

Policy Document Control Page

Title

Title: Scanning and Uploading Documents to Clinical Information Systems Procedure

Version: 2

Reference Number: CO94

Supersedes

Supersedes: V1

Description of Amendment(s):

- Slight change to name of protocol to allow for easier searching on the intranet

Important Notice

From May 2018 the UK will be adopting the European General Data Protection Regulations. These regulations will be replacing the Data Protection Act 1998. In the UK we are still awaiting some health sector specific guidance and instruction regarding GDPR, and as such have deemed that, unless there is a legal requirement or a fundamental change that is required in a policy, all policies, regardless of review date, shall remain current, valid and must be followed for the foreseeable future, to be reviewed prior to the implementation of GDPR from May 2018. Any queries in relation to this statement should be directed to the Trust Information Governance Manager.

Originator

Originated By: Carole McCarthy

Designation: Records Manager

Equality Analysis Assessment (EIA) Process

Equality Relevance Assessment Undertaken by: C McCarthy

ERA undertaken on: 4th January 2016

ERA approved by EIA Work group on:

Where policy deemed relevant to equality-

EIA undertaken by:

EIA undertaken on:

EIA approved by EIA work group on

Approval

Referred for approval by: Carole McCarthy

Date of Referral: 21st January 2016

Approved by: Information Governance Assurance Group

Approval Date: 27th January 2016

Date Ratified by Executive Directors: N/A

Executive Director Lead: Medical Director

Circulation

Issue Date: 11th February 2016

Circulated by: Performance and Information

Issued to: An e-copy of this procedure is sent to all wards and departments

Procedure to be uploaded to the Trust's External Website? YES

Review

Review Date: February 2018

Responsibility of: Carole McCarthy

Designation: Records Manager

This procedure is to be disseminated to all relevant staff.

This procedure must be posted on the Intranet.

Date Posted: 11th February 2016

1. Introduction

- 1.1 Although the Records Management Policy provides the overarching framework for achieving high quality safe record keeping, it is based on the principle that the primary clinical record is held in paper format. The Trust has agreed a phased implementation of an electronic patient record (EPR) system named PARIS where the electronic record replaces the paper record as the primary record. During the implementation phase there will be some services whose primary records become electronic and some services whose primary records remain paper based.
- 1.2 This interim additional procedure is therefore provided to explain how scanned images or uploaded documents can be safely stored on computer networks and migrated to PARIS.
- 1.3 This procedure will establish guidelines for:
 - Authenticity, integrity and availability of stored data
 - Legal admissibility of scanned, stored and electronically communicated data

2. Purpose

- 2.1 The purpose of this procedure is to:
 - Provide guidance on process, procedure, audit in order to ensure authenticity, integrity, security and legal admissibility of scanned, stored or migrated data.
 - Improve reliability of, and confidence in, communicated information, and electronic documents to which an electronic identity is applied
 - Maximise the evidential weight which court or other body may assign to presented information
 - Provide confidence to external inspectors (i.e. regulators and auditors) that the Trust's information and business practices are robust and reliable.

3. Scope

- 3.1 All information which is scanned or uploaded into electronic clinical information systems from both Mental Health & Specialist Services and Community Services.
- 3.2 All information about a service user received electronically will be uploaded to PARIS from both Mental Health & Specialist Services and Community Services.

4. Aims

The aims of our records management system are to ensure that:

- **records are available when needed** – all documentation received into the service should be scanned and uploaded within 2 working days. Similarly any emails or electronic information such as electronic referrals should be uploaded within 2 working days;

- **records can be accessed** – all information is readily available for those clinicians who need to access it for patient care;
- **records can be interpreted** – the context of the record can be interpreted: who created or added to the record and when, during which business process, and how the record is related to other records;
- **records can be trusted** – the record reliably represents the information that was actually used in, or created by, the business process, and its integrity and authenticity can be demonstrated;
- **records can be maintained through time** – the qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the record is needed, perhaps permanently, despite changes of format;
- **records are secure** – from unauthorised or inadvertent alteration or erasure, that access and disclosure are properly controlled and audit trails will track all use and changes. To ensure that records are held in a robust format which remains readable for as long as records are required;
- **records are retained and disposed of appropriately** – using consistent and documented retention and disposal procedures, which include provision for appraisal and the permanent preservation of records with archival value; and
- **staff are trained** – so that all staff are made aware of their responsibilities for record-keeping and record management.

