



Health Service Executive Standards and Recommended Practices for Healthcare Records Management

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National General Healthcare Record

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National Maternity Healthcare Record

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Part 1

Introduction

Introduction

1 Introduction

1.1 *Communication*

In healthcare organisations the word 'communication' takes many forms, from a formal written document to an informal chat among colleagues. This communication involves the exchange of service user information among healthcare professionals. Structuring and organising service user information in the healthcare record is the responsibility of all users and can result in improved service user safety and quality of care.

1.2 *The importance of record keeping*

Within healthcare organisations, the healthcare record performs a number of functions in that it:

- a. maintains the history of service user care.
- b. records decisions relating to the care plan of the service user.
- c. supports the workflow of the clinical and administrative functions within the organisation for healthcare professionals and other relevant staff.
- d. supports the communication of medical information with external sources such as laboratory and radiology departments as well as consultations with and referrals between colleagues.
- e. justifies care delivery in the context of legislation, professional standards, guidelines, evidence, research and professional and ethical conduct.

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The Health Information and Quality Authority (HIQA) has developed the National Standards for Safer, Better Care to describe what a high quality, safe service looks like. They set out the need for healthcare decisions to be based on the best available evidence and information. Records are a valuable resource because of the information they contain. High-quality information underpins the delivery of high-quality evidence based safe healthcare for service users, and many other key service deliverables. Information has most value when it is accurate, up to date and accessible when it is needed. An effective records management service ensures that information is properly managed, is available whenever and wherever there is a justified need for that information, in whatever medium it is required and which is compliant with the relevant legislation.

1.3 Types of record covered by the Standards and recommended practices for healthcare records management

The Standards and recommended practices apply to healthcare records of all types (including records of service users treated on behalf of the Health Service Executive in the private healthcare sector where the Health Service Executive healthcare record is used) regardless of the medium on which they are held.

These may consist of:

- a. service user healthcare records (electronic or paper based, including those concerning all specialties).
- b. emergency department, birth, theatre, minor operations and other related registers.
- c. x-ray and imaging reports, output and images.
- d. photographs, slides, and other images.
- e. microform (i.e. microfiche/microfilm).
- f. audio and video tapes, cassettes, CD-ROM etc.
- g. computerised records.
- h. scanned records.

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1.4 *The healthcare record*

- 1.4.1 The healthcare record and its content form an essential part of care allowing communication between healthcare professionals and demonstrating that the practitioner's duty of care has been fulfilled.
- 1.4.2 The healthcare record refers to all information collected, processed and held in both manual and electronic formats pertaining to the service user and their care. It includes demographics, unique identification, clinical data, images, investigations, samples, correspondence and communications relating to the service user and his/her care.
- 1.4.3 The healthcare record is a legal document designed to provide an overview of the service user's state of health before, during, and after a particular therapy. This overview is normally compiled by different steps:
 - a. handwritten notes made during clinical encounters.
 - b. particular events or changes in the health condition of the service user that are subsequently entered into the healthcare record.
 - c. the entire body of information is summarised in a cumulative report at the time of discharge from the healthcare organisation. Each step depends on the healthcare professional's time, resources, experience and healthcare record routines and may be susceptible to neglect and data loss if documentation cannot be recorded immediately.

1.5 *Healthcare organisation environment*

Many healthcare organisations lack effective mechanisms for managing their healthcare records. This has resulted in significant amounts of information either being incorrectly filed or being recorded in poorly managed records. Active management of such information is necessary to facilitate the efficient operation of the healthcare organisation and to promote the provision of a high quality, safe service.

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1.6 *Information governance*

- 1.6.1 Information is a vital asset that not only facilitates the provision of healthcare to individuals but is also key to the efficient management of services and resources. It plays a key part in clinical governance, service planning and performance management. It is, therefore, essential that information is effectively managed and that appropriate policies, procedures, protocols and guidelines (PPPGs) and organisational structures provide a robust governance framework for information and knowledge management.
- 1.6.2 Each healthcare organisation should establish and maintain PPPGs to ensure that service users are assured that their medical information is treated in confidence and not shared inappropriately. Maintaining service user confidentiality is not only an issue of professionalism it is also a legal requirement to be compliant with the Data Protection Acts (1988) and (2003).

1.7 *Healthcare records management*

What is healthcare records management?

- 1.7.1 Healthcare records management is the systematic and consistent control of all healthcare records throughout their lifecycle:
- a. systematic - records are managed in a planned and methodical way.
 - b. consistent - records of the same kind are managed in the same way.
Whether electronic or paper, the management of the record should be consistent.
- 1.7.2 Consistency over time - managing records is always vital whether resources are adequate or scarce.
- 1.7.3 Control - organisations need to control how records are produced, received, organised, registered, stored, retrieved, retained, destroyed or permanently preserved.
- 1.7.4 All records - this includes all documents, active and inactive, formal and informal, regardless of the medium in which they are held.

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1.8 *Compliance with healthcare records management*

To comply with good healthcare records management all healthcare organisations should ensure that:

- 1.8.1 Complete and accurate records of the organisation's activities and decisions pertaining to service user care are created as soon as possible after the event.
- 1.8.2 Each healthcare record is registered on the Patient Administration System (PAS).
- 1.8.3 Any new information (whether created internally or received from elsewhere) is associated with the correct healthcare record.
- 1.8.4 Information is filed in accordance with the HSE order of filing for healthcare records.
- 1.8.5 Non-record documentary material, where appropriate, is associated with the official healthcare record by healthcare record number.
- 1.8.6 Records are kept secure and cannot be tampered with.
- 1.8.7 Service user confidentiality is maintained at all times.
- 1.8.8 All areas used for the storage of healthcare records should be secure, free of obvious hazards, protected from fire and flooding, have stable levels of temperature and relative humidity and should be kept clean and tidy.

1.9 *Other good practices*

The following are other good healthcare records management practices:

- 1.9.1 When a healthcare record has been closed, no further documents (from that date forward) should be added.
- 1.9.2 All documents received for filing should bear the appropriate record number of the healthcare record in which it is to be filed.
- 1.9.3 Paper clips and pins should be removed from documentation before filing, as these can damage the paper and if rusted can be a health hazard.

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- 1.9.4 Healthcare record covers should provide adequate protection for the documentation contained within and should be replaced if they become torn or damaged.
- 1.9.5 Healthcare records should not contain any loose documentation.
- 1.9.6 Avoid duplication of documentation – only one copy of each document should be filed unless notes have been made on a copy before the original was issued.
- 1.9.7 Healthcare records should not start with a document referring to another document that is not in the healthcare record (copy from previous volume if necessary).
- 1.9.8 Everyone has a responsibility to ensure that all documentation is filed in the correct order in the appropriate healthcare record.
- 1.9.9 The staff member who initiates a document is responsible for filing it, or ensuring that it is filed.
- 1.9.10 The staff member who issues a document for comment or a form for completion should ensure that a copy is placed on file.
- 1.9.11 If replies or comments are received in response to this document, the replies/ comments should be filed appropriately.

1.10 Development of the Standards and recommended practices for healthcare records management

The Standards and recommended practices were developed as follows:

- Extensive literature search.
- Consideration of the opinion of experts knowledgeable in the subject.
- Consideration of the available current best practice, both in Ireland and internationally, that may impact on healthcare records management.
- National workshops held with key stakeholder groups including service users to provide an opportunity for input into draft documents.

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- Development of draft Standards and recommended practices for distribution to key stakeholders for consultation.
- Feedback considered and, where appropriate, incorporated into the current version of the Standards and recommended practices.

The Code of Practice for Healthcare Records Management V2.0 is replaced by the Standards and Recommended Practices for Healthcare Records Management V3.0.

1.11 *Definition*

Standards = Organisational structures and processes needed to identify, assess and manage specified risks in relation to healthcare records management.

- Each Standard has a **title**, which summarises the area on which that Standard focuses.
- This is followed by the Standard **statement**, which explains the level of performance to be achieved.
- The **rationale** section provides the reasons why the Standard is considered to be important.
- The Standard statement is expanded in the section headed **criteria**, where it states what needs to be achieved for the Standard to be reached.

The Standards reflect the values and priorities of the Health Service Executive and will be used to direct and evaluate healthcare records management in acute hospitals.

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Recommended practices for healthcare records management = recommendations concerning the structure, content and management of the healthcare record.

The Recommended Practices are intended to define correct healthcare records management and promote service user safety. They are also intended to serve as the basis for policy, procedure, protocol and guideline development in healthcare records management in the Health Service Executive.

- Each recommended practice has an **introduction**, summarising the area on which the recommended practice focuses.
- This is followed by the **scope**, which explains the objective and why it is considered to be important.
- The contents section outlines the **content** of the recommended practice.
- This is expanded in the section headed **procedure**, where it states how each recommended practice can be achieved.



Part 2

Standards

Suitability of physical facilities

1. Suitability of physical facilities

1.1 *Statement*

Healthcare records are stored in a well-designed, secure area, which is free of obvious hazards, is protected from fire and flooding and has stable levels of temperature and relative humidity. The facility is designed so that it is a secure department with **limited and restricted access**. For guidance see Health Building Note 47. Additional detailed guidance regarding the storage and exhibition of archival documents is available in BS 5454:2000.

1.2 *Rationale*

Healthcare records are exceptionally important records. They are usually kept for long periods of time and may in some cases be selected for extended preservation. Suitable physical facilities safeguard the records from damage and destruction, optimise retrieval of records when required and provide a safe working environment.

1.3 *Criteria*

- 1.3.1 The area is maintained in a good condition and is cleaned regularly.
- 1.3.2 There is lighting over each gangway, including gangways that will exist when mobile units are in operation.
- 1.3.3 The interior is light and pleasant with an adequate level of illumination that can be varied to suit functional activities.
- 1.3.4 Healthcare records are protected from the damaging effects of sunlight.
- 1.3.5 There are sufficient electricity supply, computer terminal points and work stations within the facility to allow optimum use of Information Technology (IT), Management Information Systems (MIS) and on-line training.

Suitability of physical facilities

- 1.3.6 The ventilation system is appropriate to provide a comfortable working environment.
- 1.3.7 Temperature is maintained as close as possible to 18°C.
- 1.3.8 The floor covering does not present a hazard to staff or to the movement of wheeled equipment.
- 1.3.9 Confidentiality and security of healthcare records is maintained at all times; the healthcare records department is secure. Unauthorised access to the department is not possible.
- 1.3.10 The doors, floor and wall surfaces and furniture of healthcare records departments are designed to withstand the constant traffic of healthcare record trolleys and supply trolleys.

(Note: To minimise damage, consideration should be given to the use of protective corners and plates and to proper continuation of floor surfacing).
- 1.3.11 Healthcare records are stored on fixed and/or mobile shelving units.
- 1.3.12 There are appropriate items of equipment available to access and transport healthcare records.
- 1.3.13 There are suitable access and facilities for people with a disability who have problems of mobility or orientation.
- 1.3.14 Doors are wide enough to allow a clear space for people using a walking aid and for the passage of wheelchairs and trolleys.
- 1.3.15 Door springs are not too strong; (otherwise access for people with a physical disability is very difficult).
- 1.3.16 Fire safety training is part of induction and orientation of all staff and is reinforced throughout their term of employment.
- 1.3.17 Staff are aware of the location of fire extinguishers in their work area.

Suitability of physical facilities

Shelf filing

- 1.3.18 Healthcare records are filed on metal shelves.
- 1.3.19 Shelves are in 900mm runs, with side pieces and backing sheets.
- 1.3.20 Mobile units are approximately 5.4m in length.
- 1.3.21 Shelves are 300mm deep and set with 380mm centres between shelves, and divided by supports at 300mm intervals.
- 1.3.22 There is an adequate amount of shelf space to store all records.
- 1.3.23 The highest shelf is accessible by all staff using a kick stool/platform ladder.
- 1.3.24 Gangways 900mm wide are provided between the rows of shelving to allow for trolleys and kick stools/platform ladders.
- 1.3.25 Main access aisles are at least 1.5m wide to allow for trolleys passing each other, and for exit in the event of fire.
- 1.3.26 If mobile units are used, sufficient gangways and fixed units are allowed so that access is not impeded.

Storage facilities

- 1.3.27 Records are retrievable on a 24-hour/7 day arrangement to allow prompt treatment of:
 - a. emergency admissions.
 - b. elective admissions.
 - c. outpatient attendees.

Structure of the healthcare record

2. Structure of the healthcare record

2.1 *Statement*

All records relating to the service user are kept in a healthcare record that is structured using the agreed Health Service Executive (HSE) healthcare record order of filing. The structure facilitates documentation of the chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes. The structure also facilitates the monitoring of standards, audit, quality assurance and the investigation of complaints.

2.2 *Rationale*

The healthcare record provides a safe and effective means of communication to all healthcare providers in a structured agreed format which is easy to access.

2.3 *Criteria*

- 2.3.1 There is a unified healthcare record that all healthcare professionals use.
(*Note: For general medical service users this is the national general healthcare record, for maternity service users it is the national maternity healthcare record.*)
- 2.3.2 Each service user is assigned a healthcare record number, which is used as a unique identifier and which is printed on the outside of the healthcare record where this is in hard copy format.
- 2.3.3 The healthcare organisation follows the agreed HSE format for filing of information within the healthcare record.
- 2.3.4 Where the healthcare record is in hard copy format the folders are 485gsm quality manilla, measuring 312mm x 240mm.
- 2.3.5 Healthcare record folders have a gusset along the spine to allow for expansion to a maximum of 80mm as more documents are added.

Structure of the healthcare record

- 2.3.6 The dividers are of 200gsm quality card.
- 2.3.7 The dividers have reinforced/laminated printed tabs.
- 2.3.8 Healthcare records that have become too full (approx. 80mm thick) are closed and a new volume is opened.
- 2.3.9 There is a designated place to indicate the volume number, the date for opening and closing the new volume and the name(s) of the staff member who has opened/closed the healthcare record volume.
- 2.3.10 Where the service user has more than one healthcare record the healthcare organisation has robust and effective systems in place to bring the records together quickly and effectively.

Content of the healthcare record

3. Content of the healthcare record

3.1 *Statement*

The content of the healthcare record provides an accurate chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes. The content of each record complies with clinical guidance provided by professional bodies and legal guidance provided by the Clinical Indemnity Scheme. This standard applies to both hardcopy and electronic documentation.

3.2 *Rationale*

The healthcare record and its content form an essential part of care allowing communication between healthcare professionals and demonstrating that the practitioner's duty of care has been fulfilled.

3.3 *Criteria*

Correct identification

- 3.3.1 The service user's name is on each side of each page where service user information is documented and each side of each page has the correct unique service user identification number and/or identification label. This requirement also applies to every screen on computerised systems.
- 3.3.2 Where appropriate, before the healthcare professional makes an entry in the service user's healthcare record, s/he establishes that the record belongs to the service user being attended.
- 3.3.3 This is done by verifying name and date of birth with the service user and for in-patients/day-cases by cross-referencing the service user's identification band with the healthcare record.

Content of the healthcare record

Legibility

- 3.3.4 All documentation is clear and legible.
- 3.3.5 When prescribing, writing is in legible lower case text or block capitals.
- 3.3.6 All entries are in permanent black ink.

Documenting date and time

- 3.3.7 It is always clear from the healthcare record the date (day/month/year) that an entry was made.
- 3.3.8 The time (24 hour clock) is noted against each healthcare entry.

Author identification

- 3.3.9 All entries are signed with a clear signature, PRINTED NAME, job title and bleep number/identification number (e.g. Irish Medical Council number) where relevant.

Note 1: Section 43 (8) of the Medical Practitioners Act 2007 requires all registered medical practitioners to quote their Irish Medical Council (IMC) registration number on all medical prescriptions and all other documentation and records, whether in paper or electronic format, relating to their medical practice.

Note 2: Regulations associated with the Irish Medicines Board (Miscellaneous Provisions) Act 2006 state that the An Bórd Altranais registration number, also known as the Personal Identification Number (PIN), must be stated on any prescription written by a Registered Nurse Prescriber.

- 3.3.10 Where entries have been made by a student healthcare professional, they are counter-signed by the supervising healthcare professional.

Content of the healthcare record

Corrections

- 3.3.11 Deletions or alterations are made by scoring out with a single line followed by:
- signature (plus name in capitals) and counter-signature, if appropriate.
 - date and time of correct entry.
 - reason for amendment.
- 3.3.12 Corrections are made as close to the original recording as possible.

Documenting evidence of care

- 3.3.13 Records provide information on physical, psychological and social factors that may affect the service user.
- 3.3.14 Records provide accurate, correct, comprehensive and concise information concerning the condition and care of the service user and associated observations.
- 3.3.15 All entries in the record by healthcare professionals are made as soon as possible after each intervention and at least once every 24 hours (medical/nursing/midwifery) during the working week for acute in-patient episodes.
- 3.3.16 There is an entry in the record at least twice a week for rehabilitative care (where the service user is an in-patient).
- 3.3.17 The name of the primary clinician who is assuming overall responsibility for the service user's care is clearly identifiable in the healthcare record at all times.
- 3.3.18 The clinician's name in the healthcare record is the same clinician's name entered into the Patient Administration System (PAS).
- 3.3.19 A change in the primary clinician during the course of treatment is noted on the healthcare record and on the PAS.
- 3.3.20 Input into all records is multidisciplinary where multidisciplinary care is provided.
- 3.3.21 There are no blank spaces or pages between entries.

Content of the healthcare record

Retrospective entries

- 3.3.22 Retrospective documentation is:
- a. dated.
 - b. timed.
 - c. signed (and counter-signed as appropriate).
- 3.3.23 The reason why the retrospective entry is being made is clearly stated.
- 3.3.24 It is clear that the entry is a retrospective entry.

Abbreviations

- 3.3.25 Abbreviations used in the healthcare record are on the list of HSE approved abbreviations. If not on this list the term is written in full followed by the abbreviation in brackets and this procedure is followed on every page where the abbreviation is used.
- 3.3.26 Abbreviations are not used on:
- a. documentation that is used for transfer, discharge or on external referral letters.
 - b. consent forms, death certificates and communications sent from the healthcare organisation.

Relevancy

- 3.3.27 If an incident has not been observed but is relevant to service user care then this is clear e.g. service user states that...

Content of the healthcare record

Verbal instructions via telephone

- 3.3.28 Conversations/instructions regarding service user care from a healthcare professional via the telephone are documented, dated, timed and signed. Where possible the record of such conversations/instructions is later counter-signed by the healthcare professional responsible for giving them.

Test results

- 3.3.29 Where test results are available electronically, the report (and image where applicable) will be available via any computer on the HSE National Health Network or the Local Area Network in the healthcare organisation (provided the user has appropriate authorisation and a valid username and password which provide for tracking of access).
- 3.3.30 Where the electronic system cannot produce an access audit trail down to service user level access by a healthcare professional/user, test results are printed and signed and dated by a healthcare professional before being filed.
- 3.3.31 The signature and date are placed on the printed report adjacent to the results.
- 3.3.32 There is a note in the healthcare record of any significant abnormal results found and communicated to the relevant healthcare professional. Where appropriate, the resulting action to be taken is recorded in the healthcare record.
- 3.3.33 This includes a record of who has been informed e.g. the healthcare professional's name.
- 3.3.34 The note is made by appropriate healthcare personnel.

Content of the healthcare record

Medications

- 3.3.35 Medications are only administered and documented in the presence of clear unambiguous prescriptions or medication protocols and in accordance with the healthcare organisation's policies, procedures, protocols and guidelines.
- 3.3.36 Medication names are always written in full and are never abbreviated under any circumstances.
- 3.3.37 Where possible and appropriate only generic names are used for the medication record. Where this is not best practice (i.e. insulin, anti-epileptic medications), the medication name used is on the local approved list/formulary of trade name medications.
- 3.3.38 Chemical symbols are not used.
- 3.3.39 Where a prescription is no longer appropriate, the prescription is discontinued and a new prescription is written, if appropriate.

Language

- 3.3.40 Records are written in English.
- 3.3.41 Records are phrased clearly and unambiguously.
- 3.3.42 Records are devoid of witticisms or derogatory remarks.

Advice

- 3.3.43 Healthcare professionals' advice on care, in any format (e.g. verbal, leaflet), is documented in notes of advice given.

Content of the healthcare record

Registration

- 3.3.44 Registration information includes the following:
- a. title.
 - b. full name (forename and surname). The forename should be the name on the service user's birth certificate.
 - c. alias: the name by which the service user likes to be known, if different from the service user's name.
 - d. date of birth.
 - e. home address/current address (if different).
 - f. previous address.
 - g. two contact telephone numbers (landline and mobile, if possible).
 - h. name and address of the person to be contacted in the case of an emergency (if the service user is a minor or an incapacitated adult, the contact person should be a parent or legal guardian).
 - i. two contact telephone numbers (landline and mobile, if possible) of the person to be contacted in the case of an emergency (if the service user is a minor or an incapacitated adult, the contact person should be a parent or legal guardian).
 - j. gender.
 - k. marital/civil partnership status.
 - l. occupation.
 - m. GP name and GP contact details.
 - n. healthcare record number assigned at registration.
 - o. referral source.
 - p. mode of arrival.

Content of the healthcare record

- q. medical insurance (for inpatient activity).
- r. medical card (yes/no) - medical card number if yes.
- s. mother's maiden name.
- t. religious preferences.
- u. ethnicity.
- v. spoken language (indicate if an interpreter is needed).
- w. accompanied by.
- x. school (where relevant).
- y. All registration information should be checked on every attendance and updated where necessary, as this information is essential in the case of an emergency.

Alerts and allergies

- 3.3.45 The healthcare organisation's procedure regarding alerts and allergies is adhered to.

Referral letters

- 3.3.46 Referral letters are opened by authorised staff (e.g. OPD/Outpatient Central Referral Office) on the date they are received.
- 3.3.47 Referral letters are immediately date stamped on receipt (referral receipt date).
- 3.3.48 Referral letters are recorded on an appropriate IT system on date of receipt.
- 3.3.49 The date the referral letter is sent for triage is recorded.
- 3.3.50 Referral letters are triaged by the appropriate healthcare professional and the triage outcome and date triaged is recorded.
- 3.3.51 Referral letters that have been triaged are returned to the relevant staff (e.g. OPD/Outpatient Central Referral Office) within five working days.

Content of the healthcare record

- 3.3.52 The date the referral letter is returned from triage to the Outpatient Central Referral Office is recorded.
- 3.3.53 Where there are referrals between members of the multidisciplinary team these are processed as detailed above.
- 3.3.54 Following triage, receipt of the referral letter is acknowledged to the GP/ source of referral and the patient.
- 3.3.55 Referral letters that are logged on the appropriate IT system are tracked for completion within five working days.
- 3.3.56 Where the service user is an inpatient, receipt of referrals from within the multidisciplinary team is documented on an integrated discharge planning tracking form in the service user's healthcare record within 24 hours of receiving the referral.
- 3.3.57 Referral is made to diagnostic services by the appropriate personnel and this is documented, as appropriate.
- 3.3.58 Referral letters are stored safely according to local PPPGs from the time of receipt until they are required for clinic preparation/clinic attendance at which stage referral letters are filed in the correspondence section of the healthcare record.

Admission entry

- 3.3.59 The following minimum, general service user information is included in the record entry for acute medical admissions and may also be supplemented with additional specialty information:
 - a. reason for healthcare encounter.
 - b. presenting problem/complaint.
 - c. history of presenting problem.
 - d. estimated length of stay (ELOS).
 - e. current diagnoses.

Content of the healthcare record

- f. service user alerts/allergies.
- g. past illnesses.
- h. procedures and investigations.
- i. medications (including over-the-counter and/or non prescription) and diets including nutritional supplements.
- j. social circumstances.
- k. functional state (self-care/baseline mobility/walking aids and appliances).
- l. family history.
- m. systems review.
- n. examination findings.
- o. results of investigations.
- p. problem list.
- q. overall assessment.
- r. management plan.
- s. intended outcomes.
- t. information given to service user.

