical Standards for timeliness must be followed for these entries.

23 DOCUMENTS UPLOADED ONTO RIO

23.1 It is the responsibility of the person who uploads an image to make sure the Health Care Professionals are aware of the document, e.g. via an email, phone call, local agreed process. It is the health care professional's responsibility to check documents received and action accordingly

23.2 Where a follow up/action is required, it is the responsibility of the HCP (or team leader) to carry this out, not the administrative support

23.3 When a document has been saved onto RiO, a note should be entered into progress notes to reference this

23.4 **The Standard entry should as a minimum comprise of**:
<Document type> <Document name> has been uploaded on <date> by <user>

24 NAMING CONVENTIONS FOR DOCUMENTS UPLOADED ONTO RIO IMAGES

24.1 Document types are listed in the scanning guide appendix.

24.2 The document should be named to make it as clear as possible what the document is about to others.

24.3 The naming convention is a service identifier (listed below), followed by the document name, followed by team name

- Older People = OP
- Forensics = Forensics
- CYPS = CYPS
- Addictions services= D.A
- Adult = Adults
- Neuro psychiatry and rehabilitation services = Neuro
- Learning disability = LD
- Specialty services = SS

e.g. Document Type: MAPPA
Document name: OP referral form Akenside

Document Type Correspondence to GP
Document name CYPS Clinic letter Benton House

25 USE OF RiO SUPPORT FILE AND SECONDARY FILES

25.1 A RiO Support file is only for service users who have documents that are not directly recorded and/or scanned onto RiO.

25.2 The secondary paper file which supplements the electronic record will be known as the RiO Support File (Purple file), and will be labeled as such and tracked online via Patient Document Tracking.

25.3 The purple file must be:

- created or retrieved upon receipt of a referral/re-referral
- logged on PDT
- follow the patient through the pathway of care
- be available to the HCP who is seeing the patient
- be returned to Medical Records when the patient is discharged

25.4 The filing instructions on the tabs inside the RiO support file should be adhered to at all times.

25.5 The front sheet of the RiO Support File should be printed from RiO using the Care Coordination Registration Form and the Personal Contacts screen(s). This should be checked regularly with the service user to ensure all details are correct and up to date. Any changes must be recorded on RiO and a new front sheet printed.

25.6 Additional secondary files may be requested from the Group Effective Q&P subgroup, with approval from the MDT, for those Services who need to store specific data/information that should not be made widely available, e.g. certain psychology tools, working formulation documents that are used and modified with clients at each session, diaries completed by clients and reviewed, artwork produced by clients during a period of art therapy. See MR-PGN-01 Operational Guidance for creating, retrieving and maintaining a health record for more detail.

25.7 All paper files must be logged on the Patient Document Tracking system (**See MR-PGN-03 - Tracking and Tracing).**

26 DISCHARGE

26.1 Process for Discharging from Inpatient Services on RiO

- **See training guide** via this link

26.2 Process for Discharging Referrals from RiO

- **See training guide** a link will be put in to take you there

26.3 Process for Discharging from CPA

- **See training guide** a link will be put in to take you there

26.4 When discharging a referral this also needs discharging from the appropriate clinician(s) case load.

26.5 If the discharging of the referral means that the service user is discharged from all NTW services then they should also be deregistered from Care co-ordination (CPA) via the CPA management screen. If the team does not have access to RIO then the Information Team should be contacted to undertake deregistration.

27 NON-NTW CARE COORDINATOR/LEAD PROFESSIONAL

27.1 If local authority documentation is used to record the assessment then the document should be scanned onto RiO. The paper assessment once scanned, can be uploaded and associated into the Core Assessment. This can then be directly viewed from the assessment screen and also via document view.

