Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

Title

Title: The Transition from Paper to Electronic Records and How to Volumise Procedure

Version: 2

Reference Number: CO95

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 (EAA) 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 and Ratification

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

TRANSITION FROM PAPER TO ELECTRONIC RECORDS AND HOW TO VOLUMISE

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.

1.2 There is an approved volumising procedure within the Records Management Policy (CO20) for paper records (Appendix 1) and this should be continued to be used until the service implements the electronic clinical information system.

1.3 The Trust has agreed a phased implementation of an electronic patient record (EPR) named PARIS where the electronic record replaces the paper record as the primary record.

1.4 During the implementation phase there will be some services whose primary records become electronic and some services whose primary records remain paper based.

1.5 This interim additional procedure is therefore provided to explain how to volumise during the transition from paper to electronic and vice versa depending on when the service implements the electronic information system.

2. Paper to Electronic Records Volumising Procedure

Once the service goes 'live' with the electronic clinical information system there is no longer a need to create paper documents. The following procedure outlines the process of transition from paper to an electronic information system:

- All documentation should be stored in the paper record until the 'Go Live' date.
- The newly created electronic volume must contain the full risk assessment, care plans and further relevant information cross referenced to the previous volume e.g. Pennine Assessment Documentation (PAD) in Mental Health Services. This information should be scanned into the electronic information system.
- Any alerts identified in the paper record should be transferred into the electronic information system
- Reference should be made in the electronic information system to say how many paper volumes there are and where these are currently stored. (In effect when the electronic clinical information system is commenced this is an additional volume).
- All blank history sheets should be removed from the paper file so that no additional information can be added.

- On the ‘Go Live’ date a coloured printed sheet should be inserted into the notes with the closed date of the paper volume and the start date of the electronic records (Appendix 2).
- The paper volume should then have a closed date added to the front cover (Appendix 3) and a year sticker applied.
- All paper volumes should be retained in the borough that the service user received the most recent treatment
- Any filing that relates to the client prior to the ‘GO Live’ date should be retained in the paper clinical document. The paper record should be complete at this date.
- Subsequent paper documentation must be scanned into the electronic information system.
- In the service areas where historically the paper records have followed the client around from borough to borough this will continue during the transition phase. This may be reviewed in the future.

3. Electronic Records to Paper Volumising Procedure

During the transition stage there might be transfers of patient care from a service using electronic records to a service which still uses paper records where continuity of care means that the ‘receiving’ service would need a copy of the electronic document.

- Once a request has been received from a service who currently uses electronic records then a note must be added to the electronic document to say that the primary record is now held in paper format, the service and the date must be recorded and the information printed off the system and sent to the requestor. No more information should be added to the electronic system at this stage.
- The information must then be filed by the requesting service in the appropriate dividers.
- Any alerts should also be transferred to the paper record.
- The paper records should be tracked using the usual method by that service.
- If a new volume(s) is created because of the paperwork received then these should be volumised as usual (outlined in Appendix 1).

Appendix 1

Volumising procedure (i.e. splitting and cross-referencing oversize case notes)

Case notes should not be in excess of 8cms thick because they are unmanageable in the operational clinical area and should be therefore split into volumes as follows: -

a) The case notes should be split on a chronological basis with the most recent documentation in the latest volume and the case notes should be checked meticulously for current episodes of care as both an inpatient and an outpatient.

b) The newly created volume must contain the full risk assessment, care plans and further relevant information cross referenced to the previous volume i.e. Pennine Assessment Documentation (PAD) in Mental Health Services

c) The 'old' volume of case notes should be checked for loose filing and all documentation secured to the body of the folder in the appropriate location.

d) The volumes should then be clearly marked "Volume 1", "Volume 2" on the outside front cover in the area provided with the start and end date of Volume 1 and the start date of Volume 2 being clearly recorded on the front cover of the case notes.

e) Older volumes should be crossed through and "Volume Closed" written clearly on the front cover. No further documentation should be inserted into closed volumes.

f) The closed volume should have year of last attendance sticker affixed, which corresponds to the year of the last documented attendance in that volume. (nb. When culling records for destruction, all volumes must be destroyed. This sticker will only refer to the date the retention period is calculated from if it is the last volume of notes.)

g) If the case notes are electronically tracked this should be updated to indicate that there are multiple volumes of case notes.