Follow-up entry

- 3.3.60 The following service user information is included in the follow up entries for acute medical admissions:
- a. reason for clinical encounter.
 - b. review of case.
 - c. overall assessment including any change since previous encounter.
 - d. management care plan.
 - e. information given to service user and carers.

Content of the healthcare record

Communication with service users

- 3.3.61 All relevant communication with service users and families is documented in the relevant part of the healthcare record.

Documenting consent in the healthcare record

- 3.3.62 The giving or refusal of consent is easily and clearly identifiable, either documented in the healthcare record or on a consent form which is retained as part of the healthcare record.
- 3.3.63 Consent documentation clearly identifies the service user by name and healthcare record number.
- 3.3.64 Consent documentation clearly states the procedure/treatment/care involved and the risks and benefits of that procedure/treatment/care, where appropriate.
- 3.3.65 Key elements of discussions held with, and information provided to the person giving consent regarding the procedure/treatment/care/risks/benefits and/or alternatives are carefully documented, where appropriate, in the healthcare record.
- 3.3.66 The method of providing this information (e.g. information leaflets, verbally etc.) is documented in the healthcare record.
- 3.3.67 The person giving or refusing consent is clearly identified in consent documentation. Where consent is being given or refused by a legally empowered representative of the service user, this person and their relationship to the service user is clearly identified.
- 3.3.68 Consent documentation is dated, timed and signed by the healthcare professional obtaining it, including clear signature, PRINTED NAME, job title and bleep number/identification number (e.g. Irish Medical Council number etc.) where relevant.
- 3.3.69 If verbal consent is provided where written consent is normally required this verbal consent is witnessed by another member of the multidisciplinary team who will date, time and sign the entry with a clear signature,

Content of the healthcare record

PRINTED NAME, job title and bleep number/identification number (e.g. Irish Medical Council number etc.) where relevant.

- 3.3.70 If an interpreter is used, the name and contact details of this individual is recorded in the healthcare record.

Service user wishes

- 3.3.71 The involvement of the service user in decisions about his or her care is documented in the clinical notes section of the healthcare record under 'service user wishes'.

Death entry

The death entry contains the following information:

- 3.3.72 Date and time death was confirmed.
- 3.3.73 Details of the examination made to confirm death.
- 3.3.74 Events leading to death and the cause(s) of death.
- 3.3.75 Clear signature, PRINTED NAME, job title and bleep number/identification number (Irish Medical Council number) of the registered medical practitioner confirming death.
- 3.3.76 Final diagnosis (to include principal diagnosis and all procedures).

Death notification

The following information is entered on the healthcare record of the deceased:

- 3.3.77 If any of the deceased's family members were present at the time of death.
- 3.3.78 Where no family members were present at the time of death, whether and how the deceased's relatives have been informed of the death.
- 3.3.79 Whether and how the General Practitioner has been or will be informed.
- 3.3.80 Whether and how other relevant care services have been or will be notified of the death.

Content of the healthcare record

Care and documentation after death

All care given to the deceased post-mortem and the completion of any required documentation is recorded in the healthcare record of the deceased, for example:

- 3.3.81 The performance of Last Offices/Laying out Procedures.
- 3.3.82 Listing of property/valuables.
- 3.3.83 Mortuary transfer documentation
- 3.3.84 Part 1 of the Death Notification Form Booklet (include the name of Registered Medical Practitioner who completed form and date and time of completion).
- 3.3.85 Cremation medical form, if required.
- 3.3.86 Documentation associated with a Hospital Post Mortem Examination or a Coroner's Post Mortem Examination if required (Detailed guidance on this documentation is given in the Standards and recommended practices for Post Mortem Examinations).

Deaths reportable to the Coroner

Detailed guidance on deaths reportable to the coroner is given in the Standards and recommended practices for Post Mortem Examinations. If the death is reportable to the coroner, the following information is recorded in the healthcare record:

- 3.3.87 The reason why the death is reportable to the coroner.
- 3.3.88 The name of the person who made the decision to notify the coroner.
- 3.3.89 The date and time of such notification.
- 3.3.90 The name of the person who was notified in the coroner's office.
- 3.3.91 The decision taken by the coroner's office.

Clinical coding

4. Clinical coding

4.1 *Statement*

The hospital uses HIPE (Hospital In-Service user Enquiry System), a computer based health information system that collects clinical and administrative data on discharges, day cases and deaths from acute hospitals.

4.2 *Rationale*

HIPE coding performs an essential function in providing quality, accurate and uniform health information and greatly contributes to the continuous growth of health knowledge.

4.3 *Criteria*

- 4.3.1 Clinical coders undergo regular training under the guidance of the HIPE Unit, Economic Social Research Unit (ESRI).
- 4.3.2 The coding system used is ICD-10-AM 6th edition (the Australian modification of the international classification of diseases produced by the World Health Organisation).
- 4.3.3 Clinical staff participate in validating the coding process.
- 4.3.4 Clinical coding is complete for all in-patient and day case episodes within the timescale set down by the Department of Health and Children/ESRI guidelines, i.e. March 31st and September 30th.
- 4.3.5 HIPE co-ordinators are responsible for, and implement regular audits of the quality of clinical coding.



Part 3

Recommended Practices

Unified Healthcare Record

Structure of the Healthcare Record

1. Unified Healthcare Record

1.1 Introduction

It is considered to be in the best interest of service users and their care that the full history of care is available to the current multidisciplinary team. The healthcare record should follow the service user through every discipline in the healthcare organisation in which that service user receives care. Documents within the record should reflect the continuum of care.

1.2 Scope

The objective of this recommended practice is to ensure that all service users treated in the healthcare organisation have a unified healthcare record, in order to provide comprehensive clinical information for effective treatment.

(Note: For general medical service users this is the national general healthcare record, for maternity service users it is the national maternity healthcare record.)

1.3 Contents

- Section One: Healthcare record
- Section Two: Contents of the healthcare record
- Section Three: Marking the healthcare record

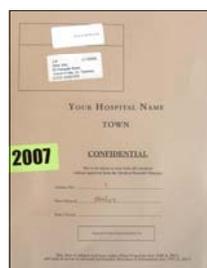


Figure 1.1 National General Healthcare Record



Figure 1.2 National Maternity Healthcare Record

Unified Healthcare Record

1.4 Procedure

Section One: Healthcare record

- 1.4.1 Healthcare records should be of 485gsm quality manilla, measure 312mm x 240mm, and have a gusset along the spine to allow for expansion to a maximum of 80mm as more documents are added. The width of the healthcare record cover should allow for protection of all inserts.
- 1.4.2 The healthcare record can have a colour on the spine and/or along the bottom of the front cover. This applies to healthcare organisations who wish to use this type of colour coding terminal digit filing system (not necessary for organisations that use colour stickers for this process).
- 1.4.3 The dividers should be of 200gsm quality card and should have reinforced/laminated printed tabs.
- 1.4.4 Each service user should be assigned a healthcare record number, which should be printed on the outside of the healthcare record and used as a unique identifier for that service user.

Section Two: Contents of the healthcare record

(a) National general healthcare record

1.4.5 Administrative Section

- a. patient/service user identification labels.
- b. front sheets/registration sheets.
- c. relevant billing/private insurance forms (pending completion only).



Figure 1.3: Sections of the General Healthcare Record

Unified Healthcare Record

1.4.6 Correspondence

- a. referral letters.
- b. discharge communication.
- c. ambulance transfer sheets.
- d. living wills.
- e. other correspondence relevant to service user care.

1.4.7 Clinical Notes

- a. clinical notes (inpatient and outpatient) including integrated care pathways and intensive care unit notes.
- b. emergency department documentation.
- c. treatment notes in relation to health & social care professionals and nurse specialists.

1.4.8 Nursing Notes e.g.

- a. vital signs observation sheets.
- b. fluid balance sheets.
- c. nursing care plans.
- d. intensive care unit nursing notes.
- e. evaluations.

Unified Healthcare Record

1.4.9 Procedures e.g.

- a. procedure forms.
- b. anaesthetic records.
- c. epidural infusion records.
- d. implant records.
- e. blood loss sheets.
- f. swab count sheets.
- g. instrument count sheets.
- h. theatre checklists.
- i. theatre nursing care plans.

1.4.10 Consent

- a. consent forms.
- b. discharge against medical advice forms.

1.4.11 Clinical Measurement e.g.

- a. cardiovascular/haemodynamic reports.
- b. vascular reports.
- c. neurophysiology reports.
- d. pulmonary function tests.
- e. gastrointestinal tract physiology (GIT) reports.
- f. urologic physiology reports.
- g. audiology reports.
- h. electroencephalogram (EEG) reports.

Unified Healthcare Record

1.4.12 Laboratory Results

- a. haematology/blood group results.
- b. biochemistry results.
- c. immunology results.
- d. microbiology results.
- e. histopathology/cellular pathology results (including hospital post mortem reports).
- f. molecular diagnostic results.

1.4.13 Radiology & Diagnostic Imaging Results

- a. radiology & diagnostic imaging reports.

1.4.14 Prescribed Medicines/Blood Products e.g.

- a. drug prescribing sheets.
- b. prescriptions.
- c. nutritional supplements.
- d. blood transfusion support.

1.4.15 Health & Social Care Professionals

- a. assessment forms.
- b. care cards.
- c. food diaries.
- d. specialised dietary regimes/meal plans etc.

Unified Healthcare Record

(b) National maternity healthcare record

1.4.16 Administrative Section

- a. patient/service user identification labels.
- b. front sheets/registration sheets.
- c. relevant billing/private insurance forms (pending completion only).



Figure 1.4: Sections of the National Maternity Healthcare Record

1.4.17 Correspondence

- a. referral letters.
- b. discharge communication.
- c. ambulance transfer sheets.
- d. other correspondence relevant to service user care.

1.4.18 Antenatal Outpatients

- a. optional information page.
- b. current pregnancy.
- c. risk factors assessment.
- d. obstetric history.
- e. medical history.
- f. partner/family history.
- g. record of antenatal visits.
- h. infant feeding antenatal checklist.
- i. birth plan.

Unified Healthcare Record

1.4.19 Fetal Assessment

- a. mount sheet for ultrasound reports/images.
- b. obstetric ultrasound findings.
- c. obstetric ultrasound notes.
- d. circumference size charts.
- e. femur length size chart.
- f. umbilical artery AB ratio chart.
- g. doppler diagrams.
- h. fetal weight centiles tables.
- i. Obstetric Day Unit documentation.
- j. Early Pregnancy Unit documentation.

1.4.20 Antenatal Inpatient Records

- a. emergency attendance documentation.
- b. record of antenatal admissions.
- c. antenatal record.
- d. antenatal daily observation records.

1.4.21 Prescribed Medicines/Blood Products e.g.

- a. documentation relating to drug prescribing, prescriptions, blood transfusions and nutritional supplements.

Unified Healthcare Record

1.4.22 Labour and Delivery Records

- a. induction/augmentation of labour record.
- b. delivery suite admission.
- c. intrapartum record/partogram.
- d. epidural record.
- e. epidural infusion monitoring record.
- f. summary of labour/delivery/birth summary – baby.
- g. perineal repair/operative vaginal delivery record.
- h. shoulder dystocia.

1.4.23 Theatre/Procedures

- a. preoperative checklist.
- b. anaesthetic preoperative assessment.
- c. anaesthetic record.
- d. perioperative nursing care record.
- e. perioperative count sheet.
- f. caesarean section operation form.
- g. operation notes.
- h. recovery room care plan.

Unified Healthcare Record

1.4.24 Postnatal

- a. postnatal admission record.
- b. suggested observations.
- c. daily postnatal observation record – mother.
- d. daily postnatal observation record – baby.
- e. postnatal records.
- f. discharge checklist – mother.
- g. discharge checklist – baby.

1.4.25 Consent

- a. antenatal bloods.
- b. discharge against medical advice.
- c. consent for anaesthesia.
- d. other consent forms as necessary.

1.4.26 Laboratory

- a. haematology.
- b. blood group.
- c. biochemistry.
- d. serology.
- e. microbiology.
- f. histopathology/cellular pathology.
- g. molecular diagnostics.

Unified Healthcare Record

1.4.27 Radiology & Diagnostic Imaging Results

- a. radiology & diagnostic imaging reports.

1.4.28 Cardiotocograph (CTG) Folder

- a. CTGs to be filed in the pocket/folder provided.

Section Three: Marking the healthcare record

1.4.29 When a healthcare record is created, the volume number and the date opened should be clearly marked, dated and signed on the front cover.

1.4.30 A service user identification label should be placed in the appropriate space on the front cover of the healthcare record.

1.4.31 In the absence of an electronic monitoring system a current year sticker should be applied to indicate record activity.

1.4.32 A colour sticker should be placed appropriately on the healthcare record to facilitate terminal digit filing in the healthcare record library.

1.4.33 In the event that there are two service users with the same first and second names in the same location a (removable) warning sticker should be placed on the front cover of the healthcare record. The sticker should be removed as soon as the risk has passed or at the time of discharge.

1.4.34 In the event of death a RIP sticker should be placed on the front cover of the healthcare record .

Unified Healthcare Record

Marking the healthcare record

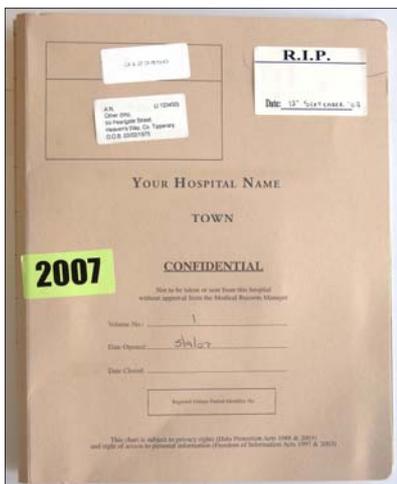


Figure 1.5: RIP sticker



Figure 1.6: Warning sticker

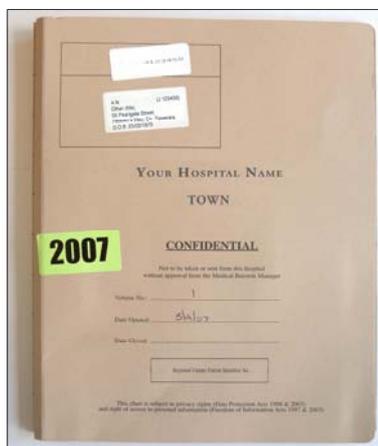


Figure 1.7: Year sticker



Figure 1.8: Terminal digit filing sticker

Part 3
Recommended Practices

Healthcare record order of filing

2 Healthcare record order of filing

2.1 Introduction

Standardised and structured healthcare records promote better communication and facilitate continuity of care. To ensure that service users are treated efficiently and effectively the current health and social care team need access to high quality healthcare records. All staff should be aware of their responsibilities for the upkeep, correct filing and acceptable presentation of healthcare records.

2.2 Scope

The objective of this recommended practice is to outline the sections within the healthcare record and what should be contained within. Correct filing in the healthcare record is crucial for ease of retrieval of information and also to assist in the coding of these healthcare records.

2.3 Contents

(a) National general healthcare record

Section One: Administrative section

Section Two: Correspondence section

Section Three: Clinical notes

Section Four: Nursing notes

Section Five: Procedures

Section Six: Consent

Section Seven: Clinical measurement

Section Eight: Laboratory results

Healthcare record order of filing

Section Nine: Radiology and diagnostic imaging results

Section Ten: Prescribed medicines/blood products

Section Eleven: Health and social care professionals

(b) National maternity healthcare record

Section One: Administrative section

Section Two: Correspondence section

Section Three: Antenatal outpatients

Section Four: Fetal assessment

Section Five: Antenatal inpatient records

Section Six: Prescribed medicines/blood products

Section Seven: Labour and delivery records

Section Eight: Theatre/procedures

Section Nine: Postnatal

Section Ten: Consent

Section Eleven: Laboratory results

Section Twelve: Radiology and diagnostic imaging results

Section Thirteen: CTG Folder

2.4 Procedure

Directions for entry/filing of information are provided on the divider of each section of the healthcare record and should be adhered to.

Healthcare record order of filing

(a) National general healthcare record

Section One: Administrative section

- 2.4.1 This section should contain service user identification labels, front sheets/registration sheets and any relevant billing/private insurance forms pending completion.
- 2.4.2 Filing should be in reverse chronological order, i.e. the most recent documentation to the front.
- 2.4.3 There should be a current, dated front sheet/registration sheet in this section of the healthcare record for every service user's first point of contact with the healthcare organisation. This sheet should contain the service user's personal details.
- 2.4.4 Thereafter, service user details should be checked for accuracy on each attendance. If there is any change in details the healthcare record should be updated and a current, accurate front sheet /registration sheet printed and placed in reverse chronological in the administrative section of the healthcare record.
- 2.4.5 Administrative staff that register or amend information should be identified on the service user's front sheet/registration sheet.
- 2.4.6 All personal details should be obtained at time of registration/admission. In the event that some details are omitted, then any member of staff who is dealing with that service user should obtain the missing information from either the service user or their relatives at the earliest opportunity.
- 2.4.7 The missing information should be passed onto the appropriate personnel, e.g. admissions office or ward clerk for entry into the healthcare organisation's information system and an updated front sheet/registration sheet should be provided and filed in reverse chronological order in the administrative section of the healthcare record.
- 2.4.8 There should be sufficient service user identification labels in the administrative section at all times.

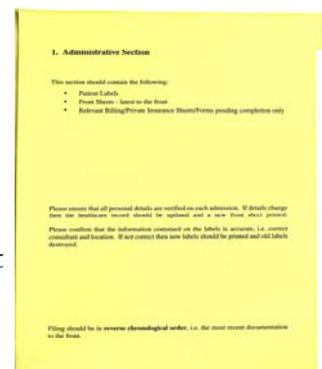


Figure 2.1:
Administrative Section

Healthcare record order of filing

- 2.4.9 All service user identification labels should be checked for accuracy on each attendance. If there is any change in details the unused identification labels should be removed from the healthcare record, shredded and replaced with a current, accurate set.
- 2.4.10 The minimum data set on each identification label should include the following service user information – healthcare record number, name, address and date of birth.

Section Two: Correspondence section

- 2.4.11 This section should contain referral letters, discharge communications, ambulance transfer sheets, living wills and any other correspondence relevant to the service user's care.
- 2.4.12 Filing should be in reverse chronological order, i.e. the most recent documentation to the front; this includes the letters sent to and from the healthcare organisation.
- 2.4.13 Only one copy of each letter of correspondence should be stored unless notes have been made on more than one copy.

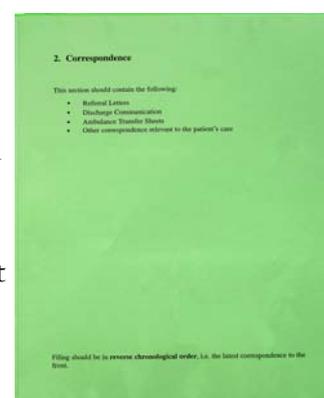


Figure 2.2:
Correspondence

Section Three: Clinical notes

- 2.4.14 This section should contain all clinical notes including Integrated Care Pathways, Intensive Care Unit notes and Emergency Department documentation. It should also be used for treatment notes in relation to Health & Social Care Professionals and Nurse Specialists.
- 2.4.15 Each side of each sheet where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.

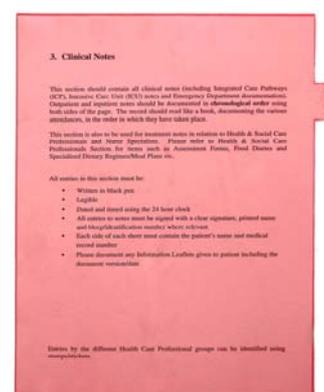


Figure 2.3:
Clinical Notes

Healthcare record order of filing

- 2.4.16 All entries in this section should be:
- written in black pen.
 - dated and timed using the 24 hour clock.
 - signed with a clear signature, PRINTED NAME, job title and bleep/ identification number (e.g. IMC No.), where relevant.
- 2.4.17 Only HSE approved abbreviations should be used.
- 2.4.18 Filing should be in chronological order, i.e. the record should read like a book, documenting the various attendances, in the order in which they have taken place (inpatient and outpatient). This facilitates prompt and precise retrieval of data.
- 2.4.19 Information leaflets given to the patient/service user should be documented including the document version/date.
- 2.4.20 Any audio-visual recordings taken by healthcare professionals should be documented in this section of the healthcare record.
- 2.4.21 Any documentation that has become loose should be reinforced and filed back into the appropriate place.
- 2.4.22 Social workers should determine if it is appropriate to include certain sensitive information in this section of the healthcare record.

Section Four: Nursing notes

- 2.4.23 This section should be used for all relevant nursing documentation.
- 2.4.24 Filing should be in chronological order, i.e. the record should read like a book, documenting events in the order in which they have taken place. This facilitates prompt and precise retrieval of data.

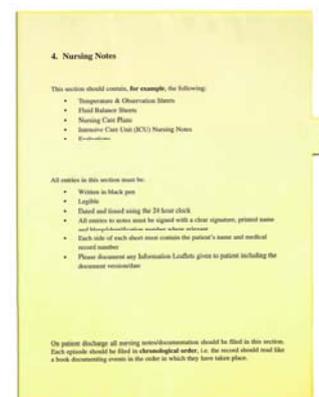


Figure 2.4: Nursing Notes

Healthcare record order of filing

- 2.4.25 All entries in this section should be:
- written in black pen.
 - the time (24 hour clock) should be noted against each healthcare entry.
 - signed with a clear signature, PRINTED NAME, job title and bleep/identification number (e.g. IMC No.), where relevant.
- 2.4.26 Each side of each sheet where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.
- 2.4.27 Information leaflets given to the service user should be documented including the document version/date.
- 2.4.28 Only HSE approved abbreviations should be used.
- 2.4.29 Any audio-visual recordings taken by nursing staff should be documented in this section of the healthcare record.

Section Five: Procedures

- 2.4.30 This section should be used for all relevant procedures.
- 2.4.31 Filing should be in reverse chronological order, i.e. the most recent documentation to the front.
- 2.4.32 All entries in this section should be:
- written in black pen.
 - dated and timed using the 24 hour clock.
 - signed with a clear signature, PRINTED NAME, job title and bleep/identification number (e.g. IMC No.), where relevant.



Figure 2.5: Procedures

- 2.4.33 Each side of each sheet where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.

Healthcare record order of filing

- 2.4.34 Information leaflets given to the service user should be documented including the document version/date.
- 2.4.35 Only HSE approved abbreviations should be used.
- 2.4.36 The procedure note for all procedures should be held in this section, although the corresponding report may be filed elsewhere.

Section Six: Consent

- 2.4.37 This section should be used to file all relevant consent forms.
- 2.4.38 Filing should be in reverse chronological order, i.e. the most recent documentation to the front.
- 2.4.39 All entries in this section should be:
 - a. written in black pen.
 - b. dated and timed using the 24 hour clock.
 - c. signed with a clear signature, PRINTED NAME, job title and bleep/identification number (e.g. IMC No.), where relevant.
- 2.4.40 Each side of each sheet where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.
- 2.4.41 Abbreviations should never be used on consent forms.
- 2.4.42 Each operation/procedure record should have a corresponding consent.

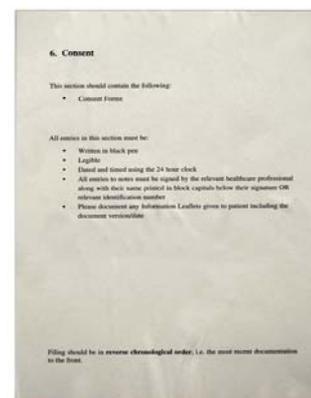


Figure 2.6: Consent

Healthcare record order of filing

Section Seven: Clinical measurement

2.4.43 This section should be used to store all reports associated with clinical measurement, for example, cardiovascular/ haemodynamic reports, vascular reports, neurophysiology reports, pulmonary function tests, gastrointestinal tract (GIT) physiology reports, urologic physiology reports, audiology reports and electroencephalogram reports.