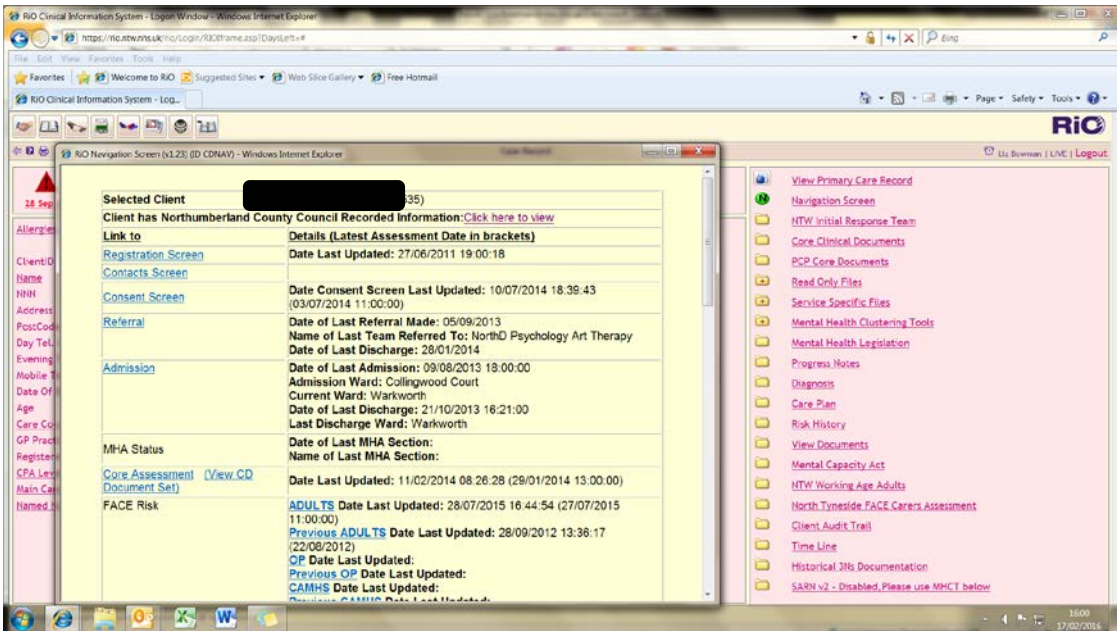
27.2 A standard entry should also be made in progress notes. This may be the complete record of an assessment, and if there has been no change of circumstances and no reassessment is required at this stage

27.3 Risk Assessments may be carried out in Partnership with other organisations, using frameworks other than FACE Risk Profile. In these cases, for service users with enhanced needs NTW staff must complete the FACE Risk Profile scoring sections in RiO as a minimum. A copy of the Partnership assessment should be scanned onto RiO and must be referenced in the FACE risk profile summary that directs to the location of the full assessment and a standard entry made in progress notes. For service users who do not have enhanced needs, and where FACE is not being used, NTW staff must reference the scanned Partnership assessment in the narrative risk tool. In both cases if NTW clinicians are aware of risk issues that are not reflected in the Partnership assessment these must be added to the appropriate risk tool and communicated to other members of the care team.

27.4 If local authority documentation is used to record of the care plan then the document should be scanned onto RiO. The paper care plan, once scanned, can be uploaded and associated into the relevant care plan section appropriate to the service user's level of need. This can then be directly viewed from the care plan screen and also via document view. A standard entry must also be made in progress notes.

27.5 If local authority documentation is used to record of the review then the document should be scanned onto RiO. The paper review, once scanned, can be uploaded and associated into the relevant review section appropriate to the service user's level of need. This can then be directly viewed from the review screen and also via document view. The review date must also be recorded on the CPA/standard care management screen. A standard entry must also be made in progress notes.

27.6 If local authority documentation is used to record care plans / risk assessments / review and is transferred via an exchange between RiO and the Local Authority system (Newcastle and Northumberland) this should be referenced in the associated clinical form on RiO and can be accessed via the link on the navigation screen of the service user's record.



27.7 Where a service user has an external Care Coordinator or Lead Professional, an agreed member of NTW staff will ensure the record on RiO is completed as described above. If only one NTW clinician is involved, it is their responsibility to ensure the RiO record is completed.

28 CARE COORDINATION INFORMATION TO BE CIRCULATED TO NON-NTW PERSONNEL/NTW STAFF IN A CARE TEAM WITHOUT CLINICAL RiO ACCESS

28.1 Whilst NTW personnel with Clinical RiO access can access a service user's Care coordination documentation (and associated Risk Assessment/Risk Management plans) electronically via RiO, other stakeholders in the patient's care (e.g. GP/Family/Paid Carer's/Advocates/Health and Social Care Professionals from other organisations) require access to such documents via paper copies

28.2 The Care Coordinator or Lead Professional is responsible for ensuring such paper copies are provided.

29 STAFF WITHIN THE SAME TEAM WHO USE DIFFERENT ELECTRONIC RECORDING SYSTEMS

29.1 Where staff in the same team are using different electronic recording systems, e.g. SWIFT and RIO then the Unified health record, i.e. cream/buff file, is retained and maintained for that team until all the team are on the same electronic recording system, e.g. all staff within the team using RiO or all staff in the team using SWIFT.