5. Legal admissibility

- 5.1 Legal admissibility is a core Records Management principle and if a document is scanned it must be a true representation of the original.
- 5.2 Proving the authenticity of a scanned document is crucial if required as evidence in court and that any document scanned into or uploaded has not been changed since the time of its storage. For example, a referral letter received by fax and uploaded to PARIS via a folder on the network is a true representation of the original.
- 5.3 The organisation has a duty to ensure documents created or scanned, stored and migrated through electronic systems meet the evidential weight as outlined in the Civil Evidence Act 1995 to ensure Legal Admissibility should a Court require it.
- 5.4 Compliance with this procedure does not guarantee legal admissibility. It is possible to maximise the evidential weight of a record/ document by setting up authorised procedures and being able to demonstrate in court that those procedures have been followed.

6. Preparation of paper documents prior to scanning

All paper documents need to be examined prior to the scanning process, to ensure that as high a quality image as possible is obtained.

- Remove all staples, clips or other document bindings ensuring that there is no damage to the original that may affect the capture of information from the document
- Remove any poly pockets / plastic wallets
- Ensure that all physical attachments e.g. post it notes, medical results attached to mount sheets, are removed and photocopied separately before scanning (See Appendix 2 for what can go wrong)
- Anything stuck onto a page such as labels must be firmly attached, especially at the edges. They should not be obscuring anything underneath
- Where the paper is very old and thin and unlikely to pass through the scanner this should be photocopied initially and then scanned.
- If the quality of the print is poor this should be photocopied with a higher resolution using the photocopier. Handwriting (or hand drawing) using pencils can be faint, and difficult to reproduce. Care should be taken when scanning to ensure that image brightness and contrast are appropriate for these images.
- Check the physical state of the paper. The top edges of each sheet have to be 'grabbed' by the scanning rollers, so they should be straightened out if folded if using a scanner with rollers (See Appendix 3 that shows folded over corners)
- Ensure all pages of a multi- page document is kept together and in the appropriate order before, during and after scanning
- Where originals are photocopied please check the quality of the photocopy.
- Ensure that all the information contained on the original is retained on the photocopy
- Anything that has been successfully photocopied can be removed and destroyed in the confidential waste bin. (Thus ensuring that nothing is duplicated in the scanning process).
- If the document is not an original but a photocopy this should be stamped as 'COPY' to indicate this (Appendix 4).
- Ensure every page and the entire page is copied/scanned
- Scan the documents in chronological order.
- Check that all the information in the document pertains to the same patient (NHS number, name and date of birth). If misfiled information is found it must be removed and relocated in the appropriate record.

7. Scanning equipment

- Only Trust approved scanning equipment must be used and set to scan at least 200dpi.
- Scanning equipment must be regularly cleaned and maintained.
- The procurement of scanners should always be completed via the Trust ICT ordering process. Approved equipment can be found on the ICT quote page of the intranet. There are currently three types of scanners:-
 - Single page and single use scanners
 - Multipage and single use scanners
 - Multiple pages and team scanners
- Trust Multifunction Unit (MFU's) or All-In-One photocopier units can be used to scan; these devices will email the images via NHSmail but require setup by the Trust ICT Department.

8. Temporary storage of scanned or uploaded documents

A temporary folder should be created within your department/service's G Drive folder; this will be used to temporarily store the scanned documents. Once the document has been uploaded the scanned image should be removed. Staff should not retain scanned documents once it has been successfully uploaded, this will reduce the risk of duplication.

9. Naming conventions/indexing

Naming conventions provide a set of rules, which assist the individual end user in allocating a framework for the naming of folders that hold a group of documents

9.1 Naming conventions for record titles should aim to:

- Give a unique title to each record
- Give a meaningful title which closely reflects the records contents
- Express elements of the title in a structured and predictable order
- Locate the most specific information at the beginning of the title and the most general at the end
- Give a similarly structured and worded title to records which are linked (e.g. an earlier and a later version)

9.2 Scanned records, emails or documents uploaded such as email attachments pertaining to a client should be stored under an approved naming convention **i.e. Surname, First name, NHS number, date of birth, date.**

10. How to scan & upload it to your computer

10.1 Local Scanner

- 10.1.1 Insert the documents facedown in the scanner. If it is a flatbed scanner or put it into the document feeder, make sure that the scanner is clean and free of debris.
- 10.1.2 Press the 'Scan' button. If the scanner does not have a scan button, open Microsoft Word or imaging software for the scanner and initiate the scan.
- 10.1.3 On the Scanning options ensure that the image resolution is set to a minimum of 200dpi and image type is Jpeg or PDF.
- 10.1.4 Wait for the document to scan and once completed check the scanned image is acceptable. If acceptable save with an appropriately named file to a team shared area on the G:Drive. If the scanned image falls short of being acceptable, the scan process will need to be repeated.
- 10.1.5 Login into the PARIS and follow the process to upload a document, and when selecting where to acquire the image select the G;Drive location for your team and choose the document you wish to upload and press OK. You will need to add some additional information regarding the document during the upload process.
- 10.1.6 Once the scanned document has been uploaded successfully can has been tested, the copy on the team G:\ Drive location should be removed.