2.4.44 All sheets/reports should be punched and filed in reverse chronological order, i.e. the most recent documentation to the front.

2.4.45 All reports should contain the service user's name, healthcare record number and date of birth.

2.4.46 Each side of each sheet where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.

2.4.47 Where reports are in hard copy format, only one copy should be filed in this section, unless notes have been made on a downloaded copy before the original report was issued.

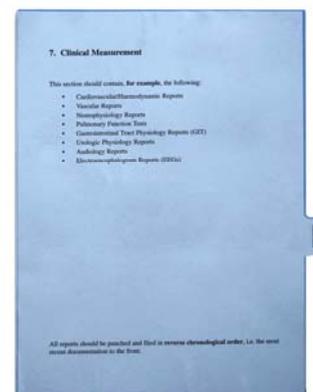


Figure 2.7
Clinical Measurement

Section Eight: Laboratory results

2.4.48 This section should be used to store all hard copy laboratory results. It should be sub-divided and have corresponding mount sheets as follows:

- haematology/blood group results (pink)
- biochemistry results (green)
- immunology results (blue)
- microbiology results (yellow)
- histopathology results/cellular pathology results (white)
- molecular diagnostic results (grey)

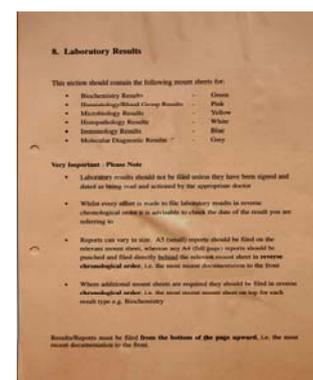


Figure 2.8:
Laboratory Results

Healthcare record order of filing

- 2.4.49 Where test results are available electronically, the report should be available via any computer on the HSE National Health Network or the Local Area Network in the Healthcare Organisation (provided the user has appropriate authorisation and a valid username and password which provide for tracking of access).
- 2.4.50 Where the electronic system cannot produce an access audit trail down to service user level access by a healthcare professional/user, test results should be printed and signed and dated by a healthcare professional before being filed. **Test results should not be filed before being signed and dated.**
- 2.4.51 All printed reports should be signed no later than twenty four hours of the result being available (this recommended timeframe is based on clinical need and may be shorter in some cases).
- 2.4.52 The signature and date should be placed on the printed report adjacent to the results.
- 2.4.53 It should be noted in the healthcare record if any significant abnormal results are found and communicated to the relevant healthcare professional including who has been informed. Where appropriate, the resulting action to be taken should be recorded in the healthcare record.
- 2.4.54 Where reports are in hard copy format, only one copy should be filed in this section, unless notes have been made on a downloaded copy before the original report was issued from the laboratory.
- 2.4.55 Each mount sheet should have eleven self-adhesive strips that facilitate the filing of eleven reports. These should be numbered with number one being where the first report is to be filed, etc.
- 2.4.56 While every effort is made to file reports in date order, the user should check the date of the report being referred to.
- 2.4.57 The colour of the mount sheet should correspond to the colour of the laboratory reports.
- 2.4.58 A5 (small) reports should be filed on the laboratory mount sheet from the bottom of the page upwards.

Healthcare record order of filing

- 2.4.59 A4 (full page) reports should be punched and filed directly behind the mount sheet in reverse chronological order.
- 2.4.60 When a mount sheet is full, additional reports should never be sellotaped or stapled to the full mount sheet. A new mount sheet should be added in reverse chronological order with the most recent mount sheet on top for each result type.

Section Nine: Radiology and diagnostic imaging results

- 2.4.61 This section should be used to store hard copy radiology and diagnostic imaging reports.
- 2.4.62 Where radiology and diagnostic imaging results are available electronically, the report (and image where applicable) should be available via any computer on the HSE's National Health Network or the Local Area Network in the healthcare organisation (provided the user has an appropriate and valid log-in username and password which will allow tracking of access).
- 2.4.63 Where the electronic system cannot produce an access audit trail down to service user level access by a healthcare professional/user, test results should be printed and signed and dated by a healthcare professional before being filed. **Test results should not be filed before being signed and dated.**
- 2.4.64 All printed reports should be signed no later than twenty four hours of the result being available (this recommended timeframe is based on clinical need and may be shorter in some cases).
- 2.4.65 The signature and date should be placed on the printed report adjacent to the results.
- 2.4.66 It should be noted in the healthcare record if any significant abnormal results are found and communicated to the relevant healthcare professional including who has been informed. Where appropriate, the resulting action to be taken should be recorded in the healthcare record.

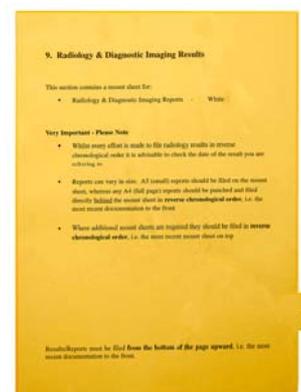


Figure 2.9:
Radiology & Diagnostic
Imaging Results

Healthcare record order of filing

- 2.4.67 Where reports are in hard copy format, only one copy should be filed in this section, unless notes have been made on a downloaded copy before the original report was issued from the radiology department.
- 2.4.68 Each mount sheet should have eleven self-adhesive strips that facilitate the filing of eleven reports. These should be numbered with number one being where the first report is to be filed, etc.
- 2.4.69 While every effort is made to file reports in date order, the user should check the date of the report being referred to.
- 2.4.70 A5 (small) reports should be filed on the radiology mount sheet from the bottom of the page upwards.
- 2.4.71 A4 (full page) reports should be punched and filed directly behind the mount sheet in reverse chronological order.
- 2.4.72 When a mount sheet is full, additional reports should never be sellotaped or stapled to the full mount sheet. A new mount sheet should be added in reverse chronological order with the most recent mount sheet on top for each result type.

Section Ten: Prescribed medicines/blood products

- 2.4.73 This section should be used for all documentation relating to prescribed medicines, nutritional supplements and blood products administered.
- 2.4.74 Filing should be in reverse chronological order, i.e. the most recent documentation to the front.

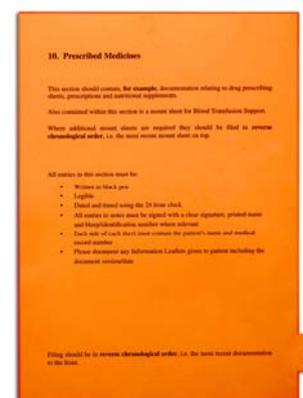


Figure 2.10:
Prescribed Medicines/
Blood Products

Healthcare record order of filing

- 2.4.75 All entries in this section should be:
- written in black pen.
 - dated and timed using the 24 hour clock.
 - signed with a clear signature, PRINTED NAME, job title and bleep/identification number (e.g. IMC No.), where relevant.

(Note - An Bórd Altranais registration number, also known as the personal identification number (PIN), should be stated on prescriptions written by the Registered Nurse Prescriber (RNP))

- 2.4.76 Each side of each sheet/medication record where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.
- 2.4.77 Information leaflets given to the service user should be documented including the document version/date.
- 2.4.78 Medication names should always be written in full and never abbreviated under any circumstances.

Section Eleven: Health and social care professionals

- 2.4.79 This section is where all health and social care professionals should file assessment forms, care cards, food diaries, specialised dietary regimes/meal plans etc.
- 2.4.80 Filing should be in reverse chronological order, i.e. the most recent documentation to the front.
- 2.4.81 All entries in this section should be:
- written in black pen.
 - dated and timed using the 24 hour clock.
 - signed with a clear signature, PRINTED NAME, job title and bleep/identification number (e.g. IMC No.), where relevant.

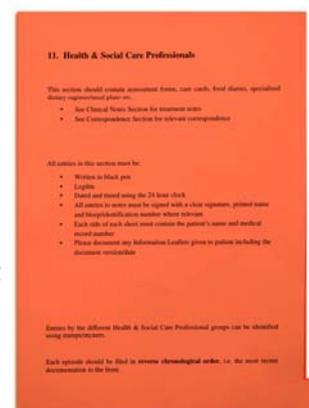


Figure 2.11:
Health & Social Care
Professionals

Healthcare record order of filing

- 2.4.82 Each side of each sheet where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.
- 2.4.83 Information leaflets given to the service user should be documented including the document version/date.
- 2.4.84 Only HSE approved abbreviations should be used.
- 2.4.85 Entries by the different health and social care professional groups should be identified using stamps/stickers/sub-dividers.

(b) National maternity healthcare record

Section One: Administrative section

- 2.4.86 This section should contain service user identification labels, front sheets/registration sheets and any relevant billing/private insurance forms pending completion.
- 2.4.87 Filing should be in reverse chronological order, i.e. the most recent documentation to the front.
- 2.4.88 There should be a current, dated front sheet/registration sheet in this section of the healthcare record for every service user's first point of contact with the healthcare organisation. This sheet should contain the service user's personal details.
- 2.4.89 Thereafter, service user details should be checked for accuracy on each attendance. If there is any change in details the healthcare record should be updated and a current, accurate front sheet/registration sheet printed and placed in reverse chronological order in the administrative section of the healthcare record.
- 2.4.90 Administrative staff that register or amend information should be identified on the service user's front sheet/registration sheet.

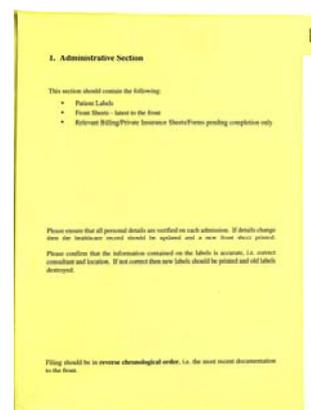


Figure 2.12: Administrative Section

Healthcare record order of filing

- 2.4.91 All personal details should be obtained at time of registration/admission. In the event that some details are omitted, then any member of staff who is dealing with that service user should obtain the missing information from either the service user or their relatives at the earliest opportunity.
- 2.4.92 The missing information should be passed onto the appropriate personnel, e.g. admissions office or ward clerk for entry into the healthcare organisation's information system and an updated front sheet/registration sheet should be provided and filed in reverse chronological order in the administrative section of the healthcare record.
- 2.4.93 There should be sufficient service user identification labels in the administrative section at all times.
- 2.4.94 All service user identification labels should be checked for accuracy on each attendance. If there is any change in details the unused identification labels should be removed from the healthcare record, shredded and replaced with a current, accurate set.
- 2.4.95 The minimum data set on each identification label should include the following service user information – healthcare record number, name, address and date of birth.

Section Two: Correspondence section

- 2.4.96 This section should contain referral letters, discharge communications, ambulance transfer sheets and any other correspondence relevant to the service user's care.
- 2.4.97 Filing should be in reverse chronological order, i.e. the most recent documentation to the front; this includes the letters sent to and from the healthcare organisation.
- 2.4.98 Only one copy of each letter of correspondence should be stored unless notes have been made on more than one copy.

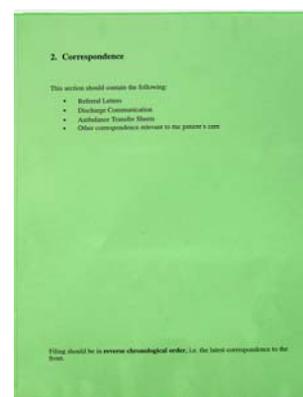


Figure 2.13:
Correspondence

Healthcare record order of filing

Section Three: Antenatal Outpatients

- 2.4.99 This section should aim to ensure the collection of all information required to assess each individual woman's maternity care needs and plan appropriate care provision.
- 2.4.100 Each side of each sheet where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.
- 2.4.101 All entries in this section should be:
- written in black pen.
 - dated and timed using the 24 hour clock.
 - signed with a clear signature, PRINTED NAME, job title and bleep/identification number (e.g. IMC No.), where relevant.
- 2.4.102 Only HSE approved abbreviations should be used.
- 2.4.103 Filing should be in chronological order, i.e. the record should read like a book, documenting events in the order in which they have taken place. This will facilitate prompt and precise retrieval of data.



Figure 2.14:
Antenatal Outpatients

Section Four: Fetal Assessment

- 2.4.104 This section should be used for the collection of all information related to fetal assessment and attendance by the woman to the obstetric day unit and/or early pregnancy assessment unit (EPAU).
- 2.4.105 All reports should contain the service user's name, healthcare record number and date of birth.
- 2.4.106 Each side of each sheet where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.

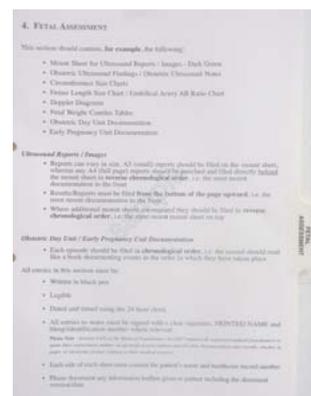


Figure 2.15:
Fetal Assessment

Healthcare record order of filing

2.4.107 All entries in this section should be:

- a. written in black pen.
- b. dated and timed using the 24 hour clock.
- c. signed with a clear signature, PRINTED NAME, job title and bleep/identification number (e.g. IMC No.), where relevant.

2.4.108 Only HSE approved abbreviations should be used.

2.4.109 Filing of ultrasound reports/images should be from the bottom of the page upward, i.e. the most recent documentation to the front.

2.4.110 Filing of obstetric day unit/early pregnancy unit documentation should be in chronological order. The record should read like a book, documenting the various attendances, in the order in which they have taken place. This will facilitate prompt and precise retrieval of data.

Section Five: Antenatal Inpatient Records

2.4.111 This section should contain all documentation relating to the antenatal inpatient stay and also any documentation relating to emergency attendance at the hospital.

2.4.112 Each side of each sheet where service user information is documented should have a service user identification label.

In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.

2.4.113 All entries in this section should be:

- a. written in black pen.
- b. dated and timed using the 24 hour clock.
- c. signed with a clear signature, PRINTED NAME, job title and bleep/identification number (e.g. IMC No.), where relevant.

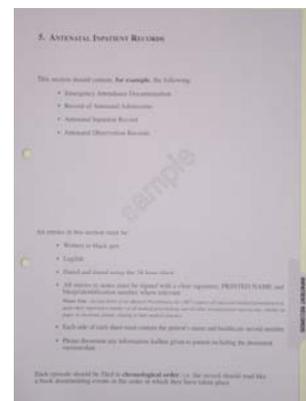


Figure 2.16: Antenatal Inpatient Records

Healthcare record order of filing

- 2.4.114 Only HSE approved abbreviations should be used.
- 2.4.115 Filing should be in chronological order, i.e. the record should read like a book, documenting events in the order in which they have taken place. This will facilitate prompt and precise retrieval of data.

Section Six: Prescribed Medicines/Blood Products

- 2.4.116 This section should contain all documentation relating to prescribed medicines, nutritional supplements and blood products administered.
- 2.4.117 Each side of each sheet/medication record where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.

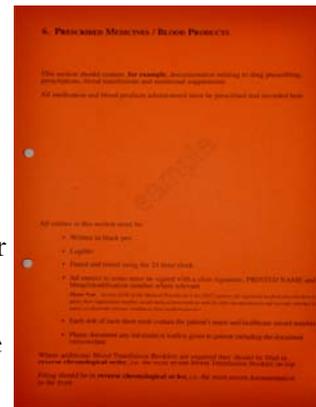


Figure 2.17: Prescribed Medicines/Blood Products

- 2.4.118 All entries in this section should be:
- written in black pen.
 - dated and timed using the 24 hour clock.
 - signed with a clear signature, PRINTED NAME, job title and bleep/identification number (e.g. IMC No.), where relevant.
- 2.4.119 All registered medical practitioners should quote their Irish Medical Council (IMC) registration number on all medical prescriptions and all other documentation and records, whether in paper or electronic format, relating to their medical practice (Section 43(8) of the Medical Practitioners Act 2007).
- 2.4.120 An Bórd Altranais registration number, also known as the personal identification number (PIN), should be stated on prescriptions written by the Registered Nurse Prescriber (RNP) (Irish Medicines Board (Miscellaneous Provisions) Act 2006).

Healthcare record order of filing

- 2.4.121 Medication names should always be written in full and never abbreviated under any circumstances.
- 2.4.122 Filing should be in reverse chronological order, i.e. the most recent documentation to the front.

Section Seven: Labour and Delivery Records

- 2.4.123 This section should contain all documentation relating to labour and delivery.
- 2.4.124 Each side of each sheet where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.



Figure 2.18: Labour and Delivery Records

- 2.4.125 All entries in this section should be:
- written in black pen.
 - dated and timed using the 24 hour clock.
 - signed with a clear signature, PRINTED NAME, job title and bleep/ identification number (e.g. IMC No.), where relevant.
- 2.4.126 Only HSE approved abbreviations should be used.
- 2.4.127 Filing should be in chronological order, i.e. the record should read like a book, documenting events in the order in which they have taken place. This will facilitate prompt and precise retrieval of data.

Healthcare record order of filing

Section Eight: Theatre/Procedures

- 2.4.128 This section should contain all documentation associated with care provided in theatre.
- 2.4.129 Each side of each sheet where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.
- 2.4.130 All entries in this section should be:
- written in black pen.
 - dated and timed using the 24 hour clock.
 - signed with a clear signature, PRINTED NAME, job title and bleep/identification number (e.g. IMC No.), where relevant.
- 2.4.131 Only HSE approved abbreviations should be used.
- 2.4.132 Filing should be in chronological order, i.e. the record should read like a book, documenting events in the order in which they have taken place. This will facilitate prompt and precise retrieval of data.



Figure 2.19: Theatre/Procedures

Section Nine: Postnatal

- 2.4.133 This section should contain documentation relating to postnatal care provision.
- 2.4.134 Each side of each sheet where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.

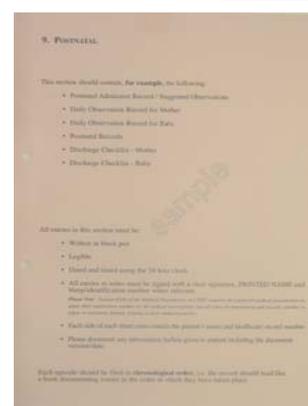


Figure 2.20: Postnatal

Healthcare record order of filing

- 2.4.135 All entries in this section should be:
- written in black pen.
 - dated and timed using the 24 hour clock.
 - signed with a clear signature, PRINTED NAME, job title and bleep/identification number (e.g. IMC No.), where relevant.
- 2.4.136 Only HSE approved abbreviations should be used.
- 2.4.137 Filing should be in chronological order, i.e. the record should read like a book, documenting events in the order in which they have taken place. This will facilitate prompt and precise retrieval of data.

Section Ten: Consent

- 2.4.138 This section should be used to store all consent forms used during the provision of maternity care.
- 2.4.139 Each side of each sheet where service user information is documented should have a service user identification label. In the absence of such labels, the service user's name, healthcare record number and date of birth should be written.



Figure 2.21: Consent

- 2.4.140 All entries in this section should be:
- written in black pen.
 - dated and timed using the 24 hour clock.
 - signed with a clear signature, PRINTED NAME, job title and bleep/identification number (e.g. IMC No.), where relevant.
- 2.4.141 Abbreviations should never be used on consent forms.
- 2.4.142 Each operation/procedure record should have a corresponding consent.
- 2.4.143 Filing should be in reverse chronological order, i.e. the most recent documentation to the front.

Healthcare record order of filing

Section Eleven: Laboratory Results

2.4.144 The laboratory results section should be sub-divided and have corresponding mount sheets as follows:

- a. haematology (pink)
- b. blood group results (pink)
- c. biochemistry results (green)
- d. serology results (blue)
- e. microbiology results (yellow)
- f. histopathology results/cellular pathology results (white)
- g. molecular diagnostic results (grey)

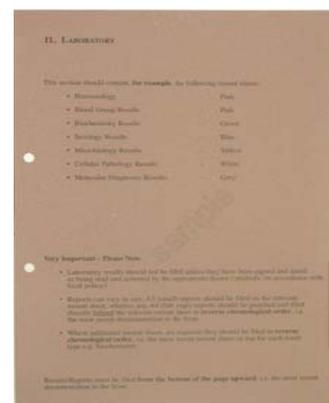


Figure 2.22:
Laboratory Results

2.4.145 Where test results are available electronically, the report should be available via any computer on the HSE National Health Network or the Local Area Network in the Healthcare Organisation (provided the user has appropriate authorisation and a valid username and password which provide for tracking of access).

2.4.146 Where the electronic system cannot produce an access audit trail down to service user level access by a healthcare professional/user, test results should be printed and signed and dated by a healthcare professional before being filed. **Test results should not be filed before being signed and dated.**

2.4.147 All printed reports should be signed no later than twenty four hours of the result being available (this recommended timeframe is based on clinical need and may be shorter in some cases).

2.4.148 The signature and date should be placed on the printed report adjacent to the results.

2.4.149 It should be noted in the healthcare record if any significant abnormal results are found and communicated to the relevant healthcare professional including who has been informed. Where appropriate, the resulting action to be taken should be recorded in the healthcare record.

Healthcare record order of filing

- 2.4.150 Where reports are in hard copy format, only one copy should be filed in this section, unless notes have been made on a downloaded copy before the original report was issued from the laboratory.
- 2.4.151 Each mount sheet should have eleven self-adhesive strips that facilitate the filing of eleven reports. These should be numbered with number one being where the first report is to be filed, etc.
- 2.4.152 While every effort is made to file reports in date order, the user should check the date of the report being referred to.
- 2.4.153 When a mount sheet is full, additional reports should never be sellotaped or stapled to the full mount sheet. A new mount sheet should be added in reverse chronological order with the most recent mount sheet on top for each result type.
- 2.4.154 The colour of the mount sheet should correspond to the colour of the laboratory reports.
- 2.4.155 A5 (small) reports should be filed on the laboratory mount sheet from the bottom of the page upwards.
- 2.4.156 A4 (full page) reports should be punched and filed directly behind the mount sheet in reverse chronological order.

Section Twelve: Radiology & Diagnostic Imaging Results

- 2.4.157 This section should be used to store hard copy radiology and diagnostic imaging reports.
- 2.4.158 Where radiology and diagnostic imaging results are available electronically, the report (and images where applicable) should be available via any computer on the HSE National Health Network (provided the user has an appropriate and valid log-in username and password which will allow tracking of access).

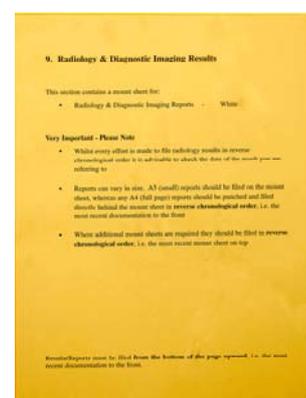


Figure 2.23: Radiology & Diagnostic Imaging Results

Healthcare record order of filing

- 2.4.159 Where the electronic system cannot produce an access audit trail down to service user level access by a healthcare professional/user, test results should be printed and signed and dated by a healthcare professional before being filed. **Test results should not be filed before being signed and dated.**
- 2.4.160 All printed reports should be signed no later than twenty four hours of the result being available (this recommended timeframe is based on clinical need and may be shorter in some cases)
- 2.4.161 The signature and date should be placed on the printed report adjacent to the results.
- 2.4.162 It should be noted in the healthcare record if any significant abnormal results are found and communicated to the relevant healthcare professional including who has been informed. Where appropriate, the resulting action to be taken should be recorded in the healthcare record.
- 2.4.163 Where reports are in hard copy format, only one copy should be filed in this section, unless notes have been made on a downloaded copy before the original report was issued from the radiology department.
- 2.4.164 Each mount sheet should have eleven self-adhesive strips that facilitate the filing of eleven reports. These should be numbered with number one being where the first report should be filed, etc.
- 2.4.165 While every effort is made to file reports in date order, the user should check the date of the report being referred to.
- 2.4.166 When a mount sheet is full, additional reports should never be sellotaped or stapled to the full mount sheet. A new mount sheet should be added in reverse chronological order with the most recent mount sheet on top for each result type.
- 2.4.167 A5 (small) reports should be filed on the radiology mount sheet from the bottom of the page upwards.
- 2.4.168 A4 (full page) reports should be punched and filed directly behind the mount sheet in reverse chronological order.