29.2 Where staff in the same team are continuing to use different recording systems, individual clinicians are responsible for ensuring that documents and entries made on the systems they use are printed and shared via the UHR.

30 RECORDING CLINICAL SUPERVISION AND PEER REVIEW

30.1 The Clinical Supervision and Peer Review Policy provides guidance regarding recording in the Clinical Record when Clinical Supervision or Peer review has taken place, using the key word Clinical Supervision or Peer Review so that evidence can be readily accessed from the record for audit or investigation (SUIs and complaints).

30.2 Entries recording supervision should be made in progress notes and should have the heading Clinical Supervision (or Peer Review for Consultant Psychiatrists). This enables the search facility on the electronic patient record (RiO) to bring up all such entries which facilitates audit, after action reviews, complaint and SUI investigations etc.

30.3 Any new insights regarding assessment and bio-psycho-social formulation or differential diagnosis, and any action points arising from supervision or peer review should be recorded.

30.4 Any potential changes to the service user's care plan arising from supervision or peer review should be discussed with the service user (and carer where appropriate) and with others involved in the care plan, and if agreed, the care plan should then be updated accordingly. Any clinical supervision that influences care plans must be cross referenced between progress notes and the actual care plan entries

30.5 Inpatient settings: Key-workers for service users in hospital should record their clinical supervision in relation to these clients on the electronic patient record (RiO). Other staff involved in their care may choose whether to record their clinical supervision in relation to clients for whom they are not the keyworker, but should always do so if new issues in relation to the client's care and treatment arise during supervision.

30.5 Community settings: All staff who are providing individual elements of a service user's care plan, including support workers, should record their supervision sessions in relation to the client on the client's electronic patient record (RiO)

Appendix 1

Relevant Policy Documentation

- Individual Service Specific Guides V3.x
- NTW(O)09 Management of Records Policy
    - MR-PGN-01 Operational Guidance for creating, retrieving and maintaining a health record PGN
    - MR-PGN-03 Tracking and Tracing PGN
    - MR-PGN-04 Retention and Destruction of Clinical Records PGN
    - MR-PGN-05 Subject Access Requests in accordance with the Date Protection Act 1998 (DPA 1998) PGN
    - MR-PGN-06 Taking clinical records/information off Trust and/or Local Authority premises PGN
    - MR-PGN-10 – Psychological Practitioners-Record Keeping PGN
- NTW(C)20 Care Coordination (including CPA) Policy and associated PGN's
- NTW(C)48 Care Coordination Care Programme Approach – Children and Young People Services Policy and associated PGN's
- NTW(O)14 Limited Access and Patient Electronic Records (RiO) Policy
- RiO Clinical Training Guide
- RiO Performance Appointment Management

Appendix 2

RiO SUPPORT FILES ('PURPLE FILES' and Psychological Practice Support Files)

Although we have moved to electronic patient records, it is acknowledged that there are still some documents which need to be retained in paper format. Work has been carried out to produce a format for a Trust health record which will **support** the RiO electronic patient record. This file, which is being referred to as the 'purple file' is a reduced version of the previous standard cream health record used in the Trust prior to the implementation of RiO, and will be divided into the following sections:

- Personal details
- MHA
- Specialist Assessments
- Kardex/Prescriptions
- Observations
- Finance
- Service Specific

The RiO support file is to be used only for those documents which cannot be captured on RiO, and have been agreed to be stored within the Purple Support File. It should be managed in line with the Trust's NTW(O)09 - Records Management Policy and will be subject to the same standards of governance and scrutiny. Once created, the support file must be tracked and managed through the Patient Document Tracking (PDT) system on RiO.

The RiO support file should

- be created or retrieved upon receipt of a referral/re referral
- be logged on PDT
- follow the patient through the pathway of care
- be available to the HCP who is seeing the patient
- be returned to Medical Records when the patient is discharged

Implementation of the new file will be from 1 August 2010 for all new and existing patients. Within 6 months of that date, all patients will have an electronic record on RiO, with a purple support file if required. All historical records will be archived and will be accessible at any point if necessary.