10.2 Network/Photocopier Scanner

- 10.2.1 Insert the documents in the scanner or put the documents into the document feeder, make sure that the scanner is clean and free of debris.
- 10.2.2 Enter your personal PIN and Select the 'Scan' option on the photocopier panel, If the scanner does not have a scan option see manual.
- 10.2.3 On the scanning options ensure that the image resolution is set to a minimum of 200dpi and Scan to Email option is selected, this will send the image as PDF file. You may be required to select or enter your email address.
- 10.2.4 On receipt of the emailed images check the scanned image is acceptable. If acceptable save with an appropriately named file to a team shared area on the G:Drive. If the scanned image falls short of being acceptable, the scan process will need to be repeated.
- 10.2.5 Login into the PARIS and follow the process to upload a document, and when selecting where to acquire the image select the G;Drive location for your team and choose the document you wish to upload and press OK. You will need to add some additional information regarding the document during the upload process.

10.2.6 Once the scanned document has been uploaded successfully can has been tested, the copy on the team G:\ Drive location should be removed.

11. Quality Control

- 11.1 Following scanning a check should be made of the paper document against the scanned document, ensuring that:-
 - The same amount of pages has been scanned
 - All pages are legible
 - They are the exact replicas of the originals
- 11.2 When starting scanning initially a relatively large sample may be selected (20%), which may be reduced (e.g. to 10% or even 5%) once the consistency of meeting the required standards has been demonstrated.
- 11.3 The quality control check should take place by someone other than the person who scanned the document to assure confidence in the quality control process and to ensure that the all pages are legible, the same amount of pages have been scanned and they are exact replicas of the originals.
- 11.4 Quality Control checks should be undertaken within one month unless an alternative time period has been formally agreed with the Records Manager.
- 11.5 Training will be provided for staff who quality control scanned documents.
- 11.6 Once a document is scanned it should not be reprinted for clinical purposes, (unless an area which uses paper records requests it) with the exception of outside agencies or a subject access request
- 11.7 Quality control sheets (Appendix 1) must be retained for audit purposes.

12. Uploading documents

- 12.1 Documents such as scanned documents, e-mails and e-mail attachments pertinent to a clinical record should be transferred to the Electronic Patient Record (EPR) i.e PARIS
- 12.2 Open the EPR application, locate the correct patient by using the NHS number as the unique identifier.
- 12.3 Select the correct section to upload your document i.e. Referrals and upload the scanned referral into the insert documents tab.

13. Retention

- 13.1 Original documentation should be kept until quality checks have taken place and assurance that the scanned documents are legible and stored securely
- 13.2 All original documentation should be retained appropriately in alphabetical order and chronologically in either a lever arch file or document wallets (no plastic wallets).
- 13.3 Once quality control checks have taken place then the original documentation should be confidentially destroyed.
- 13.4 It is not necessary to keep the electronic version. To avoid any alterations or later amendments the scanned image or uploaded document must be deleted from the network drive. This is to prevent duplication of systems and information and the potential for information to be missed, incorrectly added to or otherwise inappropriately processed.

14. Guidance

- 14.1 A simple steps guidance procedure for scanning and uploading documents can be found as an appendix. This may be laminated and used as an aide memoire to assist when scanning/uploading documents.

15. Audit

- 15.1 The procedure and processes will be audited annually to ensure that procedures are being observed.

Scanning & Uploading Documents Quality Control


Date	Name of person who scanned/uploaded document	NHS Number	Appropriately named file on PC drive	Uploaded to correct patient on PARIS	Overall Legibility	Contains all pages	Contains 'COPY' stamp if appropriate	Issues e.g. Mechanical, human error	Action	Date Corrected
The above records have been quality assured										

Print Name:

Signature:

Designation:

Service:



BOYS WITH CHART
(BIRTH - 18 YEARS)
Long cross-sectional reference data: 1905/1
S: 9L WEEKS GESTATION 42
MIPUTER No. _____

RING
JOE BLOSSGS

3426

Please place a sticker (if available) otherwise write in space provided.