Healthcare record order of filing

Cardiotocograph (CTG) Folder

2.4.169 All CTG's recorded during the provision of maternity care should be filed in the CTG folder.

2.4.170 A second or subsequent folder should be used, if required.

2.4.171 If more than one folder is required then one folder should be closed and the date of closure documented on the outside so that specific CTG's may be located more easily.

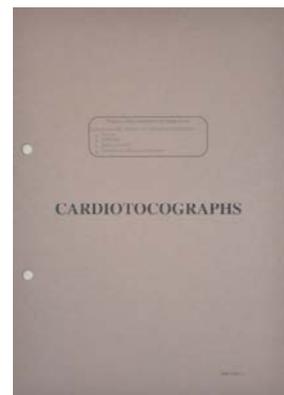


Figure 2.24:
CTG Folder

General requirements for all entries in the healthcare record

Content of the Healthcare Record

3. General requirements for all entries in the healthcare record

3.1 *Introduction*

The Health Service Executive is committed to providing high quality, safe care. The quality of clinical documentation in the healthcare record is essential to:

- a. ensure the continuity and delivery of safe, quality healthcare.
- b. document and facilitate communication of care between service user, family and healthcare teams and provide evidence of same.
- c. justify care delivery in the context of legislation, professional standards, policies, procedures, protocols and guidelines, evidence, research and professional and ethical conduct.

This includes demonstrating accountability and defending care delivery within the context of medico-legal issues.

The healthcare record should contain sufficient information to identify the service user, support the diagnosis, justify treatment, document the treatment course and results and facilitate continuity of care among healthcare providers.

3.2 *Scope*

The purpose of this recommended practice is to provide guidance to healthcare professionals on good practice for healthcare documentation.

3.3 *Contents*

Section One: Ensuring correct identification

Section Two: Legibility

General requirements for all entries in the healthcare record

- Section Three: Documenting date and time
- Section Four: Author identification
- Section Five: Corrections
- Section Six: Documenting evidence of care
- Section Seven: Retrospective entries
- Section Eight: Abbreviations
- Section Nine: Relevancy
- Section Ten: Verbal instructions
- Section Eleven: Abnormal results
- Section Twelve: Medications
- Section Thirteen: Language
- Section Fourteen: Advice

3.4 Procedure

Section One: Ensuring correct identification

- 3.4.1 The service user's name should be on each side of each page where service user information is documented and each page should have the correct unique service user identification number and/or identification label. This requirement should also apply to every screen on computerised systems.
- 3.4.2 Before the healthcare professional makes an entry in the service user's healthcare record, he/she should establish that the record belongs to the service user being attended.

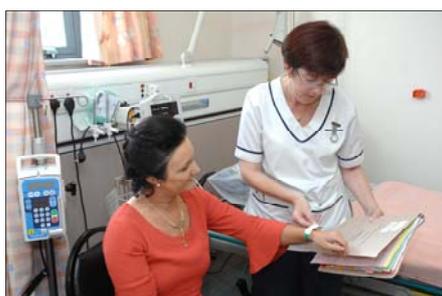


Figure 3.1: Ensure correct identification—verify with the service user and cross reference the service user's ID band with the healthcare record

General requirements for all entries in the healthcare record

- 3.4.3 This should be done by verifying name and date of birth with the service user and for in-patients/day-cases by cross-referencing the service user's identity band with the healthcare record.

Section Two: Legibility

- 3.4.4 Writing should be clear and legible.
- 3.4.5 When prescribing, writing should be in legible lower case text or block capitals.
- 3.4.6 All entries should be in permanent black ink.

Section Three: Documenting date and time

- 3.4.7 It should always be clear from the healthcare record the date an entry was made.
- 3.4.8 The time (24 hour clock) should be noted against each healthcare entry.

Section Four: Author identification

- 3.4.9 All entries should be signed with a clear signature, PRINTED NAME, job title and bleep number/identification number (e.g. Irish Medical Council number) where relevant.
- 3.4.10 Any references to individual healthcare professionals should state their full name and title. Documentation stating, "seen by physio" or "reviewed by SHO" is unacceptable.
- 3.4.11 Where entries have been made by a student healthcare professional, they should be counter-signed by the supervising healthcare professional.
- 3.4.12 Each healthcare organisation should have a signature bank of all staff (clinical and non-clinical) that may have occasion to write in the healthcare record.

General requirements for all entries in the healthcare record

- 3.4.13 The mechanism for achieving this should be considered and progressed in each healthcare organisation in consultation with both the human resource and medical manpower departments.

Section Five: Corrections

- 3.4.14 Deletions or alterations should be made by scoring out with a single line followed by:
- signature (plus name in capitals) and counter signature, if appropriate.
 - date and time of correct entry.
 - reason for amendment.
- 3.4.15 Corrections should be made as close to the original record as possible.

Section Six: Documenting evidence of care

- 3.4.16 Records should provide information on physical, psychological and social factors that may affect the service user.
- 3.4.17 Records should provide accurate, correct, comprehensive and concise information concerning the condition and care of the service user and associated observations.
- 3.4.18 All entries in the record by healthcare professionals should be made as soon as possible after each intervention and at least once every 24 hours (medical/nursing/midwifery) during the working week for acute inpatient episodes.
- 3.4.19 There should be an entry in the record at least twice a week for rehabilitative care (where the service user is an in-patient).
- 3.4.20 The name of the primary clinician who is assuming overall responsibility for the service user's care should be clearly identifiable in the healthcare record at all times.

General requirements for all entries in the healthcare record

- 3.4.21 The clinician's name in the healthcare record should be the same clinician's name entered into the Patient Administration System (PAS).
- 3.4.22 A change in the primary clinician during the course of treatment should be noted on the healthcare record and on the PAS.
- 3.4.23 Input into all records should be multi-disciplinary where multidisciplinary care is provided.
- 3.4.24 There should be no blank spaces or pages between entries.

Section Seven: Retrospective entries

- 3.4.25 Retrospective documentation should be:
 - a. dated.
 - b. timed (using the 24 hour clock).
 - c. signed with a clear signature, PRINTED NAME, job title and bleep/ identification number (e.g. IMC No.), where relevant (and counter-signed as appropriate).
- 3.4.26 The reason why the retrospective entry is being made should be clearly stated.
- 3.4.27 It should be clear that the entry is a retrospective entry.

Section Eight: Abbreviations

- 3.4.28 Abbreviations should be avoided if at all possible, but in the event of abbreviations being utilised, only those approved by the National Quality & Patient Safety Directorate and contained within the HSE approved abbreviations document are permitted.
- 3.4.29 If an abbreviation is used that is not contained within the HSE abbreviations document the full term used, followed by the abbreviation in brackets, should be written on each side of each page where the abbreviation is used.

General requirements for all entries in the healthcare record

- 3.4.30 Abbreviations should not be used on:
- documentation that is used for transfer or discharge.
 - communication sent from the healthcare organisation, e.g. external referral letters.
 - consent forms.
 - death certificates.
 - medication sheets.



Figure 3.2: Abbreviations

Section Nine: Relevancy

- 3.4.31 If an incident has not been observed but is relevant to service user care then this should be clear e.g. service user states that....

Section Ten: Verbal instructions via telephone

- 3.4.32 Conversations/instructions regarding service user care from a healthcare professional via the telephone should be documented, dated, timed and signed. Where appropriate the record of such conversations/instructions should be later counter-signed by the healthcare professional responsible for giving them.

General requirements for all entries in the healthcare record

Section Eleven: Test results

- 3.4.33 Where test results are available electronically, the report (and image where applicable) should be available via any computer on the HSE National Health Network or the Local Area Network in the healthcare organisation (provided the user has appropriate authorisation and a valid username and password which provide for tracking of access).
- 3.4.34 Where the electronic system cannot produce an access audit trail down to service user level access by a healthcare professional/user, test results should be printed and signed and dated by a healthcare professional before being filed. **Test results should not be filed before being signed and dated.**
- 3.4.35 All printed reports should be signed no later than twenty four hours of the result being available (this recommended timeframe is based on clinical need and may be shorter in some cases).
- 3.4.36 The signature and date should be placed on the printed report adjacent to the results.
- 3.4.37 It should be noted in the healthcare record if any significant abnormal results are found and communicated to the relevant healthcare professional including who has been informed. Where appropriate, the resulting action to be taken should be recorded in the healthcare record.
- 3.4.38 This note should be made by appropriate healthcare personnel.

Section Twelve: Medications

- 3.4.39 Medications should only be administered and documented in the presence of clear unambiguous prescriptions or medication protocols and in accordance with the healthcare organisation's policies, procedures, protocols and guidelines.

General requirements for all entries in the healthcare record

- 3.4.40 Medication names should always be written in full and never abbreviated under any circumstances.
- 3.4.41 Where possible and appropriate, only generic names should be used for the medication record. Where this is not best practice (i.e. insulin, anti-epileptic medications), the medication name used should be on the local approved list/formulary of trade name medications.
- 3.4.42 Chemical symbols should not be used.
- 3.4.43 Where a prescription is no longer appropriate, the prescription should be discontinued and a new prescription written, if appropriate.

Section Thirteen: Language

- 3.4.44 Records should be written in English.
- 3.4.45 Records should be phrased clearly and unambiguously.
- 3.4.46 Records should be devoid of witticisms or derogatory remarks.

Section Fourteen: Advice

- 3.4.47 Healthcare professionals' advice on care, in any format (e.g. verbal, leaflet), should be documented in notes of advice given.

Alerts in the healthcare record

4 Alerts in the healthcare record

4.1 Introduction

An alert in the healthcare record can be defined as an early warning of the presence of a medical condition/allergy/risk factor or any other such factor that requires consideration before treatment is initiated. There should be a documented policy, procedure, protocol or guideline (PPPG) for indicating an alert to risk factors in the healthcare record and it is imperative that this information is accurately maintained and is referred to by healthcare professionals.

4.2 Scope

The purpose of this recommended practice is to provide guidance to relevant staff regarding alerts in the healthcare record.

4.3 Contents

Section One: General principles

4.4 Procedure

Section One: General principles

- 4.4.1 Alerts/allergies and adverse drug reactions should be recorded in the appropriate section of the healthcare record by healthcare staff.
- 4.4.2 This information should be dated and signed with a clear signature, PRINTED NAME, job title and bleep/identification number (e.g. IMC No.), where relevant.
- 4.4.3 There should be an end-date for the alert, if appropriate.

Alerts in the healthcare record

- 4.4.4 If electronic patient systems are in place, alerts should also be recorded on these systems.
- 4.4.5 A clear policy, procedure, protocol or guideline as to who should enter alerts, when alerts should be entered and the procedure for removing alerts from the healthcare record should be drawn up locally by the healthcare organisation. The procedure should also set out who is responsible for transferring alerts when a subsequent volume is created.

Referral letters

5 Referral letters

5.1 Introduction

The GP/source of referral should forward a referral letter to the Outpatient Central Referrals Office for any service user that requires a healthcare consultation. This section gives general guidance that will support a consistent, safe and effective approach to referral management, however, more detailed information will be available in the 'HSE Management of Referrals to Outpatient Services Policy'.

5.2 Scope

The objective of this recommended practice is to ensure that a record is kept of every service user referred for services in the healthcare organisation and that all service users are kept on a waiting list until they are seen. Service users who do not attend for a scheduled appointment should be managed in line with the HSE Management of Referrals to Outpatient Services Policy.

5.3 Contents

Section One: General principles

5.4 Procedure

Section One: General principles

- 5.4.1 Referral letters should be opened by authorised staff (e.g. OPD/Outpatient Central Referral Office staff) on the date they are received.
- 5.4.2 Referral letters should be immediately date stamped and recorded on the appropriate IT system on date of receipt (referral receipt date).
- 5.4.3 The date the referral letter was sent for triage should be recorded.
- 5.4.4 Referral letters should be triaged by the appropriate healthcare professional and the triage outcome and date triaged should be recorded.

Referral letters

- 5.4.5 Referral letters that have been triaged should be returned to the relevant staff (e.g. OPD/Outpatient Central Referral Office) within five working days.
- 5.4.6 The date the referral letter was returned from triage to the Outpatient Central Referral Office should be recorded.
- 5.4.7 Where there are referrals between members of the multidisciplinary team these should be processed as detailed above.
- 5.4.8 Following triage, receipt of the referral letter should be acknowledged to the GP/source of referral and the patient.
- 5.4.9 Referral letters that have been logged on the appropriate IT system should be tracked for completion within five working days.
- 5.4.10 Where the service user is an inpatient, receipt of referrals from within the multidisciplinary team should be documented on an integrated discharge planning tracking form in the service user's healthcare record within 24 hours of receiving the referral.
- 5.4.11 Referral should be made to diagnostic services by the appropriate personnel and this should be documented, as appropriate.
- 5.4.12 Referral letters should be stored safely according to local PPPGs from the time of receipt until they are required for clinic preparation/clinic attendance at which stage referral letters should be filed in the correspondence section of the healthcare record.

Clinic correspondence timeframes

6 Clinic correspondence timeframes

6.1 Introduction

Following consultation at an outpatient clinic it is good practice for a healthcare professional to write a letter of response to the GP/referral source that referred the service user. Such correspondence will improve the ability of GPs to treat service users in the community and facilitate other referral sources in providing continuing care.

6.2 Scope

The objective of this recommended practice is to provide guidance to relevant staff regarding clinic correspondence and the recommended timeframes.

6.3 Contents

Section One: General Principles

6.4 Procedure

Section One: General Principles

- 6.4.1 Healthcare professionals should send clinic correspondence to the referral source within 14 days of the consultation at the outpatient clinic.
- 6.4.2 Clinic letters should identify the service user by healthcare record number, name, address and date of birth.
- 6.4.3 Clinic letters should be verified by an appropriate healthcare professional and signed with a clear signature, PRINTED NAME, job title and identification number (e.g. IMC No.), where relevant.
- 6.4.4 The healthcare record should be checked to confirm the referral source and to be certain there are no restrictions as to whom or where information can be sent.

Clinic correspondence timeframes

- 6.4.5 Clinic letters should be sent to the referral source in a sealed envelope.
- 6.4.6 A copy of the clinic letter should be filed in reverse chronological order in the correspondence section of the healthcare record.

Admission entry

7 Admission entry

7.1 Introduction

Care of the service user may be affected if complete admission information is not available to aid decisions around treatment.

7.2 Scope

The purpose of this recommended practice is to outline the minimum service user information that should be included in the record entry for medical admissions which may also be supplemented with additional specialty information.

7.3 Contents

Section One:	Reason for healthcare encounter
Section Two:	Presenting problem/complaint
Section Three:	History of presenting problem
Section Four:	Estimated length of stay (ELOS)
Section Five:	Current diagnoses
Section Six:	Service user alerts/allergies
Section Seven:	Past illnesses
Section Eight:	Procedures and investigations
Section Nine:	Medications (including over-the-counter and/or non prescription) and diets including nutritional supplements
Section Ten:	Social circumstances
Section Eleven:	Functional state (self-care/baseline mobility/walking aids and appliances)

Admission entry

Section Twelve:	Family history
Section Thirteen:	Systems review
Section Fourteen:	Examination findings
Section Fifteen:	Results of investigations
Section Sixteen:	Problem list
Section Seventeen:	Overall assessment
Section Eighteen:	Management plan
Section Nineteen:	Intended outcomes
Section Twenty:	Information given to service user

(Note: Other headings may be used locally in addition to those listed).

7.4 Procedure**Section One: Reason for healthcare encounter**

7.4.1 The reason for a healthcare encounter should be the administrative reason for the service user's contact with the healthcare professional. (e.g. clinical review, referred by GP etc).

Section Two: Presenting problem/complaint

7.4.2 The presenting problem/complaint should be the sign, symptom or condition that has occasioned the admission of the service user to the healthcare organisation. In circumstances where this does not apply, the reason for the admission should be recorded.

Section Three: History of presenting problem

7.4.3 This section should include the history of the presenting problem/complaint.

Admission entry

Section Four: Estimated length of stay (ELOS)

- 7.4.4 Each service user should have a documented ELOS.
- 7.4.5 The ELOS should be identified by the admitting consultant in conjunction with the multidisciplinary team, during pre-assessment, on the post-take ward round or within 24 hours of admission to the healthcare organisation.
- 7.4.6 The ELOS should be based on the anticipated time needed for tests and interventions to be carried out and for the service user to be clinically stable and fit for discharge. *(Note: the actual length of stay is dependent on the service user's condition and circumstances)*
- 7.4.7 The ELOS should be discussed and agreed with the service user/family and carers and this communication should be documented in the service user's healthcare record.
- 7.4.8 The ELOS should be proactively managed against the treatment plan (usually by ward staff) on a daily basis; changes should be documented in the healthcare record and communicated to the service user/family, carer and community services as appropriate.
- 7.4.9 Any changes to the ELOS should be communicated to community services, as appropriate.

Section Five: Current diagnoses

- 7.4.10 Current diagnoses should be disorders, syndromes and diseases that the person currently suffers from, including allergies. Specific professional rules may exist for particular diseases being classified as diagnoses, even if they have potentially been resolved (e.g. treated cancer).

Section Six: Service user alerts/allergies

- 7.4.11 Allergies should include any hypersensitivity reactions or other adverse event (s) related to medications. If the service user has no known allergies, this should also be recorded. Dates should be noted.

Admission entry**Section Seven: Past illnesses (where applicable)**

7.4.12 Past illnesses should include previous disorders, syndromes and diseases that are not currently affecting the service user. Dates should be noted.

Section Eight: Procedures and investigations

7.4.13 Procedures should include any operations, interventions or investigations that the service user has had.

Section Nine: Medications (including over-the-counter and/or non prescription) and diets including nutritional supplements

7.4.14 Medications should include any substance being taken by the service user on a regular or as required basis. Dose, frequency, route of administration and duration should be recorded for each medication.

7.4.15 Diets should include any special dietary needs or requirements.

7.4.16 Nutritional status should be recorded including any nutritional supplements.

Section Ten: Social circumstances

7.4.17 Social circumstances should include domestic, employment and lifestyle information.

Section Eleven: Functional state

7.4.18 Functional state should be recorded as a validated score if appropriate.

7.4.19 This should include information on: self-care/baseline mobility/walking aids and appliances.

Admission entry

Section Twelve: Family history

- 7.4.20 The family history should list the health status of immediate family members as well as the cause of their death (if known) where appropriate. This should include a genogram if appropriate.

Section Thirteen: Systems review

- 7.4.21 The review of systems should be a series of questions grouped by organ systems including: General/Constitutional, Skin/Breast, Eyes/Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Reproductive, Neurologic/Psychiatric, and Allergic/Immunologic/Lymphatic/Endocrine.

Section Fourteen: Examination findings

- 7.4.22 Examination findings should include general observations (e.g. pulse, blood pressure) as well as specific systems (e.g. cardiovascular, respiratory, central nervous) and body areas (e.g. ear, nose and throat, abdomen).

Section Fifteen: Results of investigations

- 7.4.23 Results of investigations should include test results or results of other assessments made of the service user's condition (e.g. stairs assessment). Dates should be noted.

Section Sixteen: Problem list

- 7.4.24 Problems should include any issues that require action from the healthcare professional or team and should include the service user's presenting problem, clinical findings, test results, and diagnoses. If there is uncertainty about a diagnosis then the most appropriate problem (symptom, sign or test result) should be used until the diagnosis is confirmed.

Admission entry

Section Seventeen: Overall assessment

7.4.25 Overall assessment should be the healthcare professional's overall assessment of the service user's condition.

Section Eighteen: Management plan

7.4.26 A management plan should include any procedures or medications that relate to resolving the identified problems. It should also include plans for review, follow-up and discharge planning.

Section Nineteen: Intended outcomes

7.4.27 Intended outcomes should include prognosis and 'do not resuscitate' orders.

7.4.28 Proposed time-frames should also be included.

Section Twenty: Information given to service user

7.4.29 This should include any information given to the service user (both written and verbal) on any of the items listed above. A note of the information given to the service user should be documented in the healthcare record.

Follow-up entry

8 Follow-up entry

8.1 *Introduction*

Every follow-up entry should clearly record what has happened to the service user since the previous entry including interventions and response to same and the assessment of the service user's condition. The new management care plan should be stated and any information given to the service user should be documented.

8.2 *Scope*

The objective of this recommended practice is to outline the service user information that should be included in follow up entries for acute medical admissions.

8.3 *Contents*

The contents should include the following where applicable:

Section One: Reason for clinical encounter

Section Two: Review of case

Section Three: Overall assessment including any change since previous encounter

Section Four: Management care plan

Section Five: Information given to service user and carers

8.4 *Procedure*

Section One: Reason for clinical encounter

8.4.1 Reason for clinical encounter should simply be 'ward round' or 'asked to see service user'.

Follow-up entry**Section Two: Review of case**

- 8.4.2. Review of case should include any new information that relates to the service user's care.

Section Three: Overall assessment including any change since previous encounter

- 8.4.3 Overall assessment should be the healthcare professional's overall assessment of the service user's condition including any change since previous encounter. If there is no change then 'no change' should be recorded.

Section Four: Management care plan

- 8.4.4 If the plan has not changed since the last entry then 'continue' should be recorded.

Section Five: Information given to service user and carers

- 8.4.5 Information given to service user and carers should include any information the service user has been given (both written and verbal). This should include information on any of the items listed above.

Service user consent

9 Service User Consent

9.1 Introduction

Service users have a right to make decisions about their health and well-being and healthcare professionals have a corresponding responsibility to provide sufficient information to ensure that such decisions are taken on an informed basis. It is important to appreciate that securing informed consent is an integral part of providing care and is not an administrative task. The consent form exists to demonstrate that a process of communication has taken place during which the service user has learned about his/her illness and treatment options and reached a point where they can decide, on an informed basis, to proceed with, restrict or decline the proposed intervention. This section gives general guidance on service user consent; more detailed information is available in the documentation referenced in appendix 5.

9.2 Scope

The objective of this recommended practice is to provide guidelines to staff in seeking informed consent to treatment.

9.3 Contents

Section One: General principles

Section Two: Documenting consent in the healthcare record

Section Three: Service user wishes

Section Four: Advance Healthcare Directives

Service user consent

9.4 Procedure

Section One: General principles

- 9.4.1 There are five crucial elements to consent and they should all be present for consent to be valid.
- a. **disclosure:** service users should be given sufficient information, in a way that they can understand, to enable them to exercise their right to make informed decisions about their care.
 - b. **comprehension:** service user comprehension can be increased by avoidance of complex medical terminology. Where possible, lay language, common everyday analogies, numerical explanation of risk factors, pictorial representation of relevant procedures, large font on information leaflets etc. should be used. Where possible, time should be given to reflect on the information and questions should be answered.
 - c. **voluntary:** the consent should be voluntary and should not be controlled by factors that engineer the outcome, such as persuasion by family members.
 - d. **competence:** it should be presumed that every adult is competent to give consent on his/her own behalf. Sometimes competence can be affected by age or infirmity, but this should not justify any impairment of human dignity or personal integrity. A service user may temporarily lack competence, or have fluctuating competence because of unconsciousness, the effects of drugs, shock, severe pain, severe fatigue or some impairment or disturbance of mental functioning. Therefore, the healthcare professional should be satisfied that the service user is competent to make healthcare decisions each time consent is obtained.
 - e. **agreement:** consent given by a service user should be the exercise of choice, the giving of permission for the intervention. The service user should not feel that their consent is simply a formality, a signature on a page. The objective of consent is to give the service user the right to decide what is to happen to his/her body, including the right to decide whether or not to undergo any medical intervention even where a refusal may result in harm to themselves or in their own death.