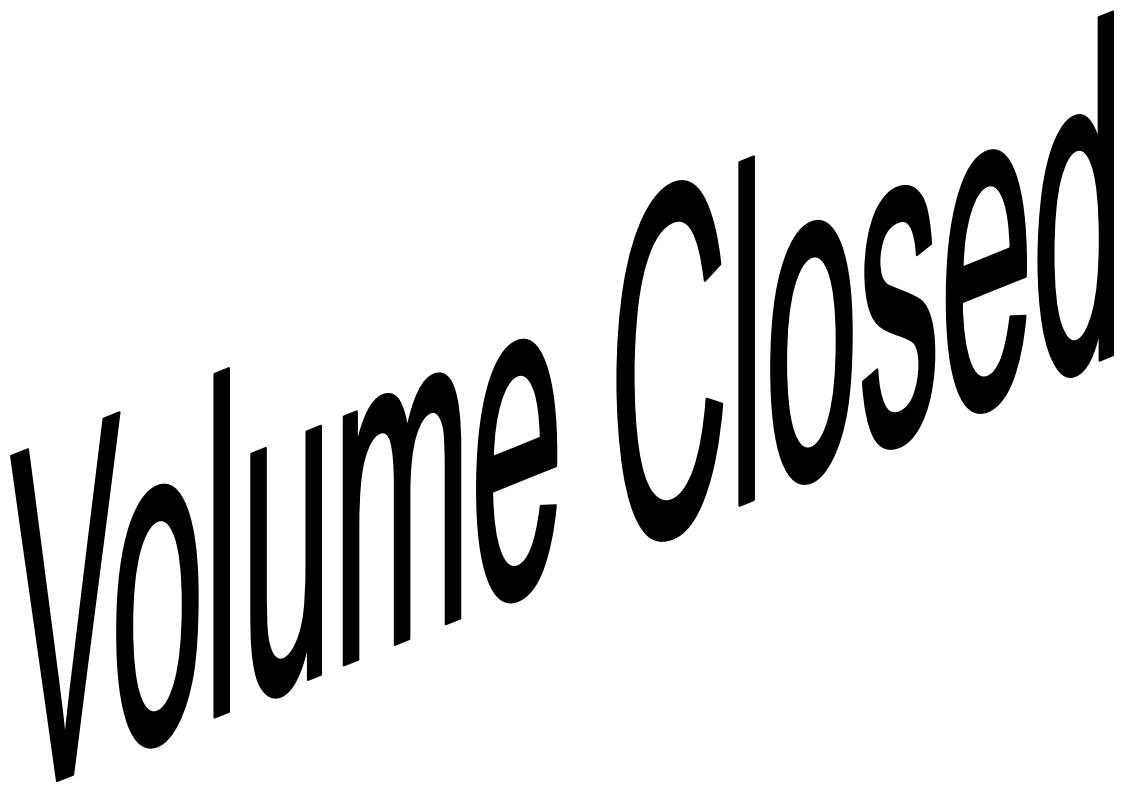
h) The most recent volume should always be used and tracked electronically, where appropriate in the normal way.

i) If older volumes are requested these must also be tracked electronically, where appropriate.

j) All volumes should be retained in the borough that the service user received the most recent treatment