Record the measurement using the boxes on this chart immediately you have taken it. Enter the date, specify the measurement in the box with the asterisk (i.e. H/C = head circumference, H = height, L = length, W = weight) and initial your entry. You might find it helpful to enter his current age in the appropriate column. Plot each measurement on the grid with a well defined dot. Trace the growth curve with a line but leave the dots clearly visible. A normal growth curve is one that always runs roughly on/parallel to one of the printed centile lines. If it doesn't, consider these guidelines:-

Refer any boy whose single height falls above the 99.6th or below the 0.4th centiles. In an otherwise healthy child refer him if his growth curve crosses between two centiles between two annual measurements at any age (e.g. moving from the 25th to the 9th centile). If his curve crosses one centile between three measurements (e.g. between 2-5 yrs) he should have one further measurement one year later by the health visitor or school nurse. At that point a judgement must be made about referral or discharge but refer if in doubt.

adult height potential

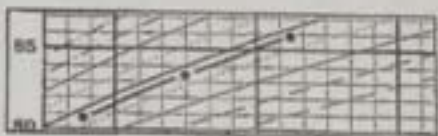
The data in the illustration shows how the potential adult height of a boy - mid-parental height (MPH) - is calculated. It indicates that his growth curve should follow the 50th centile - mid-parental centile (MPC) - to reach 175cm as an adult. It may follow a centile somewhere between the 91st - 9th (MPH ± 10cm) yet still be within his target centile range (TCR). N.B. This calculation is not appropriate if either natural parent is not of normal stature.

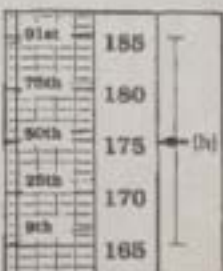
Calculate (and complete on back page) as follows:-

- (a) = father's height
- (b) = mother's height
- (c) = sum of (a) and (b)
- (d) = (c) ÷ 2
- (e) = (d) + 7cm (MPH)
- (f) = MPC - nearest centile to (e)
- (g) = TCR (mid-parental height ± 10cm)

Arrow (h) the mid-parental height/centile and draw a vertical line above and below it to represent the target centile range.

Date	Age	* Measurement	Name
14-03-93	1/12	L 77.5 cm	John Smith
14-03-93	1/12	H/C 46 cm	John Smith
14-03-93	1/12	W 9.3 kg	John Smith



(a) $\frac{176}{\text{cm}}$	
(b) $\frac{150}{\text{cm}}$	
(c) $\frac{326}{\text{cm}}$	
(d) $\frac{163}{\text{cm}}$	
(e) $\frac{175}{\text{cm}}$ (f) $\frac{50\text{th}}{\text{centile}}$	
(g) $\frac{91\text{st}}{\text{centile}} - \frac{9\text{th}}{\text{centile}}$	
(h)	

References and acknowledgements

1. Cross-sectional stature and weight reference curves for the UK, 1990 LJV Freeman, TJ Cole, B Chinn, PEM Jones, EM White, MA Preece ARCH 383-CH22-1085: 13: 17-94

2. Growth Charts for ethnic populations in the UK BJ Chinn, TJ Cole, MA Preece, B Rana The Lancet March 23rd 1996: 347: 870-840

3. No growth chart centiles need a line B37 BJ Cole BMJ 1994: 308: 641-2

Copyright Child Growth Foundation

Developed: Institute of Child Health, London (Freeman JV et al)

Manufactured: British Scales Systems, Loughborough Consultants Ltd Works PBN, Norgan, NG, Hunt NJ, Hopper P80; National Study of Health and Growth (Chinn B, Rowe J); OPCS National

Appendix 3

CLIENT DETAILS

50 Male: Female: Ward:

NEST END

Employment PT Employed
Employed F/T Student
Person P/T Student

ETHNICITY:

Number of assessments

Previously seen for therapy in this service? Yes
No

Months since last episode

Is this a follow-up/review appointment? Yes
No

as many boxes as appropriate

including dependents)
Partner
for children under 5 years
for children over 5 years
Living with parents/guardian
Living with other relatives/friends

Full time carer (of disabled/elderly etc)
Living in shared accommodation (eg lodgings)
Living in temporary accommodation (eg hostel)
Living in institution/hospital
Other