Service user consent

- 9.4.2 Consent may be expressed, i.e. affirmed orally or in writing, or it may be implied by the conduct or silence of the person whose consent is required. Oral consent is usually used to obtain permission for less serious procedures.
- 9.4.3 Caution should be exercised by the healthcare professional in the area of implied consent.
- 9.4.4 There are two exceptions to the rule for obtaining consent; therapeutic privilege and in an emergency situation.
- a. **therapeutic privilege** means that the healthcare professional can withhold information if he/she feels that it would be psychologically damaging to the service user to disclose. It is rare for a healthcare professional to rely on this privilege in justifying the reasons for not telling a service user certain facts in relation to the proposed treatment. This privilege should rarely, if ever, be exercised.
 - b. **in an emergency situation** where the service user is unable to consent or to appreciate what is required, the healthcare professional may administer, in the absence of expressed consent, the medical treatment necessary to save the life or preserve the health of the service user.
- 9.4.5 If the service user chooses not to participate in the decision making process concerning their treatment or care, the service user, if willing, should be asked to sign a waiver stating that he/she does not wish to discuss the matter following advice being offered. The discussion between the healthcare professional and service user leading to the waiver should be clearly recorded in the healthcare record.
- 9.4.6 Consent should only be requested by a healthcare professional suitably qualified and experienced enough to understand the proposed procedure/treatment/care and the risks/benefits/alternatives involved.
- 9.4.7 Consent should always be requested prior to the proposed procedure/treatment/care. Under no circumstances should consent be requested from a service user who has been pre-medicated or sedated in preparation for a procedure/treatment.

Service user consent

- 9.4.8 Written consent should not be obtained more than three months before the expected procedure/treatment date. In the event of this timeframe having lapsed, the service user should be re-consented.
- 9.4.9 If there is a change in the service user's condition between the consultation and admission resulting in a significant change in the nature, purpose or risks associated with the procedure/treatment/care, consent should be requested again.
- 9.4.10 Competent adults are entitled to refuse treatment. This applies even where such refusal is not considered by the healthcare professional to be in the service user's best interest. Where a decision to refuse treatment appears "illogical", (for example on religious grounds) the implications of this decision should be carefully explained to the service user and the information documented in the service user's healthcare record. When such a situation arises, advice should be sought from a senior colleague. In these circumstances the decision to refuse treatment should ultimately rest with the service user.
- 9.4.11 Minors between their 16th and 18th birthdays may give their own consent to medical, dental and surgical procedures (Non-Fatal Offences Against the Persons Act 1997). This includes consent to an anaesthetic, which is ancillary to the treatment and also includes any procedure undertaken for the purpose of diagnosis. The minor should have the mental and intellectual capacity to understand the proposed treatment. However, there may be circumstances where it is in the best interest of the minor, or where there is a doubt on the part of the doctor as to the mental competency of the minor to give consent, to also obtain the consent of the minor's parent or guardian. Ultimately, this is a decision for the healthcare professional to make.

Section Two: Documenting consent in the healthcare record

- 9.4.12 The giving or refusal of consent should be easily and clearly identifiable, either documented in the healthcare record or on a consent form which should be retained as part of the healthcare record.
- 9.4.13 Consent documentation should clearly identify the service user by name and healthcare record number.

Service user consent

- 9.4.14 Consent documentation should clearly state the procedure/treatment/care involved and the risks and benefits of that procedure/treatment/care, where appropriate.
- 9.4.15 Key elements of discussions held with, and information provided to the person giving consent regarding the procedure/treatment/care/risks/benefits and/or alternatives should be carefully documented, where appropriate, in the healthcare record.
- 9.4.16 The method of providing this information (e.g. information leaflets, verbally etc.) should be documented in the healthcare record.
- 9.4.17 The person giving or refusing consent should be clearly identified in consent documentation. Where consent is being given or refused by a legally empowered representative of the service user, this person and their relationship to the service user should be clearly identified.
- 9.4.18 Consent documentation should be dated, timed and signed by the healthcare professional obtaining it, including a clear signature, PRINTED NAME, job title and bleep number/identification number (e.g. Irish Medical Council number etc.) where relevant.
- 9.4.19 If verbal consent is provided where written consent is normally required it should be witnessed by another member of the multidisciplinary team who should date, time and sign the entry with a clear signature, PRINTED NAME, job title and bleep number/identification number (e.g. Irish Medical Council number etc.) where relevant.
- 9.4.20 If an interpreter is used, the name and contact details of this individual should be recorded in the healthcare record.

Section Three: Service user wishes

- 9.4.21 The involvement of the service user in decisions about his or her care should be documented in the clinical notes section of the healthcare record under 'service user wishes'.

Service user consent

Section Four: Advance Healthcare Directives

The Advance Healthcare Decisions Bill 2010 was published in May 2010. The purpose of the Bill is to make provision for the creation of an Advance Healthcare Directive which formally records the wishes of an individual at a time when they have the capacity to make decisions about healthcare that may arise in the future when the person no longer has the capacity to do so. Advance Healthcare Directive is a very specific area of consent that currently has no legal standing in Ireland, however, the HSE National Consent Guideline 2011 will give detailed guidance in this area.

Some pertinent points that should be noted regarding Advance Healthcare Directives are listed below:

- 9.4.22 Advance Care Directives currently have no legal standing in Ireland, but doctors will generally give careful consideration to requests formally written or stated.
- 9.4.23 An Advance Care Directive, sometimes known as a living will, is a statement about the type and extent of medical or surgical treatment a service user wants in the future, on the assumption that they will not be able to make that decision at the relevant time.
- 9.4.24 The treating clinician should be aware that an Advance Care Directive is in existence.
- 9.4.25 Advance Care Directives should be in writing.
- 9.4.26 Advance Care Directives should be filed in the Administrative Section of the healthcare record and flagged in the designated space for recording alerts.
- 9.4.27 Healthcare Professionals should refer to the 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners' if they so wish. This is available on the Irish Medical Council website <http://www.medicalcouncil.ie/Professional-Standards/Professional-Conduct-Ethics/>

Death entry

10 Death entry

10.1 Introduction

If the death of a service user takes place in the healthcare organisation the healthcare record should document all care given including any post mortem care and provide a record of any related documentation completed. When a service user dies or when the healthcare organisation is notified of the death of a service user, the organisation's management system should be updated to reflect this.

10.2 Scope

The objective of this recommended practice is to set out the procedure for HSE staff to follow with regard to the documentation of death entries in the healthcare record.

10.3 Contents

- Section One: Death entry
- Section Two: Death notification
- Section Three: Care and documentation after death
- Section Four: Minimum information to be included in registers
- Section Five: Deaths reportable to the coroner

10.4 Procedure

Section One: Death entry

The death entry should contain the following information:

- 10.4.1 Date and time death was confirmed.
- 10.4.2 Details of the examination made to confirm death.
- 10.4.3 Events leading to death and cause(s) of death.

Death entry

- 10.4.4 Clear signature, PRINTED NAME, job title and bleep/identification number (Irish Medical Council number) of the registered medical practitioner confirming death.
- 10.4.5 Final diagnosis (to include principal diagnosis and all procedures).

Section Two: Death notification

The following information should be entered on the healthcare record of the deceased:

- 10.4.6 If any of the deceased's family members were present at the time of death.
- 10.4.7 Where no family members were present at the time of death, whether and how the deceased's relatives have been informed of the death.
- 10.4.8 Whether and how the General Practitioner has been or will be informed.
- 10.4.9 Whether and how other relevant care services have been or will be notified of the death.

Section Three: Care and documentation after death

All care given to the deceased after death and the completion of any required documentation should be recorded in the healthcare record, e.g.:

- 10.4.10 The performance of Last Offices/laying out procedures.
- 10.4.11 Listing of property/valuables.
- 10.4.12 Mortuary transfer documentation.
- 10.4.13 Part 1 of the Death Notification Form Booklet (include the name of Registered Medical Practitioner who completed form and date and time of completion).
- 10.4.14 Cremation medical form, if required.
- 10.4.15 Documentation associated with a hospital post mortem examination or a coroner's post mortem examination if required (Detailed guidance on this documentation is given in the Standards and Recommended Practices for Post Mortem Examinations).

Death entry

Section Four: Minimum information to be included in registers

It is essential that records are kept of all bodies transferred into and out of hospital mortuary facilities. Registers should contain the following data:

- 10.4.16 Demographic details as applicable including name, address, date of birth, healthcare record number, occupation, and details in relation to the death including the date, place and brief circumstances of death.
- 10.4.17 Name, address and contact details of next of kin.
- 10.4.18 Record of completion of death notification form and if a post mortem examination is to take place (post mortem examination number if applicable).
- 10.4.19 Name of funeral director.
- 10.4.20 The date and time when the deceased is transferred into and out of the mortuary and the names and signatures of the persons releasing and collecting the body.

Section Five: Deaths reportable to the coroner

Detailed guidance on deaths reportable to the coroner is given in the Standards and Recommended Practices for Post Mortem Examinations. If the death is reportable to the coroner, the following information should be recorded in the healthcare record:

- 10.4.21 The reason the death is reportable to the coroner.
- 10.4.22 The name of the person who made the decision to notify the coroner.
- 10.4.23 The date and time of such notification.
- 10.4.24 The name of the person who was notified in the coroner's office.
- 10.4.25 The decision taken by the coroner's office.

Care and maintenance of the healthcare record

Healthcare Records Management

11 Care and maintenance of the healthcare record

11.1 Introduction

It is the aim of the Health Service Executive to ensure that healthcare records are maintained and preserved in optimum condition to support the provision of high quality service user care.

11.2 Scope

The objective of this recommended practice is to guide healthcare record users through the requirements that will ensure that healthcare records are held in the optimum condition and that all information is available to all staff at all times.

11.3 Contents

Section One: Maintaining the physical state of the healthcare record

11.4 Procedure

Section One: Maintaining the physical state of the healthcare record

- 11.4.1 A service user identification label should be placed on the front cover of the healthcare record in accordance with local filing arrangements.
- 11.4.2 An adequate supply of service user identification labels should be filed in the Administrative Section.
- 11.4.3 The front sheet/registration sheet should be printed on A4 paper. This should be punched and filed in reverse chronological order in the Administrative Section.
- 11.4.4 There should be no loose documents in the healthcare record.

Care and maintenance of the healthcare record

- 11.4.5 Directions for entry/filing of information are provided on the divider of each section and should be adhered to by all healthcare record handlers.
- 11.4.6 Under no circumstances should anything be sellotaped or stapled to the healthcare record cover.
- 11.4.7 In the event of the death of a service user, the authorised RIP sticker should be placed on the front cover of the healthcare record.
- 11.4.8 When a healthcare record has reached capacity or is in poor condition, a new volume should be created.
- 11.4.9 A service user identification label should be produced and fixed to the outside cover of the new healthcare record.
- 11.4.10 Information from the previous volume regarding alerts/allergies should be reproduced and documented in the new volume, where relevant.
- 11.4.11 Personnel from outside the healthcare records department who require additional volumes should inform the healthcare records department and return the current volume to the department for records management such as date closed etc. to be completed.
- 11.4.12 Blank pages should be removed from healthcare records prior to closure.

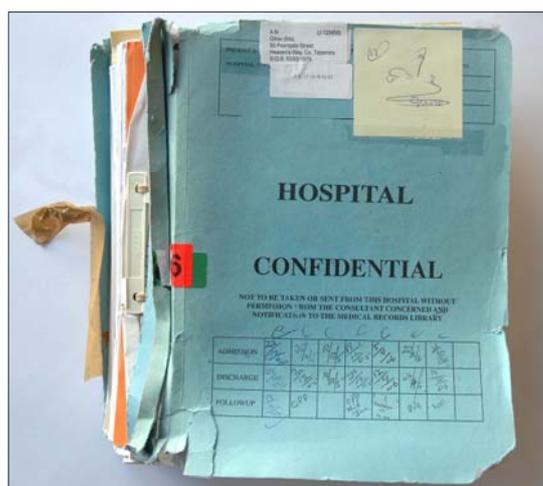


Figure 11.1: Healthcare record requiring re-covering

Service User Information Requests

12 Service User Information Requests

12.1 Introduction

Service user information requests may be dealt with in a formal way in accordance with Freedom of Information (FOI) or Data Protection (DP) legislation, or in a routine and informal way in accordance with the HSE Administrative Access Policy. This section gives general guidance on the different access regimes, more detailed information is available in the booklet “A Practical Guide for Staff” published by the FOI/DP Liaison Group and in procedural manuals that give detailed guidelines on the legislation.

12.2 Scope

The objective of this recommended practice is to set out good administrative practice for HSE staff to follow when handling requests for information, within statutory requirements and health service guidelines, including Freedom of Information and Data Protection Acts.

12.3 Contents

- Section One: Administrative access requests
- Section Two: Freedom of Information requests
- Section Three: Data Protection requests
- Section Four: Legal requests
- Section Five: Requests for information by the Gardai
- Section Six: Requests for information by other healthcare providers

Service User Information Requests

12.4 Procedure

Section One: Administrative access requests

- 12.4.1 As a matter of policy the Health Service Executive supports the right of a service user to see what information is held about him or her within its service. Generally, access to an individual's own healthcare record should be provided administratively (subject to exceptions which are detailed later).
- 12.4.2 An application for administrative access by a service user seeking access to his/her healthcare record should:
- a. be in writing and sent to the appropriate service manager.
 - b. supply relevant information to locate records.
 - c. be accompanied by appropriate identification.
- 12.4.3 The treating healthcare professional should, where possible, be involved in the handling of these applications to ensure that only information relevant to the application is released. Consultation with the service user should be encouraged, particularly to assist in the identification of the actual documents to which access is sought or to narrow the field of inquiry, for example, to a particular admission, if possible.

(a) *Records of deceased persons*

- 12.4.4 Given the level of sensitivity of information contained in healthcare records, and the inability to consult with the deceased service user, all applications for access to deceased person's records should be processed under the Freedom of Information Acts.

Service User Information Requests

(b) *Exceptions to the administrative access process*

Particular care should be taken when healthcare records contain sensitive material, for example:

- 12.4.5 Documents relating to suspected or actual child abuse.
- 12.4.6 Documents revealing the involvement and deliberations of an investigation into alleged sexual abuse.
- 12.4.7 Documents containing information in relation to testing for and/or treatment of HIV/AIDS (including statements regarding HIV status) or other notifiable diseases under the Health Acts.
- 12.4.8 The healthcare record of a deceased person.
- 12.4.9 In circumstances where it is considered that access could be prejudicial to the physical or mental well being or emotional condition of the person.
- 12.4.10 In circumstances where it is considered that the healthcare record contains matter about a third party or information received in confidence from a third party.
- 12.4.11 Any other sensitive matter such as documents revealing confidential sources of information.

(c) *Can information be released to other healthcare professionals?*

- 12.4.12 Where a service user has been transferred or discharged to another healthcare service or medical practitioner for continuing care and treatment, information from the service user's healthcare record of direct relevance to the continuing care and treatment should generally be released on written request by the healthcare service or medical practitioner. Information should also be released on confirmation by the receiving healthcare service of transfer arrangements.

Service User Information Requests

12.4.13 Where a request for information is received by telephone, information should be given to the treating healthcare professional or senior healthcare professional if urgently required for treatment of the service user. In these circumstances, care should be taken to establish the identity of the recipient of the information, the recipient's name and telephone number and authority to receive the information should be checked and the call returned before the information is given.

Section Two: Freedom of Information requests

The Freedom of Information Act confers on all persons the right of access to information held by public bodies, to the greatest extent possible, consistent with the public interest and the right to privacy. The concept of Freedom of Information is derived from the following principles.

(a) *Records*

12.4.14 Every individual has the right to know what information is held in records about him or her personally (subject to certain exemptions).

12.4.15 Every individual has the right to have inaccurate material on file corrected (subject to certain exemptions designed to protect the public interest and the right to privacy).

(b) *Decisions*

12.4.16 Individuals who are affected by decisions of public bodies have the right to know the criteria used in making those decisions.

12.4.17 Decisions by public bodies should be open to public scrutiny, thus providing greater knowledge of the issues involved and public ownership and acceptance of decisions. Citizens, as shareholders in public bodies, should have the right to examine and review the deliberations and processes of public bodies, subject to the exemptions provided for in the Acts.

Service User Information Requests

(c) *Parents, guardians and next-of kin rights*

- 12.4.18 Parents, Guardians and Next-of-Kin have been provided with rights of access to reasons for decisions in respect of certain other persons, e.g. children, deceased or disabled persons with a mental incapacity.
- 12.4.19 Parents or Guardians have also been provided with rights to apply to have personal information of certain other persons e.g. children, deceased or disabled persons with a mental incapacity, amended if they are incomplete, incorrect or misleading.

(d) *Making a Freedom of Information request*

- 12.4.20 Freedom of Information requests have to be in a specific form. A request should:
- a. be in writing and assistance should be provided for those who require it.
 - b. specify the records required and the manner in which access is sought.
 - c. state that the request is made under the Freedom of Information Act.
- 12.4.21 When a request for access under the Freedom of Information Act is received in any department of the healthcare organisation, it should immediately be sent to the member of staff (Decision Maker) in the organisation who has responsibility for processing Freedom of Information requests.
- 12.4.22 There are different forms of access to records which may be requested and granted. These are as follows:
- a. inspect original record.
 - b. obtain copy of the record.
 - c. hear/view audiovisual record (if available).
 - d. obtain a transcript of tape or shorthand.
 - e. obtain a copy of a computer disk or other electronic device.

(Note: Shorthand or code must be decoded)

Service User Information Requests

12.4.23 It is regarded as good practice that the application should be discussed with the treating healthcare professional (Medical Practitioner, Psychologist, Social Worker etc.) for a number of reasons; e.g. the records may contain information which could, in the professional's opinion, have a detrimental effect on the service user.

12.4.24 One of the grounds why a request for information may be refused is where the record is of a medical, psychiatric or social work nature relating to the requester concerned and its release, in the opinion of the Decision Maker, might be prejudicial to the physical or mental well-being of the requester. Where the Decision Maker refuses access under this provision, he/she is obliged to offer access through a registered healthcare professional, nominated by the requester, having expertise in the matter concerned.

(e) Right of review

12.4.25 A requester, if unhappy with a decision to release records, has the right of review. This includes:

(f) Internal review

12.4.26 In most cases the first avenue is for the service user to request an internal review. This should be forwarded to the delegated Internal Reviewer (who is normally a more senior member of staff within the healthcare organisation). A decision should be made within fifteen days of receipt of request for an Internal Review.

(g) Information Commissioner review

12.4.27 If the requester is unhappy with the decision of the Internal Reviewer he/she may appeal to the Information Commissioner within six months of the date of notification of the agency's decision. There is a right of appeal to the High Court, on a point of law only, if either the requester or the Healthcare Agency is unhappy with the Commissioner's decision. The Supreme Court will in turn deal with any further appeal arising out of a High Court decision.

Service User Information Requests

(f) *Staff*

Staff will be able to reduce the need for the public to use the Freedom of Information Acts by:

- 12.4.28 improving communications between staff and the public.
- 12.4.29 drafting and publishing eligibility criteria used to determine access to schemes and services.
- 12.4.30 informing persons who apply for services of the reasons for decisions and rights of appeal.
- 12.4.31 allowing access to the greatest extent possible to healthcare records via administrative means.

Section Three: Data Protection requests

Data Protection (DP) is the safeguarding of the privacy rights of individuals in relation to the processing of their personal data. People supply information about themselves to healthcare organisations and healthcare professionals. Data Protection law places obligations on such healthcare providers and all staff who keep personal information.

(a) *Data Protection rights*

- 12.4.32 Data Protection rights apply whether the information is held:
 - a. in electronic format e.g. on computer.
 - b. in a manual or paper based form.

(b) *Personal health information should be:*

- 12.4.33 Obtained and processed fairly; which means that the person providing it should know the purposes for which it will be used and the persons to whom it will be disclosed.
- 12.4.34 Relevant and not excessive.

Service User Information Requests

- 12.4.35 Accurate, complete, up-to-date and well organised.
- 12.4.36 Held no longer than is necessary.
- 12.4.37 Devoid of prejudicial, derogatory, malicious, vexatious or irrelevant statements about the individual.
- 12.4.38 Purpose specific.
- 12.4.39 Held securely.
- 12.4.40 Accessible to the individual or person acting on his or her behalf on a reasonable basis.

(c) *Request for access to records made under the Data Protection Act*

A request for access to records made under the Data Protection Act should:

- 12.4.41 Be in writing.
- 12.4.42 Be accompanied by a fee (up to and no more than €6.35 [2007]).
- 12.4.43 Specify the records required and the manner in which access is sought e.g. inspect the original, obtain photocopies etc.
- 12.4.44 State that the request is being made under the Data Protection Act.
- 12.4.45 Provide evidence of identity.
- 12.4.46 When a request for access under the Data Protection Act is received in any department of the healthcare organisation, it should immediately be sent to the member of staff in the organisation who has responsibility for processing Data Protection requests. That staff member should adhere to Data Protection procedures in dealing with the request.
- 12.4.47 Many requests may involve the release of documents, which may be accessed without resorting to the Data Protection Acts. A non Data Protection request should usually be made to the local office of the healthcare organisation in question. If the information cannot be released routinely, the requester should be advised accordingly and informed of his/her rights under the Data Protection Act.

Service User Information Requests

- 12.4.48 If a request has already been dealt with under the Freedom of Information Act it should still be processed separately under the Data Protection process, as if it were a new request.
- 12.4.49 Personal health information should only be used or disclosed for the purpose for which it was collected or for another directly related purpose. It should be used or disclosed for some other purpose only where:
- a. the service user concerned has explicitly consented to the proposed use or disclosure.
 - b. the healthcare professional reasonably believes the use or disclosure is necessary to lessen or prevent a serious and imminent threat to an individual's life, health or safety or a serious threat to public health or public safety.
 - c. the use or disclosure is required or authorised by law.
 - d. the information concerns a service user who is incapable of giving consent, and is disclosed to a person responsible for that service user to enable appropriate care or treatment to be provided.
 - e. any disclosure to a third party should be limited to that which is either authorised or required in order to achieve the desired objective.

Personal health information can be transferred to an individual or organisation outside the European Union only in certain specified circumstances.

(d) Refusing access to records where the request has been made under the Data Protection Act

- 12.4.50 Access can be refused to some or all personal health information only if:
- a. providing access would pose a serious threat to the life or health of any individual, including the requester.
 - b. providing access would have an unacceptable impact on the privacy of other individuals.

Service User Information Requests

- c. it is required or authorised by law.
- d. many requests for information, or responses to complaints, can be made by contacting the service provider directly. If this method proves unsatisfactory to the requester, the requester should then have an option to apply for personal records under the Data Protection Acts.

(e) *Data Protection rights*

Data Protection rights include:

Right to be informed

12.4.51 The healthcare organisation that obtains personal information should ensure that the service user is informed of:

- a. the name of the data controller, i.e. the organisation or the individual collecting the data.
- b. the purpose for keeping personal data.
- c. any other information which the organisation ought to provide to ensure its handling of service user's data is fair, for example, the identity of anyone to whom it will disclose the service user's personal data, and whether or not the service user is obliged to answer any of its questions.

12.4.52 Data controllers who have obtained personal data from someone else, i.e. not from the service user must, in addition, inform the service user of the types of data they hold and the name of the original data controller.