A Psychological Practice RiO support file should be opened where information needs to be stored which cannot be added to RiO, aide memoire working notes (temporary storage) and/or information for which the clinician does not have consent to share (hence a purple file cannot be used). The sections of the Psychological Practice support file are:

- Outcome measures
- Psychometrics
- Material created by Service Users
- Session (aide memoire) notes
- Formulations

Guidance re the use of the Psychological Practice Support file and clarification about what should and should not be recorded on RiO is provided within MR-PGN-08 - Psychological Practitioners and Record Keeping.

Once created, the support file must be tracked and managed through the Patient Document Tracking (PDT) system on RiO.

Key Standards and the RiO Support File

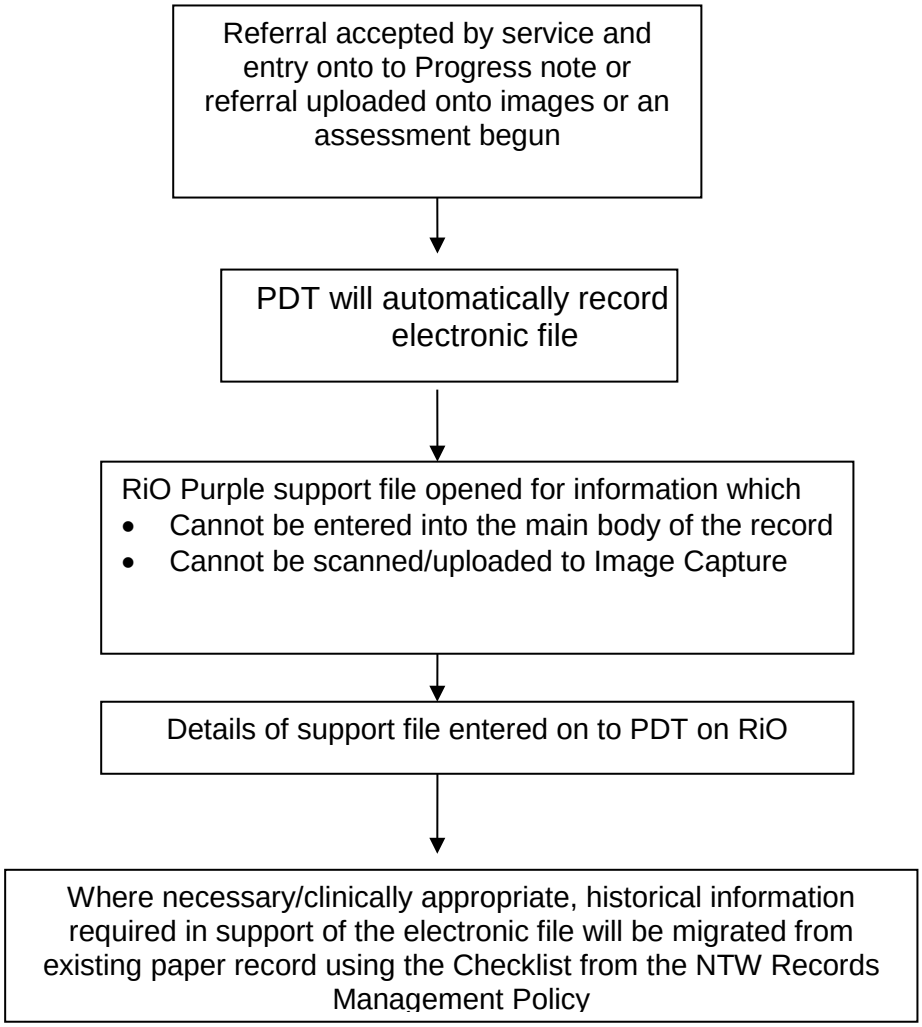
The service user's demographics are to be printed from RiO and filed in the paper record after any update to these documents, e.g. change of address, change of contact information.

When an alert has been entered on RiO (see section 12), this should also be noted on the inside cover of the RiO support file.

Process:

Either on referral to the service, when referral uploaded or on the first clinical entry for each patient on RiO, PDT will automatically record that there is an electronic file for the patient.

It will be the responsibility of individual HCP to ensure that any purple support file (if required) is opened and entered on to PDT.



Appendix 3

Shredding Documents that have been scanned

The original record should be capable of being destroyed without risk to the Health Care Professional or the Trust provided that adequate safeguards outlined in this guidance are put in place.