Current/previous use of services

Appendix 4

Pennine Care **NHS** **COPY**
NHS Foundation Trust

RT2 Number:

				needs		renewed are met
<i>To monitor Dorothy Health and physical well being (please see TSS Health and wellbeing checks List)</i>	<i>For Dorothy's health and physical wellbeing to be monitored as per guidelines and to promote physical wellbeing</i>	<i>To monitor as per treatment support checks Monthly monitoring of Blood Pressure/Temperature/Pulse/Respirations/Weight/and Height. Blood tests of FBC as per CPMS and current treatment prescription and requirements and further Blood tests every 6 months (U&E, TFT, LFT, Glucose, Lipids, calcium) (Lunsers) every six months Height every year Please see health and well-being checks list as filed. Information to be sent to the RMO and GP and any Care coordinator involved on a 6 monthly basis with update of assessment made by team during attendance checks are completed on a If any problems or advice needed to act or sign post to the relevant agency or advice. Promote and educate and share information support and help Dorothy to discuss on contact psychosocial needs or current concerns. Promote independence were possible Sign post to the relevant agencies were possible</i>	<i>Treatment Support Team</i>	<i>To monitor Dorothy for potential problems or concerns at specific time of contact and act accordingly depending on the needs</i>	<i>23/9/11</i>	<i>Six months or less if identified needs need to be renewed are met</i>
<i>To monitor Dorothy for any psychosocial needs or current concerns</i>	<i>Support Dorothy and help prevent stress and sign post to the relevant services/team etc which may help meet needs or problems</i>		<i>Dorothy Treatment Support Team</i>	<i>To monitor Dorothy for potential problems or concerns at specific time of contact and act accordingly</i>	<i>23/9/11</i>	<i>Six months or less if identified needs need to be renewed are met</i>

Simple Steps

**Important: All documentation should be scanned and uploaded
within 2 working days**

Scanning – What to do first

- Identify documents eligible for scanning
- Prepare documents for scanning

Scanning Preparation

- Remove all staples, clips or other document bindings ensuring that there is no damage to the original that may affect the capture of information from the document
- Remove any poly pockets / plastic wallets
- Ensure that all physical attachments e.g. post it notes, medical results attached to mount sheets, are removed and photocopied separately before scanning.
- Anything stuck onto a page such as labels must be firmly attached, especially at the edges. They should not be obscuring anything underneath
- Where the paper is very old and thin and unlikely to pass through the scanner this should be photocopied.
- If the quality of the print is poor this should be photocopied with a higher resolution using the photocopier. Handwriting (or hand drawing) using pencils can be faint, and difficult to reproduce. Care should be taken when scanning to ensure that image brightness and contrast are appropriate for these images.
- Check the physical state of the paper. The top edges of each sheet have to be 'grabbed' by the scanning rollers, so they should be straightened out if folded
- Ensure all pages of a multi- page document is kept together and in the appropriate order before, during and after scanning
- Where originals are photocopied please check the quality of the photocopy.
- Ensure that all the information contained on the original is retained on the photocopy
- Anything that has been successfully photocopied can be removed and destroyed in the confidential waste bin. (Thus ensuring that nothing is duplicated in the scanning process).
- If the document is not an original but a copy this should be stamped as 'COPY' to indicate this.
- Ensure every page is copied
- Scan the documents in chronological order.
- Check that all the information in the document pertains to the same patient (NHS number, name and date of birth). If misfiled information is found it must be removed and relocated in the appropriate record.

Storage of scanned/uploaded document

- Appropriately name the scanned document i.e. **surname, first name, NHS number, date of birth, date**
- Upload / scan document to a secure network drive

Quality Control

Check:

- The same amount of pages has been scanned
- All pages are legible
- They are the exact replicas of the originals
- Retain quality control paperwork

Transfer / migration of information

- Correctly identify the patient by using the NHS number
- Open the relevant page on the electronic patient record
- Upload document
- Check that the image has uploaded

Retention

- Original documentation should be kept until quality checks have taken place and assurance that the scanned documents are legible and stored securely
- All original documentation should be retained appropriately in alphabetical order and chronologically in either a lever arch file or document wallets (no plastic wallets).
- Once quality control checks have taken place then the original documentation should be confidentially destroyed.
- **It is not necessary to keep the electronic version. To avoid any alterations or later amendments the scanned image or uploaded document must be deleted from the network drive.**

This 'Simple Steps' procedure may be laminated and used as an aide memoire to assist when scanning/uploading documents

References

- Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically (2004)
- Code of Practice for Legal Admissibility and Evidential Weight of Information Stored of linking Electronic Identity to documents (2005)
- Records Code of Practice (2006) Part 1 & 2
- The Civil Evidence Act 1995
- The Public Records Act 1958
- The Data Protection Act 1998

Relevant Standards and Guidelines

- BSI BIP 0008
- The NHS Information Governance Toolkit

Relevant Policies

- CO20 Records Management Policy
- CO63 Protocol for the Creation, Filing & Retention of Electronic Records