Right of access

12.4.53 Every individual has the right to know what information is held in records about him or her personally (subject to certain exemptions designed to protect the public interest and the right to privacy).

Service User Information Requests

12.4.54 This right includes access to expressions of opinion, unless these opinions were given in confidence. The right of access does not apply in specific cases, which would prejudice a particular interest e.g. the investigation of offences.

12.4.55 An individual is also entitled to a full explanation of the logic used in any automated decision making process, where the decision significantly affects that person.

Right of rectification or erasure

12.4.56 If information kept by a data controller is inaccurate, an individual has the right to have that information rectified or, in some cases, erased.

Right to block certain issues

12.4.57 In addition to an individual having the right to correct or erase data he/she can request a data controller to block his/her data i.e. prevent it from being used for certain purposes. For example, he/she might want the data blocked for research purposes.

Right to object

12.4.58 Where the data controller is processing data and that individual is of the opinion that the data involves substantial and unwarranted damage or distress to him/her, he/she may request that the data controller stop using the personal data.

12.4.59 This right does not apply if:

- a. consent was obtained.
- b. the use is necessary for an agreed contractual obligation.
- c. the use is required by law.
- d. consent has been withdrawn under Data Protection.

Service User Information Requests

Section Four: Legal requests

12.4.60 Authorisation from the courts, coroner or solicitors for release of information should be in writing, verbal requests are not accepted.

12.4.61 Copy information should be provided, never originals. Check with the healthcare records manager or designated person before this information is released.

(a) Action taken against the Health Service Executive where a healthcare professional who is an employee of the Health Service Executive is named as a co-defendant

12.4.62 Where an action is taken by a service user against the Health Service Executive in circumstances where a healthcare professional who is an employee of the Health Service Executive is named as a co-defendant, both the Health Service Executive and healthcare professional should have the services of the one composite legal defence team.

12.4.63 Service user consent is not required where the healthcare organisation transmits the service user's healthcare record to its own solicitors for the defence of the claim as any such communications are fully protected by legal professional privilege.

12.4.64 Where this legal team are also acting for the healthcare professional the question of transmitting a copy of the service user healthcare record to a separate firm of solicitors and legal team should not arise.

(b) Action taken against a healthcare professional who is operating in a private capacity where the Health Service Executive/healthcare organisation is named as a co-defendant

12.4.65 Where an action is taken by a service user against a clinician who is operating in private capacity, in circumstances where the Health Service Executive/the healthcare organisation is named as a co-defendant and the healthcare record is held in the organisation's healthcare records department, the healthcare record should be considered to be in the organisation's possession and ownership.

Service User Information Requests

- 12.4.66 Service user consent is not required where the healthcare organisation transmits the service user healthcare record to its own Solicitors for the defence of the claim as any such communications are fully protected by legal professional privilege.
- 12.4.67 Where this legal team is also acting for the healthcare professional the question of transmitting a copy of the service user healthcare record to a separate firm of solicitors and legal team should not arise.
- (c) *Action taken against a healthcare professional who is operating in a private capacity where the HSE/healthcare organisation is not named as a co-defendant*
- 12.4.68 Where an action is taken by a service user against a healthcare professional who is operating in a private capacity, in circumstances where neither the HSE nor the healthcare organisation are named as co-defendants and the healthcare record is held in the organisation's healthcare records department, the healthcare record is considered to be in the healthcare organisation's possession and ownership.
- 12.4.69 The healthcare record should not be released without the service user's written authorisation except on foot of an Order for Discovery from the Court.
- 12.4.70 It is permissible to release copies of any medical reports or notes to the private healthcare professional created by himself/herself for which he/she would normally have been expected to retain a copy in his/her own possession. Any such release to a healthcare professional at this time should make clear that the release of the information is on the basis that it is for the healthcare professional's use only.
- 12.4.71 Any documents created by the healthcare professional himself/herself acting in his/her role as a private healthcare professional to the service user should not attract any entitlement to service user confidentiality in respect of release to the healthcare professional himself/herself.

Service User Information Requests

- 12.4.72 Where documentation is given to the healthcare professional's solicitor on foot of a Court Order for Discovery, the rules of court provide that those records should only be used by the solicitor for the purposes of the legal proceedings and for no other purposes whatsoever.
- 12.4.73 It is the responsibility of the healthcare professional's solicitor, as an officer of the court, to ensure that any such healthcare record is treated in a confidential manner and is appropriately destroyed on completion of the case.

Section Five: Requests for information by the Gardai

- 12.4.74 Current practice in assisting the Garda Síochána with their general inquiries should continue. However, where the service user has authorised Gardai to have access to information from his or her healthcare records, this should be supplied. Evidence of the service user's authorisation should be obtained.
- 12.4.75 Requests for information from the Gardai where the service user has not authorised access to information from his or her healthcare records should be dealt with by the treating healthcare professional or senior administrator and should only be supplied in accordance with a court order on the production of a search warrant or other legal authority.
- 12.4.76 Where the treating healthcare professional or senior healthcare professional in a healthcare organisation/service becomes aware, during the clinical management of a service user, that a serious crime may have been committed the agency should notify the Gardai. The agency, in the public interest and to enable Gardai to initiate appropriate action, should provide information which will usually be given by a senior healthcare professional.

Information relating to child abuse:

- 12.4.77 In general, requests for access to records containing information of alleged/suspected child abuse should be processed under the Freedom of Information Act. However, information should be released to the HSE child protection and welfare, social work department and Garda authorities where the release of such information is necessary to promote the welfare of the child.

Service User Information Requests

- 12.4.78 Caution should be exercised as to whether there is a breach of an obligation of confidentiality and, if so, whether there are grounds for breaching that obligation of confidentiality.
- 12.4.79 Refer to local HSE social work department, Child Care Act 1991 and Protection for Persons reporting Child Abuse Act 1998.

Section Six: Other Healthcare providers

- 12.4.80 With regard to requests from other healthcare providers (including the National Treatment Purchase Fund), concerning service users who have now moved into their care, the source of the request should be checked to ensure that it is a valid enquiry.
- 12.4.81 The information required should be clarified. Discharge communications can be released without service user consent, but if the other healthcare provider requires more documentation, the consent of the service user should be given. Copies should be sent and, if faxed, should be checked to ensure it is a “safe haven” fax, and that the person requesting the information is ready to pick up the copies.
- 12.4.82 Copy notes sent by registered post, should be double-wrapped, marked “confidential” and sent by recorded delivery.

Requests for the healthcare record for research purposes

13 Requests for the healthcare record for research purposes

13.1 Introduction

In order for the release of information from a service user's healthcare records for internal audits/research there should be prior approval in accordance with local policies, procedures, protocols and guidelines, to ensure that service user information is kept confidential.

13.2 Scope

The objective of this recommended practice is to guide relevant staff through the process for releasing healthcare records for research purposes.

13.3 Contents

Section One: General principles

13.4 Procedure

Section One: General principles

- 13.4.1 A healthcare organisation approval form for all proposed internal audits/research activities should be completed and signed by appropriate persons (healthcare professional, CEO/Manager, etc.).
- 13.4.2 A complete list of all healthcare records required for research should be supplied.
- 13.4.3 Research proposals should meet the organisation's policies, procedures, protocols and guidelines and be accompanied by a comprehensive protocol detailing the aims, methods and reasons for the study.
- 13.4.4 Where access to healthcare records is requested, the nature of the access requested should be clearly specified and the safeguards for privacy outlined.

Requests for the healthcare record for research purposes

- 13.4.5 Where service users are to be contacted directly by the researcher, or potentially identifying information is requested, the written consent of the service user should be obtained by the treating healthcare professional or senior healthcare professional prior to access being allowed.
- 13.4.6 Healthcare records should be tracked to the requesting healthcare professional, together with details of his/her supervising healthcare professional.
- 13.4.7 In the event that a healthcare record, which is tracked out for research purposes, is required for an out-patient clinic/emergency department/admission etc. it should be returned to the requestor without delay.
- 13.4.8 Under no circumstances should healthcare records leave the grounds of the healthcare organisation without approval of the CEO/Manager or designated officer.

Training

14 Training

14.1 Introduction

All line managers and supervisors should ensure that their staff, whether administrative or medical, are adequately trained and apply the appropriate recommended practices in relation to healthcare records management. The development/training needs of staff should be audited on an ongoing basis and additional training in relation to healthcare records management should be based on the results of these audits.

14.2 Scope

The objective of this recommended practice is to set out the training requirements for staff who deal with/handle healthcare records.

14.3 Contents

- Section One: Healthcare records management policies, procedures, protocols and guidelines
- Section Two: Confidentiality
- Section Three: Healthcare records management training
- Section Four: New staff members in the Healthcare Records Department
- Section Five: Manual handling

14.4 Procedure

Section One: Healthcare records management policies, procedures, protocols and guidelines

- 14.4.1 Policies, procedures, protocols and guidelines in relation to healthcare records management should be given to all members of staff for their attention and time should be allocated to allow staff read them.

Training

- 14.4.2 Each head of department should ensure that new members of staff are adequately trained in the organisation's policies, procedures, protocols and guidelines pertaining to healthcare records management.
- 14.4.3 Each head of department (where the department has an involvement in healthcare records) should undertake a staff training needs analysis and develop a prioritised action plan to address identified training needs in healthcare records management for personnel within their department.
- 14.4.4 Departmental records should be kept for all staff who attend/receive training in healthcare records management.
- 14.4.5 There should be a regular review of the healthcare records training programme content to ensure its relevance.
- 14.4.6 The quality and effectiveness of the training programme should be regularly evaluated.
- 14.4.7 Individual competency in healthcare records management should be regularly reviewed.

Section Two: Confidentiality

- 14.4.8 The confidentiality of information in the healthcare record should be addressed on the first day a new member commences work.
- 14.4.9 Ongoing training regarding confidentiality of service user information should take place in each local healthcare organisation.

Section Three: Healthcare records management training

The methods of healthcare records management training that may be implemented include:

- 14.4.10 An E-learning Programme for Healthcare Records Management (foundation training programme which is available on www.hseland.ie).
- 14.4.11 A formal training programme to launch and support local policies, procedures, protocols and guidelines in relation to healthcare records management.

Training

- 14.4.12 Inclusion of healthcare records management in induction training and staff handbooks.
- 14.4.13 Follow-up training.
- 14.4.14 Specific training in records management and archiving.

Section Four: New staff members in the Healthcare Records Department

- 14.4.15 The new staff member should be accompanied by the healthcare records manager or designated staff member to the wards/departments within the healthcare organisation and introduced. The work of each area should be explained to the new member of staff.
- 14.4.16 All work should be checked by the healthcare records manager or experienced member of staff until the new member is competent in his/her work.
- 14.4.17 It should be stressed to the new member of staff the importance of asking questions regarding their work to either the healthcare records manager or another member of staff.
- 14.4.18 All staff should be reminded that their personal belongings are their own responsibility and should be securely locked away during office hours.

Section Five: Manual handling

- 14.4.19 All employees, including permanent, temporary, full-time, part-time, students, agency, contract staff etc. who carry out manual handling activities as part of their work should complete manual handling training, manual handling of materials and fire safety training course/session at the commencement of their employment and annually thereafter.

Tracking the healthcare record

15 Tracking the healthcare record

15.1 Introduction

One of the primary reasons why healthcare records get misplaced or lost is because their movement between locations is not adequately recorded. Healthcare record tracking is the function used to change the location of any service user's healthcare record. The movement of records should be recorded to ensure that items can always be located when required. It is compulsory that ALL staff update the healthcare record location on each occasion that a healthcare record is moved. This should be done regardless of the length of time the healthcare record is being used for. There is a dual responsibility on the part of the person who is sending the healthcare record and the person who is receiving the healthcare record to record the location of the healthcare record on the healthcare record tracking system. Each person who has occasion to retrieve a healthcare record will benefit.

15.2 Scope

The objective of this recommended practice is to provide guidance which will ensure that the healthcare record can be located quickly and efficiently when required and to reduce the time spent by healthcare records staff retrieving healthcare records on loan from the healthcare records library.

15.3 Contents

- Section One: Computerised healthcare records tracking system
- Section Two: Manual healthcare records tracking system – tracer cards
- Section Three: Tracking in the healthcare records library
- Section Four: Tracking healthcare records removed from locations other than the healthcare records library out-of-hours
- Section Five: Tracking of healthcare records returned to the healthcare records department for filing
- Section Six: Risk management

Tracking the healthcare record

15.4 Procedure

Section One: Computerised healthcare records tracking system

- 15.4.1 The healthcare records tracking system should be used to change/update the location of healthcare records known to the system.
- 15.4.2 The 'base location' for the healthcare record should be the healthcare records library.
- 15.4.3 When a healthcare record is removed from its 'base location' the healthcare record tracking system should allow the healthcare record to be tracked from its 'base location' to its new location. The new location should be referred to as the healthcare record 'current location'.
- 15.4.4 When a healthcare record is moved from its 'current location' the healthcare record tracking system should allow the healthcare record to be tracked to another location e.g. outpatient clinic to medical secretariat.
- 15.4.5 On return of the healthcare record to its 'base location' i.e. healthcare record library, healthcare record staff should use the healthcare record tracking system to return the healthcare record from its 'current location' to its 'base location'.

Section Two: Manual healthcare record tracking system—tracer cards

- 15.4.6 The staff member retrieving/removing a healthcare record should insert the requester's name and the date on tracer cards.
- 15.4.7 The person, to whom the healthcare record is tracked, should be responsible for that healthcare record until it is returned to the healthcare records department.
- 15.4.8 If a healthcare record is transferred from one location to another without going through the healthcare records department then the person that the healthcare record is tracked out to should track it to the next location and inform the healthcare records department.

DATE	BORROWER	DATE	BORROWER	DATE	BORROWER
7/10/05	CRK				
1/8/06	JO				
10/11/07	MER				
20/11/07	Dr. Nicol (MC)				
23/11/07	Dr. Nicol (MC)				
23/11/07	NECROW MEDICALS				
16/1/07	WY - SURG				

Figure 15.1: Manual Tracking System

Tracking the healthcare record

- 15.4.9 Healthcare records staff should ensure that all healthcare records retrieved by them and all healthcare records notified to them for tracking purposes are recorded on the tracer card.
- 15.4.10 The responsibility for the whereabouts and security of a healthcare record should rest with the staff member it is tracked to.
- 15.4.11 To be effective, tracking systems should, at a minimum, record the following information:
- a. unique record reference number.
 - b. description of the record (including volume number/media type).
 - c. the person and operational area having possession of the record.
 - d. date of transfer/movement of the record.

Section Three: Tracking in the healthcare records library

- 15.4.12 When a healthcare record is requested from the healthcare records library, the person who retrieves the healthcare record should arrange collection/transport.
- 15.4.13 The responsibility for recording the movement of a healthcare record should lie with the person who is transferring it; however, every staff member should ensure that healthcare records in their possession are tracked to them.

Section Four: Tracking healthcare records removed from locations other than the healthcare records library out-of-hours

- 15.4.14 It is accepted that healthcare records will be located outside the healthcare records library e.g., medical secretaries office following discharge, etc. In these instances, every staff member should ensure that the healthcare record is tracked to his/her department/ward.
- 15.4.15 If a healthcare record is removed from an office or an area within the hospital 'out-of-hours', this should be notified to the healthcare records department to facilitate tracking on the system.

Tracking the healthcare record

Section Five: Tracking of healthcare records returned to the healthcare records department for filing

- 15.4.16 All healthcare records users should return the healthcare records in their possession to the filing room/library when they have finished with them and ensure they are tracked back.
- 15.4.17 Following that, the healthcare records staff should update the local tracking system.

Section Six: Risk management

- 15.4.18 The healthcare records library supervisor should be informed on each occasion that staff experience difficulty in retrieving a healthcare record. The healthcare records manager should be kept informed as appropriate and determine events that need to be notified to the risk management department.

Confidentiality and security of service user healthcare information

16 Confidentiality and security of service user healthcare information

16.1 Introduction

Every healthcare record (whether in hard copy and/or electronic format) is confidential and as such should be kept secure at all times. Service users have a right to expect that those working in the healthcare organisation keep healthcare records and any information relating to the service user's health and welfare, confidential and secure. The healthcare records department aims to provide a secure and confidential environment in which to store healthcare records, but cannot be responsible when records are outside of their care. This recommended practice, therefore, applies to any member of staff when healthcare records or healthcare information are in their care. It also applies to information available on computer systems.

16.2 Scope

The objective of this recommended practice is to outline the method by which the confidentiality and security of a healthcare record is preserved.

16.3 Contents

- Section One: Responsibility
- Section Two: Staff
- Section Three: Healthcare delivery associates and third parties
- Section Four: Access to healthcare records or clinical information
- Section Five: Sequestered records

Confidentiality and security of service user healthcare information

16.4 Procedure

Section One: Responsibility

- 16.4.1 Clinical Directors, Nurse Managers, Business Managers and Department Heads should ensure that staff adhere to the policies, procedures, protocols and guidelines that are in place within their area of responsibility regarding the confidentiality of service users' information such as healthcare records, appointment/attendance lists and referral letters.
- 16.4.2 Staff should ensure that the privacy of service users using the services of the Health Service Executive is maintained at all times.
- 16.4.3 Staff should report healthcare records and/or documentation located in unsecured areas to the healthcare records manager.
- 16.4.4 The healthcare records manager or designated person should manage access to the healthcare records filing room/library.
- 16.4.5 If there is any doubt as to whether a person has right of access, the healthcare records manager or designated person should be consulted immediately.
- 16.4.6 All healthcare records should be correctly tracked using the local tracking system.
- 16.4.7 All healthcare records should be stored in a secure/supervised area with restricted access.
- 16.4.8 All healthcare records should be returned to their designated storage location when not in use.
- 16.4.9 Under no circumstance should healthcare records be made available for unauthorised use.
- 16.4.10 Any staff member who has a healthcare record in their care should ensure its safety and confidentiality and should return it to the healthcare records department or to an appropriate person when finished with. An appropriate person is one who has a professional role that requires him/her to read the healthcare record or update it.

Confidentiality and security of service user healthcare information

- 16.4.11 In some care areas, e.g. midwifery, policies, procedures, protocols and guidelines (PPPGs) have been agreed to provide service user held healthcare records, however, unless these PPPGs are agreed and in place, healthcare records should not be given to service users.
- 16.4.12 Each service user has a legal right to his/her records. This right is exercised by way of a written request under the Administrative Access Policy, the Freedom of Information Acts 1997 & 2003 and the Data Protection Acts 1988 & 2003.
- 16.4.13 Healthcare records should not be placed in any unsupervised public place or where they may be viewed or accessed inappropriately.
- 16.4.14 Healthcare records should not be placed on reception desks or on trolleys except when they are required for clinics and only then under the supervision of appropriate clinic staff.
- 16.4.15 Healthcare records should not be left on desks in offices in the absence of responsible staff. Whenever an office is left unattended it should be securely locked.



Figure 16.1:
Security of the Healthcare Record

Section Two: Staff

- 16.4.16 There should be a clause in all staff contracts regarding confidentiality of service user care and the security of service user healthcare information.
- 16.4.17 Staff should regularly be reminded at staff meetings of the importance of confidentiality and security of service user healthcare information.
- 16.4.18 Staff should be informed at induction and relevant training courses of the importance of confidentiality and security of service user healthcare information.

Confidentiality and security of service user healthcare information

- 16.4.19 HSE employees or employees of a HSE funded agency should be subject to disciplinary action if he/she breaches the confidentiality and security clause.
- 16.4.20 Service user information should be restricted to HSE employees on a 'need-to-know' basis, as determined by their role or service responsibilities.
- 16.4.21 In carrying out their duties, staff may have access to, or hear information concerning the personal affairs of service user and/or staff or other healthcare service business. Such records and information are strictly confidential and on no account should any information be divulged or discussed unless acting on the instructions of an authorised officer.

Section Three: Healthcare delivery associates and third parties

- 16.4.22 Healthcare delivery associates should receive relevant, appropriate and agreed information on clients. The Health Service Executive expects healthcare delivery associates to handle this shared service user information confidentially and securely in adherence to the Data Protection Acts 1988 & 2003.
- 16.4.23 If service user information is disclosed to an authorised third party, the Health Service Executive should hold the said party to the same set of confidentiality and privacy principles that the organisation adheres to.
- 16.4.24 Service level agreements with healthcare delivery associates and third parties, where they exist, should include a confidentiality agreement.

Section Four: Access to healthcare records and/or clinical information

The healthcare record and/or its information content should be made available only to:

- 16.4.25 Medical, nursing/midwifery and other healthcare professionals who are responsible for providing or supervising the service user's care.
- 16.4.26 HSE employees authorised to process the record, to collate medical and statistical information, to collect data for authorised clinical research projects, to review the record for quality assurance, clinical audit, quality improvement, risk management or infection control purposes.

Confidentiality and security of service user healthcare information

- 16.4.27 Students or trainees in medicine, nursing/midwifery, health and social care profession or another recognised clinical professional training programme, when the students are involved in the service user's care and under the supervision of named clinical staff.
- 16.4.28 Any healthcare professional to whom the service user is being referred or transferred.
- 16.4.29 Other individuals with specific written authorisation in accordance with the Data Protection Acts 1988 and 2003 and Freedom of Information Acts 1997 and 2003.
- 16.4.30 Access to healthcare records should also be made available for research purposes where service user details are anonymised or where the healthcare organisation has obtained clear and unambiguous consent from the service users concerned for the use of their healthcare information for these purposes.

Section Five: Sequestered records

- 16.4.31 Healthcare records of designated individuals and records of cases under medico-legal investigation should be stored in a designated secure area as agreed with the CEO/Manager.
- 16.4.32 Provision should be made for these records to be accessed out-of-hours if a service user whose record is sequestered requires emergency or urgent treatment.
- 16.4.33 Certain designated healthcare records or certain designated sensitive medical documentation relating to a service user should be kept separately from the healthcare record files.
- 16.4.34 The tracking system should be used to indicate that these records are filed separately and should indicate their location so as to enable the healthcare records manager or designee to retrieve the records promptly if required.

Communication with service users

17 Communication with service users

17.1 Introduction

All information provided to service users (written or verbal) should be delivered in a form and manner which is clear, courteous and in a way that the service user can understand.

17.2 Scope

The objective of this recommended practice is to provide guidance to staff regarding appropriate communications with service users.

17.3 Contents

Section One: Communication regarding the service user's clinical status

Section Two: General communications

Section Three: Training in communications

17.4 Procedure

Section One: Communication regarding the service user's clinical status

- 17.4.1 All communications should be delivered in a form and manner that the service user is able to understand.
- 17.4.2 The service user should be allowed sufficient time to reflect on opinions and ask questions in relation to their treatment.
- 17.4.3 Key information should be repeated to help the service user understand and remember it.
- 17.4.4 A competent interpreter should be used if the service user requires this service.

Communication with service users

- 17.4.5 Information should only be given to the service user's next of kin/nominated representative with the consent of the service user. In an emergency situation where the service user is unable to consent, the healthcare professional may give information to the next of kin/nominated representative, as necessary.
- 17.4.6 Where possible, written and verbal communication should avoid jargon and should be understandable to the service user.
- 17.4.7 All relevant communications with the service user/families should be documented in the relevant section of the healthcare record.
- 17.4.8 Effective communication should take place with colleagues within and outside your own team/department, as necessary.

Section Two: General communications

When dealing with a member of the public all staff are representing the Health Service Executive and should respond:

- 17.4.9 Promptly and without undue delay.
- 17.4.10 Correctly in accordance with the law and other rules governing entitlements.
- 17.4.11 Sensitively by having regard to age, capacity to understand and any disability they may have.
- 17.4.12 Helpfully by simplifying procedures and maintaining proper records.
- 17.4.13 Fairly by treating people in similar circumstances in like manner, avoiding bias based on personal prejudice, colour, sex, marital/civil partnership status, ethnic origin, culture, language, religion, sexual orientation, attitude reputation or because of who they are or whom they know.
- 17.4.14 Confidentially with respect for service user privacy.