Once documents have been scanned/captured and uploaded into RiO, the scanned document should be viewed on screen. Once the user is confident that the image is attached to the **correct client** and is of **sufficient quality and legibility** when compared to that of the original document, then the original may be shredded.

Sufficient quality and legibility

- no corners turned over
- straight
- whole page clearly visible
- **not** upside down
- pages in the same order as the original

The scanned/uploaded image should be able to be read as easily as the original.

From a legal perspective, one of the key times the accuracy of medical records is called into question is when claims for clinical negligence are brought before the Courts. In many cases, the accuracy of the medical records covering the care which is alleged to have been negligent make the difference between being able to defend a claim or not. The medical records are only one aspect of the evidence which would be put before a Judge when a clinical negligence claim falls to be decided. Obviously, if traceable, the Health Care Professionals who were involved in the care of a particular service user will give oral evidence to the Court. However, those Health Care Professionals giving evidence will rely heavily on the contemporaneous records. Provided that the process of scanning the manual records conforms with the relevant British Standards (in particular the Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically (BIP 0008)) then the scanned record will be treated by the Judge as if it were the original record. The key follow up point here is, obviously, to seek assurances about the process for scanning used by the community teams.

Assuming that the scanning process meets the relevant standards then the retention of the original record will be unnecessary and will serve only to produce duplication with the associated risks of inadvertent disclosure or data loss.

Appendix 4

Scanning Guide

Investigations and results (see table below) contain key clinical information but due the variety of formats they require specific guidance.

Additionally scanning may not always produce an image that is sufficiently legible to conform with the relevant British Standards (in particular the Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically (BIP 0008))

To address this, the following guidance is provided:

- If results are accessed and downloaded directly as a PDF from the pathology system, e.g. ICE they can be saved **directly** in RiO images

- If results are not accessed and downloaded directly from the pathology system then:

- Where there is shared care and the care team are based on same site, then results can be stored in the RiO support file (purple) file only, as the file will be easily accessible to all of the care team.

- Where there is shared care and the care team are not on site together, then results should scanned onto RiO **AND** be stored in the RiO support file (purple) file, to maximise accessibility to the care team whilst ensuring that the original is available if the scanned image is not sufficiently legible or should it be required for legal proceedings. **The original format of the results must be maintained in the scanning processes**

Document Type	Documents to be included
Investigations and Results	ECG Radiology - X-ray EEG Reports Blood Reports Blood Report - Biochemistry Blood Report - Haematology Blood Report - Microbiology Radiology Reports Radiology - CT Radiology - MRI Scans Urine Reports

The following tables provide the names and types of documents and whether they should be scanned and saved on RiO and the associated Document Type. This is not intended to be a complete list but to serve as a guide to staff:

Documents that should be Scanned / image captured	
Document Type	**Documents to be included**
MAPPA/MARAC/ Safeguarding	Minutes Referrals Reports
Correspondence to GP	Clinic letter Assessment letter Care plan letter
Correspondence from GP	GP referral GP letter with medication changes
Correspondence to Service User and Families	Letter to Service User Therapy contract Letter to Carer / Parent
Correspondence from Service User and Families	Letter from Parent re child Email from service user

Correspondence to Others	Referral to voluntary sector Letter to non NTW Consultant
Correspondence from Others	Social services referral Advocates Correspondence
Tribunal/MHA Managers Reports	Medical Tribunal Report Nursing Tribunal Report Record of Hearing
Other Legal Documentation	Forensic 'T' Forms Deprivation of Liberty assessment Advanced Decision to Refuse Treatment Court Report
Local Authority Documents	Assessment Care plan CP1 CAF
Prescribed Treatment and Consent	Signed Consent to share information form Research Agreements
Finance	Appointee Papers Direct Payment forms DLA
Specialist Assessments	MMSE Drawings BECKS
AHP/Psychology Specialist Assessments	MOHO Physiotherapy assessment SALT assessment Neuropsychological / Cognitive Functioning Assessment
AHP/Psychology Reports	Podiatry Report Dietary Report Neuropsychological / Cognitive Functioning Report
Appointment Letters	Appointment letter with NTW service
Pre RiO Key Document	Discharge Summary(s) FACE Risk Assessment Assessment Medication Summary