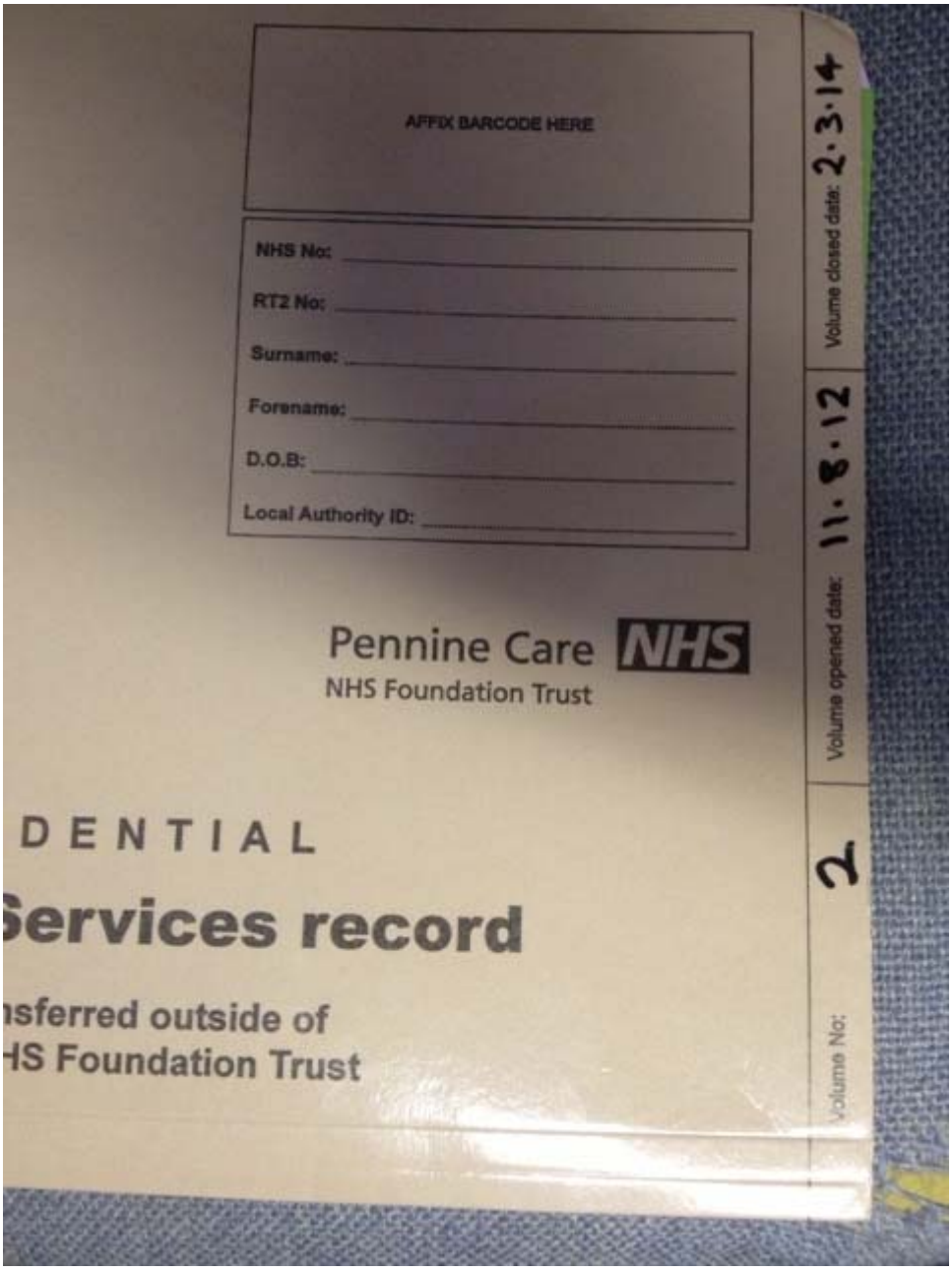
Appendix 1

Please print on coloured paper



RT2 / NHS Number:
Paper Volume Closed Date (dd/mm/yy):
Print Name:
Signature:
Print Designation:
N.b: No more paperwork should be added to this file after the date written above

Appendix 3


AFFIX BARCODE HERE
NHS No:
RT2 No:
Surname:
Forename:
D.O.B:
Local Authority ID:
Pennine Care NHS
NHS Foundation Trust
DENTIAL
Services record
nsferred outside of
HS Foundation Trust
Volume No: 2
Volume opened date: 11.8.12
Volume closed date: 2.3.14