Communication with service users

Section Three: Training in communications

- 17.4.15 All relevant staff should receive formal training in providing a personalised service and in using the Patient Administration System appropriate to their area of work.
- 17.4.16 All staff dealing with the public should have training in customer care.

Service user registration

18 Service user registration

18.1 Introduction

Service user registration is the process whereby service users are registered on the organisation's administration/information system. Each service user is allocated a unique identifier which is aligned to that service user's healthcare record. This system provides for easy identification and retrieval of healthcare records. Accurate service user registration information is essential for continuity and safety of care.

18.2 Scope

The objective of this recommended practice is to provide guidance to relevant staff regarding service user registration.

18.3 Contents

Section One: Service user registration information

Section Two: Record registration

Section Three: Service user identification

18.4 Procedure

Section One: Service user registration information

18.4.1 Service user identification information should be validated at the Emergency Department, on every admission and on every visit to an outpatient clinic. Registration information should include the following:

- a. title.
- b. full name (forename and surname). The forename should be the name on the service user's birth certificate.

Service user registration

- c. alias: the name by which the service user likes to be known, if different from the service user's name.
- d. date of birth.
- e. home address/current address (if different).
- f. previous address.
- g. two contact telephone numbers (landline and mobile, if possible).
- h. name and address of the person to be contacted in the case of an emergency (if the service user is a minor or an incapacitated adult, the contact person should be a parent or legal guardian).
- i. two contact telephone numbers (landline and mobile, if possible) of the person to be contacted in the case of an emergency (if the service user is a minor or an incapacitated adult, the contact person should be a parent or legal guardian).
- j. gender.
- k. marital/civil partnership status.
- l. occupation.
- m. GP name and contact details.
- n. healthcare record number assigned at registration.
- o. referral source.
- p. mode of arrival.
- q. medical insurance (for inpatient activity).
- r. medical card (yes/no). medical card number if yes.
- s. mother's maiden name.
- t. religious preference.
- u. ethnicity.

Service user registration

- v. spoken language (indicate if an interpreter is needed).
 - w. accompanied by.
 - x. school (where relevant).
- 18.4.2 All registration information should be checked on every attendance and updated where necessary, as this information is essential in the case of an emergency.

Section Two: Record registration

- 18.4.3 Assignment of healthcare record numbers should be consistent with approved healthcare organisation policies, procedures, protocols and guidelines.
- 18.4.4 The healthcare record number should be unique, (e.g. unique service user identifier).
- 18.4.5 Only authorised personnel should have the ability to add, amend and/or delete details from the healthcare record registration system.
- 18.4.6 Only one healthcare record number should be assigned to each service user.
- 18.4.7 Each newborn should be assigned a unique healthcare record number.

Section Three: Service user identification

- 18.4.8 The service user's personal information details should be electronically recorded when he/she presents to the healthcare organisation, either for a booked appointment or for an assessment in the emergency department.
- 18.4.9 The service user should be asked to verify their personal details to make sure that they are correct on the patient administration system.
- 18.4.10 Admission/registration staff should validate identification with any official documents (e.g. passport/driving licence) on first registration of a service user.
- 18.4.11 Thereafter service user information should be checked on each visit to confirm that there are no changes. If there are any changes the healthcare record should be updated to reflect this.

Service user registration

- 18.4.12 When all of the details have been verified on the system a front/registration sheet and service user identification labels should be generated.
- 18.4.13 The service user should be asked to sign the front /registration sheet; if he/she is able to do so, in order to verify that the details recorded are correct.
- 18.4.14 The front sheet/registration sheet and identification labels should be filed appropriately in the healthcare record checking that the signature on the latest front sheet/registration sheet matches that on the previous one.

Request for a name change in the healthcare record

19 Request for a name change in the healthcare record

19.1 Introduction

Specific consideration is required when a request is received for a name change in the healthcare record. This procedure applies to requests received from individuals to change their own name or requests received from parents/guardians requesting a change to the name of a child. There should be a local documented policy, procedure, protocol or guideline (PPPG) for dealing with requests for name change in the healthcare record.

19.2 Scope

The objective of this recommended practice is to provide guidance to relevant staff regarding the process to be followed when a request is received to change a name in the healthcare record.

19.3 Contents

Section One: General principles

Section Two: Request to change the name of a child

Section Three: Request for name change to an existing healthcare record as a result of a gender change

19.4 Procedure

Section One: General principles

19.4.1 The name of a service user should be changed on request, however, the request must be in writing and legal evidence of the name change must be provided (e.g. marriage/civil partnership certificate, birth certificate, deed pole certificate). There may be times when photo identification is required.

Request for a name change in the healthcare record

- 19.4.2 When an individual requests a name change they should be provided with a name change request form (appendix 6).
- 19.4.3 Supporting legal evidence (e.g. marriage/civil partnership certificate, birth certificate, deed pole certificate) should be photocopied and attached to the completed name change request.
- 19.4.4 The completed name change request form and supporting evidence should be reviewed by the appropriate personnel.
- 19.4.5 If the request is accepted, the name change should be processed by relevant personnel ensuring that:
- a. the name has been updated on all IT systems (including any stand-alone systems).
 - b. where a name is changed on the IT system, a record of the previous name is kept.
 - c. a revised front sheet/registration sheet and identification labels are printed and placed appropriately in the healthcare record.
 - d. unused identification labels are removed from the healthcare record and disposed of in a confidential manner.
 - e. the GP is advised of the name change, preferably in writing.
- 19.4.6 If the request is rejected the individual who submitted the request should be informed of the decision and advised regarding any further action that needs to take place to enable the request to be accepted, if appropriate.
- 19.4.7 The completed name change request form and supporting evidence should be filed appropriately in the Administrative Section of the healthcare record.
- 19.4.8 All staff involved in a name change request should be advised of the importance of maintaining confidentiality.

Request for a name change in the healthcare record

Section Two: Request to change the name of a child

- 19.4.9 The name of a child should only be changed at the request of a parent/legal guardian or a Child Care Agency in adoption cases, however, the request must be in writing and legal evidence of the name change must be provided when available (e.g. birth certificate, deed pole certificate, adoption certificate).
- 19.4.10 In relation to a name change as a result of adoption, the name change should be considered at time of placement with the adoptive parents, on receipt of a letter from the placing adoption agency confirming the placement and that the adoption application is being processed.
- 19.4.11 The adoptive parents should submit a copy of the amended adoption certificate when the adoption is finalised. It should be acknowledged that from time of placing child with an adoptive family to completion of the legal process could take over two years.
- 19.4.12 It is recognised that in Ireland the legislation only provides for closed adoption and gives protection to the identity of the birthmother. Every effort should be made to ensure that there is no record of the birthmother's surname on the child's healthcare record.

Section Three: Request for name change to an existing healthcare record as a result of gender change

- 19.4.13 On request the name of a service user may be changed as a result of gender change, however, the request must be in writing and legal evidence of the name change must be provided (i.e. deed pole certificate).
- 19.4.14 When an individual requests a name change they should be provided with a name change request form (see appendix 6).
- 19.4.15 Supporting legal evidence (i.e. deed pole certificate) should be photocopied and attached to the completed name change request.
- 19.4.16 The completed name change request form and supporting evidence should be reviewed by the appropriate personnel.

Request for a name change in the healthcare record

- 19.4.17 If the request is accepted, the name change and change of gender should be processed by relevant personnel ensuring that:
- a. the name and gender have been updated on all IT systems (including any stand-alone systems).
 - b. where a name is changed on the IT system, a record of the previous name is kept.
 - c. a revised front sheet/registration sheet and identification labels are printed and placed appropriately in the healthcare record.
 - d. unused identification labels are removed from the healthcare record and disposed of in a confidential manner.
 - e. the change of gender is flagged in the designated space for recording alerts in the healthcare record.
- 19.4.18 If the request is rejected the individual who submitted the request should be informed of the decision and advised regarding any further action that needs to take place to enable the request to be accepted, if appropriate.
- 19.4.19 The completed name change request form and the supporting evidence should be filed appropriately in the Administrative Section of the healthcare record.
- 19.4.20 All staff involved in a name change request as a result of gender change should be advised of the importance of maintaining service user confidentiality.

Filing the healthcare record

20 Filing the healthcare record

20.1 Introduction

When healthcare records are returned to the healthcare records department it is essential that they are filed in the correct location.

20.2 Scope

The objective of this recommended practice is to provide guidance to all healthcare records staff in the requirements which will ensure that healthcare records are filed correctly in the healthcare records department.

20.3 Contents

- Section One: Unit record system
- Section Two: Terminal digit
- Section Three: Sequential numerical
- Section Four: Alphabetical
- Section Five: Staff responsibilities
- Section Six: Filing of reports

20.4 Procedure

Section One: Unit record system

- 20.4.1 All inpatient, outpatient and emergency care records of an individual service user should bear the same healthcare record number, and all such records should be combined into a single unified healthcare record, to the extent feasible.

Filing the healthcare record

Section Two: Terminal digit filing (recommended system)

20.4.2 The healthcare record library should be divided into 100 primary sections, numbered 01 to 00 and healthcare records should be filed according to the last 2 digits (some systems use the last 3 or 4 digits).



20.4.3 This method spreads growth throughout the library. Figure 20.1: Terminal Digit Filing System

Section Three: Sequential numerical

20.4.4 Healthcare records should be filed in straight number order.

20.4.5 This method produces constant end growth in the library.

Section Four: Alphabetical

20.4.6 Healthcare records should be filed in alphabetical order.

20.4.7 This method is rarely used nowadays because of the large numbers of healthcare records involved.

Section Five: Staff responsibilities (healthcare records staff)

20.4.8 Healthcare records should be filed within forty-eight hours of their return to the healthcare records department.

20.4.9 Staff should ensure the healthcare record number and name correspond with the tracer card and that only one tracer card exists.

20.4.10 Where more than one tracer card exists staff should ensure that the most up to date tracer card is kept and any other cards are destroyed.

Filing the healthcare record

- 20.4.11 Staff should ensure that healthcare records and tracer cards are returned to the appropriate filing space and that filing shelves are kept tidy.
- 20.4.12 Staff should ensure that healthcare records are filed in the correct sequence. The healthcare record numbers either side of the healthcare record being filed should be checked to ensure accuracy.
- 20.4.13 Staff are responsible for the upkeep and maintenance of filing shelves assigned to them.
- 20.4.14 Staff should ensure that all healthcare records are year coded and colour coded prior to filing, where relevant.

Section Six: Filing of reports

- 20.4.15 All reports should be signed and dated by a clinician prior to filing.
- 20.4.16 Reports should be filed in the healthcare record by the end of the working day of receipt, except when the healthcare record is not available, in which case reports should be stored in a safe and secure manner that facilitates access as required.
- 20.4.17 Reports that cannot be filed in the healthcare record should be sent to locations as agreed at local level.
- 20.4.18 Robust and effective systems should be in place to file such reports in the healthcare record in a timely manner.
- 20.4.19 All available reports should be filed in the healthcare record prior to a service user's attendance at the outpatients department.

Storage of the healthcare record

21 Storage of the healthcare record

21.1 Introduction

The storage of healthcare records should take place in well designed, secure areas. This optimises the retrieval of records when required and provides a safe working environment.

21.2 Scope

The objective of this recommended practice is to outline the method by which service users' healthcare records are stored.

21.3 Contents

Section One: General principles for storage

Section Two: Storage of CD's containing service user healthcare information

Section Three: Storage facilities for non-current healthcare records

Section Four: Preparation of records for submission to the non-current store

21.4 Procedure

All healthcare records should be stored in secure locations with limited and restricted access. The healthcare records facility should conform to the principles of good building design and the environmental conditions as outlined in the Health Service Executive healthcare records management Standard – 'Suitability of Physical Facilities'.

Storage of the healthcare record

Section One: General principles for storage

- 21.4.1 The safety and quality of healthcare records is of prime importance. Knowing how long the records will need to be kept (refer to Health Service Executive retention and disposal schedule) and maintained will affect decisions on storage media.
- 21.4.2 Equipment used to store current records in all types of media should provide storage that is safe and secure with restricted access and which meets health and safety and fire regulations, but which also allow maximum accessibility of the information commensurate with its frequency of use.
- 21.4.3 Healthcare records should be easily accessible by administrative staffs that have occasion to retrieve them out of hours, e.g. for Emergency Department.
- 21.4.4 Healthcare records should be accessible, visible and preferably filed in terminal digit order.
- 21.4.5 Heads of Department, Ward Managers and Staff Officers should ensure that the Emergency Department and Healthcare Records Department have out-of-hours access to offices where healthcare records are held.
- 21.4.6 Healthcare records should be stored in such a way as to minimise the potential for deterioration and/or loss.
- 21.4.7 Healthcare records should be protected from the hazards of fire, flooding, temperature, humidity, atmospheric pollution and vandalism.
- 21.4.8 Healthcare records should be stored so that the record remains intact and is usable throughout its lifetime.
- 21.4.9 Healthcare records should be stored in buildings that are suitable for the storage of records and should comply with health and safety regulations.
- 21.4.10 Buildings or rooms used to store healthcare records should have the following features:
 - a. secure windows.
 - b. secure doors.

Storage of the healthcare record

- c. controlled access system.
 - d. sturdy construction.
 - e. secure transport mechanisms.
 - f. allow protection, recovery and access to data and information in the event of a disaster such as flood, fire and/or loss of power.
- 21.4.11 The healthcare records system should address disaster preparedness to ensure that risks are identified and appropriately addressed.

Section Two: Storage of CDs/DVDs containing service user healthcare information

- 21.4.12 CDs/DVDs containing service user healthcare information (e.g. CT scan) should be clearly marked so that it is evident who the CD/DVD refers to (name and healthcare record number) and the content.
- 21.4.13 The optimal storage solution is for CDs/DVDs to be stored separately and linked by healthcare record number.
- 21.4.14 CDs/DVDs stored in the healthcare record should be filed securely so as to minimise the risk of them getting lost/separated from the record.
- 21.4.15 This may be achieved by using CD/DVD binder sheets. However, it should be noted the disk is an unstable medium and is easily corrupted and its supporting software could also be obsolete by the time the file and contents are subject to review.



Figure 21.1: CD/DVD Binder Sheets

Storage of the healthcare record

Section Three: Storage facilities for non-current healthcare records

- 21.4.16 Any archival records, or records used on a very infrequent basis, that are still within the recommended retention period, should be stored in non-current facilities.
- 21.4.17 The non-current storage facilities should facilitate easy and rapid retrieval when required so that the health of the service user is not compromised due to the untimely receipt of their records from non-current facilities.
- 21.4.18 The non-current storage facilities should guarantee the integrity, security and confidentiality of all records.

Section Four: Preparation of records for submission to the non-current store

- 21.4.19 When healthcare records have been identified for transfer to non-current storage, such records should then be filtered. Trained staff should remove blank pages and ensure that only those documents considered vital to service user care are kept in the record.
- 21.4.20 The healthcare record should be checked to see if all activity has been coded.
- 21.4.21 If there is activity that hasn't been coded the healthcare record should be sent to the HIPE coding department.
- 21.4.22 The healthcare record should be checked to ensure that all relevant personnel (e.g. cancer research, suicide co-ordinator) have had access to the record prior to its transfer to non-current storage.
- 21.4.23 The tracking system in use in the healthcare organisation should be updated to reflect the change of location.
- 21.4.24 A record should be kept of healthcare records that have been sent to non-current/long-term storage.

Retrieval of the healthcare record

22 Retrieval of the healthcare record

22.1 Introduction

Healthcare records are essential to facilitate the provision of safe, effective care. The Health Service Executive is committed to ensuring that healthcare records are available when a service user attends for admission/consultation. This procedure details the duties of healthcare records staff in providing healthcare records for service user admission/consultation.

22.2 Scope

The objective of this recommended practice is to outline the process involved to ensure that service user's healthcare records are available upon admission and follow-up, to support safe, effective care through the provision of the service user's previous medical history. Local policies, procedures, protocols and guidelines should be in place that set out the acceptable timelines for retrieval of healthcare records.

22.3 Contents

- Section One: Retrieval of the healthcare record for elective admissions
- Section Two: Retrieval of the healthcare record for emergency admissions
- Section Three: Retrieval of the healthcare record from non-current storage which is managed in-house (within office hours)
- Section Four: Retrieval of the healthcare record from third-party non-current storage (within office hours) – this may differ between healthcare organisations.
- Section Five: Retrieval of the healthcare record from non-current storage (outside office hours)

Retrieval of the healthcare record

22.4 Procedure

Section One: Retrieval of the healthcare record for elective admissions

- 22.4.1 When a service user is admitted electively to the healthcare organisation the appropriate personnel (e.g. admission/healthcare records staff/ward clerk) should ensure that the healthcare record is available prior to the admission taking place.
- 22.4.2 The appropriate personnel (e.g. admission staff/ward clerk) should ensure that information on the Patient Administration System (PAS) is updated.
- 22.4.3 Service user identification labels should be requested/produced for the healthcare record, as appropriate.

Section Two: Retrieval of the healthcare record for emergency admissions

- 22.4.4 When a service user requires admission on an emergency basis, arrangements for registration and admission should be made by staff in the emergency department in accordance with approved policies, procedures, protocols and guidelines for such registrations and admissions.
- 22.4.5 Requests for healthcare records for emergency admissions should be notified to the healthcare records department as soon as possible, in order to facilitate their retrieval.
- 22.4.6 Healthcare records that are located outside of the healthcare organisation should be obtained and returned for emergency admissions within a maximum of 24 hours. When clinical need dictates, an express retrieval should be provided, (in some cases this may consist of faxed information from the healthcare record holder until the healthcare record can be obtained).

Section Three: Retrieval of the healthcare record from non-current storage which is managed in-house (within office hours)

- 22.4.7 Requests for healthcare records filed in non-current storage should be recorded and retained by the healthcare records department.

Retrieval of the healthcare record

- 22.4.8 The following details should be recorded:
- a. date.
 - b. healthcare record number.
 - c. requester.
 - d. retrieved by (name).
 - e. sent to.
- 22.4.9 The healthcare records supervisor should ensure that healthcare records are retrieved from the non-current store within the agreed timeframes as set out in local policies, procedures, protocols and guidelines.
- 22.4.10 It should be noted on the relevant tracking system when healthcare records that are tracked to the non-current store are retrieved.

Section Four: Retrieval of the healthcare record from third-party non-current storage (within office hours) - this will differ between healthcare organisations

- 22.4.11 When it has been identified that the healthcare record is stored off site, the filing room clerk should inform the healthcare records manager.
- 22.4.12 The healthcare records manager or designated person should contact the non-current storage company, for retrieval of records, stating the urgency.
- 22.4.13 The non-current storage company should operate delivery as required (in accordance with service level agreement).
- 22.4.14 All healthcare records should be delivered to the healthcare records library.
- 22.4.15 The healthcare records clerk should sign for the record(s) and inform the requester that they have arrived and are ready for collection/will be delivered.
- 22.4.16 The healthcare records clerk should keep a copy of the signed delivery form on file.
- 22.4.17 The healthcare records clerk and/or all appropriate personnel should ensure that healthcare records are tracked at all stages.

Retrieval of the healthcare record

Section Five: Retrieval of the healthcare record from non-current storage (outside office hours) this will differ between healthcare organisations

22.4.18 When it has been identified that the healthcare record is stored in non-current or off site storage, local policies, procedures, protocols and guidelines should be adhered to for its retrieval depending on the urgency.

Documents not held in the healthcare record

23 Documents not held in the healthcare record

23.1 Introduction

The healthcare record should contain only information that is pertinent to the diagnosis and management of the service user. Due to the complexity or sensitive nature of various types of records, not all records may be suitable to be held in the main healthcare record. However, all of these records should be identified using the service user's unique identifier and an inventory of such records should be maintained.

23.2 Scope

The purpose of this recommended practice is to outline the documents that should not be included in the main healthcare record.

23.3 Content

Section One: General principles

23.4 Procedure

Section One: General principles

23.4.1 The following documentation should not form part of the main healthcare record:

- a. administrative access requests.
- b. billing details.
- c. child protection reports.
- d. complaints.
- e. coroners post mortem reports (unless consent is obtained from the coroner).
- f. correspondence from solicitors.

Documents not held in the healthcare record

- g. Data Protection requests.
 - h. financial information.
 - i. Freedom of Information requests.
 - j. garda reports.
 - k. health & safety forms.
 - l. medico-legal reports.
 - m. incident report forms and risk management incident/complaint reviews.
 - n. welfare notification forms.
- 23.4.2 This is not an exhaustive list so if in doubt the healthcare records manager or designated person should be consulted for advice.
- 23.4.3 These documents/records should be stored in a safe and secure manner in accordance with local policies, procedures, protocols and guidelines.

Managing loose information

24 Managing loose information

24.1 Introduction

It is considered to be in the best interest of service users and their care that the full history of care is available to the current multidisciplinary team. It is thus essential that all documentation relating to the service user is filed promptly in the healthcare record.

24.2 Scope

The purpose of this recommended practice is to provide guidance on managing loose information in the event of not having prompt access to the healthcare record.

24.3 Content

Section One: General principles

24.4 Procedure

Section One: General principles

- 24.4.1 All loose reports and other documents should be filed in the proper location in the correct healthcare record by the end of the working day of receipt, except when the record is not available, in which case the reports should be stored in a safe and secure manner, that facilitates access, until the record becomes available.
- 24.4.2 In the event of results/reports/information becoming available that needs to be filed in a healthcare record that has been transferred off-site/microfilmed the following procedure should be considered:
- a. a reconstituted healthcare record cover should be used.
 - b. the relevant year sticker should be applied (referring to the year of the result/report/information).

Managing loose information

- c. the reason for the reconstitution should be documented in the healthcare record and signed and dated.
 - d. this healthcare record should then be filed in the designated area (i.e. archives)
 - e. the reconstitution should be flagged on an appropriate tracking system (i.e. PAS, IPMS or an Excel Spreadsheet) by the Healthcare Records Manager, or designated person.
- 24.4.3 Each healthcare organisation should clearly assign responsibility for the filing of loose information.



Figure 24.1: Managing loose documents

Managing the large healthcare record

25 Managing the large healthcare record (opening and closing additional volumes)

25.1 Introduction

A second or subsequent volume should be created when the healthcare record reaches capacity and/or the contents become un-manageable and there may be a risk of information becoming misplaced in the healthcare record.

25.2 Scope

The objective of this recommended practice is to outline the process to be followed when a second or subsequent volume is created.

25.3 Contents

Section One: Opening and closing additional volumes.

Section Two: Transfer of documentation/information when a second or subsequent volume healthcare record is created.

25.4 Procedure

The following should only be applied when it becomes necessary to create a second or subsequent volume for a healthcare record.

Section One: Opening and closing additional volumes

- 25.4.1 The creator of the successor volume should be familiar with local procedures for opening and closing additional volumes.
- 25.4.2 Additional volumes should be created when a healthcare record has reached approx 80mm thickness.
- 25.4.3 The service user's name, address, date of birth and healthcare record number should be checked on each volume to ensure the records relate to the same person.

Managing the large healthcare record

- 25.4.4 Blank pages should be removed from the healthcare record prior to closure.
- 25.4.5 The healthcare record should be checked before being closed to ensure it does not contain loose pages or any form of documentation stapled or sellotaped to the front or back cover. Any such documentation should be filed appropriately in the relevant section before the healthcare record is closed.
- 25.4.6 The healthcare record should then be marked 'closed' by dating and signing the designated space on the front cover.
- 25.4.7 When an additional volume is created, the volume number (e.g. volume 2) should be clearly written in the designated space on the front cover of the healthcare record and this should be dated and signed.
- 25.4.8 The number of volumes in existence should be recorded on the Patient Administration System, where this is possible.
- 25.4.9 The date the last volume was closed should be recorded on the Patient Administration System, where this is possible.
- 25.4.10 The user who creates the additional volume should record the additional volume details on the healthcare record tracking system, where appropriate.
- 25.4.11 Current service user information should only be added to the latest volume and should never be added to a closed volume.