NB: If the letter/document has been generated from RiO then it should still be uploaded into document capture and a note made in progress notes that letter has been sent**.** **Similarly** if a generated letter has been edited (so is not just a copy of what is on RiO).
Documents NOT to be Scanned
Completed Observation Charts Prescriptions in original format Signed property lists
Specialist Assessments that require professionally-based training to complete and interpret and where access to the assessment would devalue the tool, e.g. some psychological tools.
MHA section papers - (see additional guidance re all MHA forms) **NB** CTO forms 1; 10 and 11 should be scanned **and** the original kept in purple file
Service user generated tools, e.g. thoughts diary
Web-based incident reporting forms
These documents must never be shredded Also not to be shredded – information from previous UHR / Paper record that is considered clinically relevant and has been scanned onto RiO. Original should be placed back in the correct volume and section of UHR.

MHA section papers

NB: Unless indicated in the table, the original versions of all forms should be forwarded ASAP to the MHA office and a copy retained in the patient's paper health record. All of the forms are available on the Trust intranet.

Section	Statutory Forms	Local Forms	Notes
5(4)	**H2**	H3A H3B **(do not send to MHA office)** Section 5 monitoring form ***	***This form to be completed by the nurse in charge when section 5(4) ends and where section 5(2) not used. **A copy of the form should be given to the patient**
5(2)	**H1**	H3A H3B **(do not send to MHA office)** Section 5 monitoring form ***	***This form to be completed by the nurse in charge when section 5(2) ends; whether or not the patient is further detained. **A copy of the form to be given to the patient.**
135	**-**	Section 135 recording form (to be developed) H3A	This form is under development in the meantime use the S136 form and mark accordingly.
136	**-**	Section 136 recording form H3A H3B **(do not send to MHA office)**	Always ensure the form attached to NTW(C) 09 policy is used, there is some evidence that this is not always the case.
4	**A9** - if nearest relative applicant **or** **A10** - if AMHP applicant **A11** (medical recommendation) and **H3** (record of detention - part 1 and part 2 if converted to section 2)	H3A H3B **(do not send to MHA office)**	Always ensure that the local documentation is completed in all cases and that patients are given an explanation of their rights at regular intervals
2	**A1** - if nearest relative applicant **or** **A2** - if AMHP applicant and **A3** (joint medical recommendation) **or** **A4 x 2** (medical recommendations) **H3** (record of detention – part 1)	H3A H3B **(do not send to MHA office)**	As section 4 above
3	**A5** - if nearest relative applicant **or** **A6** - if AMHP applicant and **A7** (joint medical recommendation) **or** **A8 x2** (medical recommendations)**and** **H3** (record of detention – part 1)	H3A H3B **(do not send to MHA office)**	As section 4 above

Section	Statutory Forms	Local Forms	Notes
Pt 3 MHA e.g. 35, 36, 38, 37, 37/41, 48, 48/49 etc	**Court/Prison Documentation**	H3A H3B **(do not send to MHA office)**	As section 4 above
17 (leave of absence)	**-**	H17	Always ensure the form attached to NTW (C) 03-Leave of Absence policy is used as there is some evidence that this is not always the case. **A copy should be given to the patient** and where appropriate the other involved parties A local form to recall a patient from leave is being developed.
18, 21, 21A and 21B (AWOL)	**H6** - MHA 1983 Section 21B Authority for detention after absence without leave for more than 28 days		
19 (transfer)	**H4** – authority for transfer to or from a hospital **outside** of the Trust	H4A - authority to transfer to or from a hospital **within** the Trust	
20 (renewal of detention)	**H5**	-	
23 (discharge from detention (section 2,3 and 37)	**-**	H23 – local form for discharge by the Responsible Clinician	
23 (order for discharge by nearest relative	**-**	NR23 – order for discharge by the nearest relative	The nearest relative does not have to use the form supplied but their order must be in writing.
25 (restrictions discharge)	**M2** - RC report barring discharge by nearest relative	-	

Other (section) provisions	Statutory Forms	Local Forms	Notes
Part 6 (removal and return of patients within the United Kingdom etc)	**M1** - (reception of a patient in England)	-	
Miscellaneous	**-**	RC1 - (transfer of Responsible Clinician) **or** RC2 - temporary transfer of Responsi Clinician)	
Consent to Treatment (sections 57 to 62)	**Statutory Forms**	**Local Forms**	**Notes**
63	None	T63 local – record of capacity assessment and discussion with patient re consent to treatment for mental disorder (point of detention)	Nursing staff should ensure that this form (which is completed by the relevant AC) is filed in the RiO support file. (this form should be completed by the relevant AC following their capacity assessment/consent discussion (at the point of detention)
57	**T1**		
58(3)(A) (medication)	**T2** – certificate of consent to treatment		Nursing staff should not administer medication to detained patients (after 3 months) without first checking this form or form T3 is in place and that the applicable form covers **all** prescribed treatment
58(3)(B) (medication)	**T3** - certificate of second opinion	T3A (1) and T3A (2) – (statutory consultee forms)	Nursing staff should not administer medication to detained patients (after 3 months) without first checking this form or form T2 is in place and that the applicable form covers **all** treatment prescribed

Consent to Treatment (sections 57 to 62)	Statutory Forms	Local Forms	Notes
58 (3) (A) and (B)	T2 or T3	T58 (local**)** – record of capacity assessment and discussion with patient re consent to treatment for mental disorder (3 month rule)	Nursing staff should ensure that this form (which is completed by the relevant AC) is filed in the RiO support file with either the T2 or T3 as applicable. (this form should be completed by the relevant AC following their capacity assessment/consent discussion prior to the completion of either T2orT3
58A (3)(ECT)	**T4** – certificate of consent to treatment		The ward should keep 2 copies of this form – 1 to be filed in the paper health record and 1 to be kept with the Kardex
58A(4) (ECT)	**T5** - certificate of consent to treatment and second opinion	T3A (1) and T3A (2)	As above
58A(5) (ECT-under 18)	**T6** - certificate of second opinion	T3A (1) and T3A (2)	As above
61 (Review of treatment)	**Section 61** Review of Treatment form (previously Form MHAC1) **CQC form**	-	
62 (Urgent treatment)	**-**	T62A (certificate of urgent treatment)	
Community Treatment Orders (section)	**Statutory Forms**	**Local Forms**	**Notes**
17A	**CTO1** – Community Treatment Order	H3A H3B **(do not send to MHA office)**	The Responsible Clinician should is responsible for the giving of rights to patients on a CTO. The H3A should be completed at the point the patient is to be discharged on to the CTO. **Should be scanned onto RIO and original kept in purple file**
17B	**CTO2** – variation of conditions of a Community Treatment Order	-	
17C	**None** – section 17C refers to the period a CTO can remain in force (section 20A below extends the period)	-	

Consent to Treatment (sections 57 to 62)	Statutory Forms	Local Forms	Notes
17D	**None** – describes the effect of the Community Treatment Order	-	
17E	**CTO3** – notice of recall to hospital and **CTO4** – record of detention in hospital after recall	CTO4 (A) – Outcome of recall of a CTO patient	
17F (2)	**CTO6** – Authority for transfer of a CTO patient to a hospital **outside** of the Trust		
17F (4)	**CTO5** – revocation of a Community Treatment Order		
20A	**CTO7** – Report extending the community treatment period (renewal)	CTO7(A) RC notification of whether or not CTO to be extended	
21B	**CTO8** –Authority for extension of CTO after AWOL for more than 28days		
Part 6 (removal and return of patients within the United Kingdom etc)	**CTO9** – Community patients transferred to England		
19A	**CTO10** Authority for assignment of responsibility for community patient to a hospital **outside** of the Trust	CTO10A - Authority for assignment of responsibility for community patient to a hospital **in** the Trust	**Should be scanned onto RIO and original kept i purple file**
23	**-**	CTO23 – discharge from CTO	
Miscellaneous	**-**	RC1 - (transfer of RC) **or** RC2 - temporary transfer of RC)	

Consent to Treatment re CTO patients/section	Statutory Forms	Local Forms	Notes
64C	**CTO11** – certificate of appropriateness of treatment to be given to a CTO patient	CTO11A(1) & CTO11A(2) (statutory consultee forms)	**Should be scanned onto RIO and original kept i purple file**
64		CTO64 – certificate of emergency treatment for a CTO patient (not recalled to hospital)	

NB Copies of CTO documentation will only be kept in the patient's paper health record on the ward if the patient is recalled to hospital. If an inpatient area receives/uses any CTO documentation e.g. CTO4, CTO4A, CTO5, CTO8 etc, further advice on what needs to be retained on the ward and/or forwarded elsewhere can be obtained from the MHA office. SA/MHA/04/10