Section Two: Transfer of documentation/information when a second or subsequent volume healthcare record is created

- 25.4.12 The information contained in any one volume of a healthcare record should only relate to the period from the date opened to the date closed.
- 25.4.13 Documentation should not routinely be transferred from one volume to another, however, in the event that certain documentation is required it should be photocopied and the copy placed appropriately in the new volume.
- 25.4.14 Relevant information regarding service user alerts/allergies/adverse drug reactions should be transferred/transcribed by the appropriate healthcare professional. Where information has been transcribed it should be clear that the entry has been transcribed from a previous volume.

Merging duplicate healthcare records

26 Merging duplicate healthcare records

26.1 Introduction

Accurate and comprehensive recording of information and accessibility to this information are essential for effective service user care and continuity of care between different healthcare professionals. One of the basic principles of the provision of such care is that there should be one comprehensive healthcare record for each service user which is available to clinicians for treatment of the service user when required.

26.2 Scope

The objective of this recommended practice is to provide guidance to ensure that where more than one healthcare record exists, robust and effective procedures are in place to bring the records together quickly and effectively.

26.3 Contents

Section One: Merging duplicate healthcare records

Section Two: Responsibility for correct service user identification

26.4 Procedure

Section One: Merging duplicate healthcare records

26.4.1 Duplicate healthcare records may exist for a number of reasons:

- a. old specialty records which were originally held separately.
- b. error made in the registration process.

26.4.2 All service users coming to clinic or for admission should have their details checked on the Patient Administration System for any duplicate healthcare record numbers.

Merging duplicate healthcare records

- 26.4.3 Whatever the cause of the duplication, duplicate sets of healthcare records should be brought together for merging as soon as practically possible.
- 26.4.4 All existing sets of healthcare records should be obtained and physically merged using the Health Service Executive healthcare record order of filing.
- 26.4.5 All documentation held under the deleted healthcare record number should be transferred to the healthcare record that has been kept (recommend keeping original healthcare record number). Identification labels that refer to the deleted number should be discarded.
- 26.4.6 Records should only be merged on the Patient Administration System after the physical healthcare records have been merged.
- 26.4.7 Merged numbers should be held in the Patient Administration System, as an alias and should not be deleted from the service user's history. It should be possible to find merged numbers in the history when searched for correctly.
- 26.4.8 When merging healthcare records, notification to other relevant departments should form part of the process and all electronic clinical systems should be updated accordingly.

Section Two: Responsibility for correct service user identification

- 26.4.9 All staff that have any kind of service user contact should be made aware of their responsibilities to ensure that the Patient Administration System is kept up to date and accurate.
- 26.4.10 Staff who find duplicate numbers or more than one number on the system for a service user should notify the healthcare records department as soon as possible.
- 26.4.11 The healthcare records department should obtain all existing sets of healthcare records and undertake a healthcare record merger. This will ensure that all healthcare records are available for the service user's treatment and that healthcare records and the Patient Administration System are merged promptly.

Dealing with the missing healthcare record

27 Dealing with the missing healthcare record

27.1 Introduction

Information is only valuable if it can be accessed when it is required – this is particularly true for healthcare records. It is essential that policies, procedures, protocols and guidelines are in place in each healthcare organisation to ensure successful, timely location of the missing record.

27.2 Scope

The objective of this recommended practice is to outline the procedures for staff to follow when dealing with missing healthcare records.

27.3 Contents

- Section One: Notification and recording of missing records
- Section Two: When the missing record is tracked to the healthcare records department
- Section Three: When the missing record is tracked to another holder
- Section Four: Staff responsibility

27.4 Procedure

Section One: Notification and recording of missing records

- 27.4.1 The healthcare records supervisor should be notified of any ‘missing’ healthcare records (i.e. where the records are not with the person they are tracked out to).
- 27.4.2 The healthcare records supervisor should keep a written record of missing healthcare records and initiate a search following normal protocols.
- 27.4.3 When the missing record is found, the supervisor should log this, and a monthly report should be provided to the healthcare records manager.

Dealing with the missing healthcare record

Section Two: When the missing record is tracked to the healthcare records department

27.4.4 A thorough search of the healthcare records department should be made, e.g.

- a. check if tracer card is filed in the healthcare record space/check computerised tracking system and/or PAS.
- b. check other combinations of the healthcare record number.
- c. check the tracking system and PAS for any imminent clinic attendance or recent admission, to ensure they have not just been removed for that purpose and tracking has not been updated.
- d. check the shelf above and below.
- e. check the transposed numbers.
- f. check 50 healthcare records either side of the space.
- g. check 50 healthcare records either side of number on opposite shelves.
- h. check whole shelf – taking healthcare records off and checking each one for notes slipped inside, or at the back of the shelf.
- i. check who has responsibility for that shelf, and check their other shelves for misfile.
- j. check the area where healthcare records are waiting to be filed.
- k. check the healthcare records of service users who were discharged on the same day from the same area.

27.4.5 If the healthcare record is still not located the following areas should be checked:

- a. shelving where healthcare records are stored awaiting coding.
- b. HIPE coding offices.
- c. accounts office.
- d. risk manager's office.

Dealing with the missing healthcare record

- e. secretary and ward clerk's location.
- f. clinician's rooms.
- g. medico-legal co-ordinators office.
- h. Freedom of Information department.

Section Three: When the missing record is tracked to another holder

- 27.4.6 The record should be requested from the holder again, asking for a more thorough search to be carried out. If they cannot locate the record, the healthcare records shelves should be checked as in section two.
- 27.4.7 The tracking system and PAS should be checked for previous admissions and/or clinics and relevant secretaries should be asked if they still hold the healthcare records.
- 27.4.8 Copy correspondence from latest attendance should be requested to try and identify any other clinicians/departments currently involved in the service user's care that might have the healthcare record.

Section Four: Staff responsibility (healthcare records department)

- 27.4.9 Healthcare record should be logged as 'missing' in the system kept for this purpose in the healthcare records department.
- 27.4.10 A temporary healthcare record should be created using a red temporary healthcare record cover and copies of any electronically held service user records available (e.g. laboratory results, radiology results, dictated correspondence etc.) should be filed appropriately in the temporary record.
- 27.4.11 The 'missing' log should be checked on a regular basis and healthcare record areas as detailed above should be searched again.
- 27.4.12 The 'missing' log should be updated with the details of where the healthcare record was located when it is found.
- 27.4.13 The temporary healthcare record should be merged with the original healthcare record when found.

Dealing with the missing healthcare record

27.4.14 If records are missing for clinics, staff may have to contact the GP for copies of relevant reports.

27.4.15 Outpatient staff should be informed of a missing healthcare record before the service user arrives to the clinic.



Figure 27.1: Check tracking system



Figure 27.2: Check shelves above and below and on either side of the space



Figure 27.3: Take healthcare records off the shelf and check each one for records slipped inside and check for records which may have slipped down at the back of the shelf



Figure 27.4: Check area where healthcare records are waiting to be filed



Figure 27.5: Check area where healthcare records are waiting to be coded

Creating a temporary healthcare record

28 Creating a temporary healthcare record

28.1 Introduction

A temporary healthcare record should only be created in exceptional circumstances and following a thorough and comprehensive search for the original record, or in the case where the identity of a service user cannot be confirmed.

28.2 Scope

The objective of this recommended practice is to outline the steps to be taken when creating a temporary healthcare record (to be used only when the original healthcare record cannot be located or when it is impossible to retrieve the original healthcare record).

28.3 Contents

- Section One: Request to open a temporary healthcare record
- Section Two: Creation of a temporary healthcare record
- Section Three: Ward clerk or designated person
- Section Four: Filing of a temporary healthcare record
- Section Five: Merging the original healthcare record and temporary healthcare record

28.4 Procedure

Section One: Request to open a temporary healthcare record

- 28.4.1 When a healthcare record cannot be located a comprehensive search should be carried out.

Creating a temporary healthcare record

- 28.4.2 If, following a comprehensive search, the record still cannot be located; a request to create a temporary healthcare record should be made to the healthcare records officer/designated person.
- 28.4.3 The healthcare records officer/designated person should undertake a further search for the healthcare record prior to approving the creation of a temporary healthcare record.
- 28.4.4 The healthcare records officer/designated person should ensure that a search continues, on a regular basis, for the original record (in line with procedure for following up missing healthcare records).
- 28.4.5 A list of missing records should be produced and retained in the healthcare records department to help staff stay alert to missing record status.
- 28.4.6 When the original record is recovered the temporary healthcare record should be merged by healthcare records staff, in line with standard policies, procedures, protocols and guidelines.

Section Two: Creation of the temporary healthcare record

- 28.4.7 Only designated personnel should have the authority to create a temporary healthcare record.
- 28.4.8 Staff should only create a temporary healthcare record when the original healthcare record cannot be located.
- 28.4.9 As much of the healthcare record as possible should be reconstructed by printing all available relevant reports and letters from the computer system and filing appropriately in a temporary healthcare record.
- 28.4.10 The current status of temporary healthcare records should be recorded, i.e. creation and closing (when merging with the original record or when a new volume of the temporary record is created).

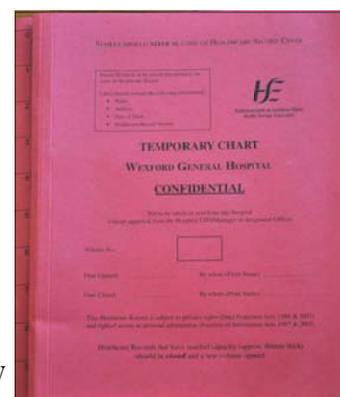


Figure 28.1:
Temporary healthcare record

Creating a temporary healthcare record

- 28.4.11 Follow-up action, where appropriate, should be taken once the location of the original healthcare record is established, i.e. who/what location was holding the record and for what reason.
- 28.4.12 If the original healthcare record is not located, the service user healthcare information should be retained in the temporary record created. This will act as a 'flag' that the original record is missing.
- 28.4.13 If the temporary healthcare record reaches capacity, a second volume of the temporary healthcare record should be created.
- 28.4.14 A log should be maintained of all temporary healthcare records in existence.

Section Three: Ward clerk or designated person

- 28.4.15 The ward clerk or designated person should request the original healthcare record of those service users who are admitted with a temporary healthcare record out of office hours.

Section Four: Filing of the temporary healthcare record

- 28.4.16 Temporary healthcare records should be filed in the healthcare records library pending follow up on the original healthcare record.

Section Five: Merging the original healthcare record and the temporary healthcare record

- 28.4.17 Where administrative personnel are holding a temporary healthcare record and the original healthcare record is received, they should merge both healthcare records (eliminating any duplication). This should be done in accordance with the Health Service Executive healthcare record order of filing.

Transfer of healthcare information

29 Transfer of healthcare information

29.1 Introduction

When a service user attends another healthcare facility for treatment, that facility may need access to the service user's history in order to deliver the best possible treatment.

29.2 Scope

The objective of this recommended practice is to outline the process to be followed when information from a service user's healthcare record is transferred to another healthcare facility.

29.3 Contents

Section One: Transfer of information from the healthcare record

29.4 Procedure

Section One: Transfer of information from the healthcare record

- 29.4.1 All telephone calls received from external medical institutions (e.g. other hospitals, healthcare organisations, nursing homes, etc) requesting healthcare records should be routed through the appropriate clinician's secretary.
- 29.4.2 Where a request for information is received by telephone, the clinician's secretary should satisfy themselves as to the identity of the requester. The requester's name, telephone number and authority to receive the information should be checked and the call returned before the information is given.
- 29.4.3 The secretary should then retrieve the service user's healthcare record and only the discharge summary and any typed correspondence should be forwarded to the requesting Medical Institution. It is unacceptable to transfer any other document from the healthcare record without obtaining permission from the healthcare records manager.

Transfer of healthcare information

- 29.4.4 Information transferred (in whatever form) should be carried out in a secure manner (e.g. the requester should be waiting at the destination fax machine to collect information if a fax is the method of transfer).
- 29.4.5 Any request forms should be filed in the appropriate section in the service user's healthcare record.
- 29.4.6 If there is an agreement in place for healthcare records to be sent from one institution to another, such records should be transferred according to Recommended Practice number 30 'Transporting the Healthcare Record'.

Transporting the healthcare record

30 Transporting the healthcare record

30.1 Introduction

Healthcare records are routinely transported from one location to another within the healthcare organisation. On occasion and where there is an agreement between institutions, it may be necessary to transport a healthcare record to an off-site location. This section refers to healthcare records that are held in hard copy or have been transferred to an alternative medium in accordance with local policies, procedures, protocols or guidelines. However, it should be noted that storing (and therefore transporting) personal or confidential information on a USB Flash drive (i.e. memory stick/pen/key), even if encrypted, is prohibited. More detailed information can be found in the HSE Information Technology/Acceptable Usage Policy which can be accessed at:

http://hsenet.hse.ie/HSE_Central/Commercial_and_Support_Services/ICT/Policies_and_Procedures/Policies/HSE_Information_Technology_Acceptable_Use_Policy.pdf

30.2 Scope

The objective of this recommended practice is to outline good practice for transporting the healthcare record to agreed locations both within the healthcare organisation and off-site.

30.3 Contents

Section One: Transporting healthcare records within the healthcare organisation

Section Two: Transporting healthcare records to an agreed location off-site

30.4 Procedure

Section One: Transporting healthcare records within the healthcare organisation

30.4.1 Healthcare records should be transported by authorised staff.

30.4.2 Healthcare records sent within the healthcare organisation should be securely bound with the destination clearly identified.

Transporting the healthcare record

- 30.4.3 Healthcare records should be transported in such a way that service users' names are not visible.
- 30.4.4 Healthcare records should never be left unattended in the course of their delivery.
- 30.4.5 The appropriate tracking system should be updated at all times when healthcare records are being transferred to other locations.

Section Two: Transporting healthcare records to an agreed location off-site

- 30.4.6 An authorised employee or agent of the healthcare organisation should conduct the transportation of healthcare records.
- 30.4.7 If healthcare records are transported by external staff that have been contracted to carry out this service (i.e. taxi), then those personnel should be made aware of the importance of service user confidentiality, privacy and security of records.
- 30.4.8 External staff who handle/transport healthcare records should sign a confidentiality agreement.
- 30.4.9 The individual conducting the transfer should be made aware of their responsibility for the healthcare record whilst in their charge and for the safe delivery of the record.
- 30.4.10 Healthcare records should never be left unattended in the course of their delivery.
- 30.4.11 If the situation arises that healthcare records have to be left in an individual's car, a taxi or ambulance (even for a very short time) they should be placed out of sight in the boot and the vehicle kept locked at all times.
- 30.4.12 Transported healthcare records should be carried in a storage case, box file or sealed confidential pouch where the name on the record(s) cannot be identified. There should be a signed chain of custody.

Transporting the healthcare record

- 30.4.13 On arrival at the agreed destination, the healthcare record should be delivered directly to the appropriate person. There should be written confirmation of the delivery of the record(s).
- 30.4.14 The movement and location of healthcare records should be controlled to ensure that a record can be easily retrieved at any time, that any outstanding issues can be dealt with, and that there is an auditable trail of record transactions.
- 30.4.15 Healthcare records being transported for use at clinics such as outreach clinics should be collected at base on the morning of the clinic and returned that evening.
- 30.4.16 The appropriate tracking system should be updated at all times when healthcare records are being transferred to other locations.
- 30.4.17 The healthcare records manager should keep a record of any healthcare records that are transferred to an agreed institution. This record should be periodically checked, and healthcare records should be requested to be returned when appropriate.

Healthcare records that may have archival value

31 Healthcare records that may have archival value

31.1 Introduction

The HSE retention and disposal schedule refers to the 'Final Action' for records covered by the policy. There are two possibilities that can be considered under final action, i.e. destroy under confidential conditions or likely to be of archival value. HSE records are not subject to the National Archives Act 1986, hence there is no obligation to transfer them. The final action as set out in the retention and disposal schedule is a suggestion rather than a stipulation.

31.2 Scope

The objective of this recommended practice is to advise staff of the process to be followed in the event of having records that may have archival value that they wish to have considered for transfer to the National Archives of Ireland.

31.3 Contents

Section One: General principles

31.4 Procedure

Section One: General principles

31.4.1 The 'Final Action' as set out in the HSE Retention and Disposal Schedule applies to the following record types where they exist in paper format:

- a. Emergency Department registers.
- b. x-ray registers.
- c. ward registers, including daily bed returns.
- d. admission books.
- e. discharge books.
- f. birth registers.

Healthcare records that may have archival value

- g. death registers.
 - h. mortuary registers.
 - i. operating theatre registers.
 - j. post mortem registers.
- 31.4.2 The advice from the National Archives is that if a healthcare organisation has records, as mentioned above, that they would like to transfer, then they should write to the Records Acquisition Division to see if they're in a position to acquire them.
- 31.4.3 The National Archives can be contacted by writing to:
- Tom Quinlan/Helen Hewson,
Records Acquisition Division,
The National Archives,
Bishop Street,
Dublin 8.
- 31.4.4 Records should not be transferred to the National Archives until they are over 30 years old.
- 31.4.5 It is normal for records that are transferred to the National Archives to be made available to the public so anything transferred should be made anonymous.
- 31.4.6 When writing to the National Archives an overall description of the type or records being offered including the age of the record should be provided.
- 31.4.7 Personnel from the National Archives will go and see the records to determine if they would be beneficial to them.
- 31.4.8 If the National Archives decide not to acquire the records then the healthcare organisation should destroy them under confidential conditions keeping a record of what's destroyed and who authorised the destruction.

Booking appointments

32 Booking appointments

32.1 Introduction

For many years problems have arisen with long queues and waiting times in outpatient clinics. There are three main points that should be considered when designing an appointments scheme:

- The time of the first appointment.
- The number of appointments given in the clinic.
- How appointments are distributed through the clinic.

Arranging appointments with these three points in mind should result in a significant reduction in waiting times for service users.

32.2 Scope

The objective of this recommended practice is to provide guidance to relevant staff so as to ensure an appropriate appointment system is in place that will optimise performance, minimise service user delays and deliver an efficient, effective service in outpatient clinics.

32.3 Contents

- Section One: General principles
- Section Two: New appointments
- Section Three: Review appointments
- Section Four: Cancellation of appointments

Booking appointments

32.4 Procedure

Section One: General principles

- 32.4.1 Service users can be issued with an outpatient appointment following:
- a. a previous outpatient visit.
 - b. discharge from hospital.
 - c. receipt of a referral letter sent by their GP, other consultant or other healthcare organisation.
 - d. a telephone call from their GP, other consultant or other healthcare organisation (in urgent cases).
 - e. a visit to the emergency department.

Section Two: New appointments

- 32.4.2 If a waiting list exists, the service user referral should be logged on an appropriate tracking system, receipt of the referral should be acknowledged to the GP/referral source and an appointment should be sent to the service user in due course.
- 32.4.3 Where there is no waiting list an appointment should be booked and the service user notified of the appointment details.
- 32.4.4 Where time permits all new appointments should receive postal notification by means of a standard appointment letter/card which should contain sufficient information as follows:
- a. name of clinic and/or healthcare professional.
 - b. date of appointment.
 - c. time of appointment.
 - d. advice on any necessary items to bring (e.g. medication, glasses, documentation).

Booking appointments

- e. a telephone number/e-mail to contact in the event of cancellation.
- f. appropriate information as necessary (e.g. parking, parking charges etc.)

Section Three: Review appointments

32.4.5 Review patients should normally receive their appointment on exit from the clinic at which point the appropriate information as detailed above will be provided.

Section Four: Cancellation of appointments

32.4.6 Local policies, procedures, protocols and guidelines should be in place to deal with cancellation and confirmation of appointments.

Retrieval and preparation of healthcare records for outpatient clinics

33 Retrieval and preparation of healthcare records for outpatient clinics

33.1 Introduction

The timely provision of healthcare records is essential to good service user care. Clinic retrieval and preparation is the process carried out by healthcare records staff/OPD staff/secretaries to ensure healthcare records are delivered on time, in good condition and hold all relevant information necessary prior to a service user's attendance at clinic.

33.2 Scope

The objective of this recommended practice is to guide relevant staff through the process to ensure that healthcare records are available for outpatient clinics.

33.3 Contents

Section One: General principles

33.4 Procedure

Section One: General principles

- 33.4.1 Clinic lists should be produced from the patient administration system and delivered to/collected by appropriate personnel to retrieve the healthcare records for upcoming clinics.
- 33.4.2 Healthcare records should be retrieved from the healthcare records library.
- 33.4.3 Healthcare records not filed in the healthcare records library should be requested/obtained from the person/area that is recorded as currently holding that record.

Retrieval and preparation of healthcare records for outpatient clinics

- 33.4.4 The clinic list should be updated with the current location of records, and the date that the healthcare record was requested from the other holder.
- 33.4.5 The healthcare record location should be updated on the tracking system.
- 33.4.6 Healthcare records for clinics should be bundled and clearly labelled.
- 33.4.7 A complete clinic list should be attached to the top of the bundle.
- 33.4.8 Healthcare records should be stored on the appropriate shelves until time for delivery to clinic areas.
- 33.4.9 A day or two before the clinic date, a new clinic list should be printed from the patient administration system and any amendments (additions/removals from clinic) dealt with appropriately.
- 33.4.10 Any staff member who adds a service user to a clinic after this timeframe should contact the healthcare records department to inform them so that the healthcare record can be retrieved for the clinic.
- 33.4.11 Any healthcare records still to come from other areas should be noted and the person holding the healthcare record should be requested to provide urgent return to the healthcare records department.
- 33.4.12 Healthcare records should be delivered to appropriate clinic areas in accordance with local policies, procedures, protocols and guidelines. The delivery should include an up-to-date clinic list and a note for OPD clinic staff regarding any outstanding healthcare records awaiting delivery from other holders.
- 33.4.13 Each healthcare record should be checked for completeness by the appropriate personnel and results not on the healthcare record obtained.
- 33.4.14 Each healthcare record should be date stamped and checked to ensure it contains:
- a. adequate service user identification labels
 - b. sufficient space for the healthcare professional to document their care at the time of consultation at clinic.

Retrieval and preparation of healthcare records for outpatient clinics

- 33.4.15 New attendances should have a referral letter filed appropriately in the healthcare record.
- 33.4.16 Review attendances should have all relevant up to date information relating to their care since the last visit filed appropriately in the healthcare record.
- 33.4.17 All information should be filed in accordance with the 'Order of filing' as detailed in the HSE general healthcare record/national maternity healthcare record.
- 33.4.18 Outside covers should be checked and replaced where necessary.
- 33.4.19 Healthcare records should be closed, if necessary, and a new volume opened. Complete clinic lists should be produced on the day of clinic for use in clinic reception area(s).
- 33.4.20 At the end of each clinic session, the Patient Administration System should be updated (clinic management) and the healthcare records should be delivered to the relevant secretary.

Retrieval and preparation of healthcare records for outpatient clinics



Figure 33.1: Produce clinic lists



Figure 33.2: Pull healthcare records

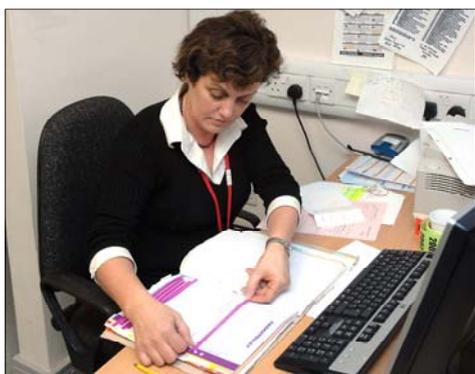


Figure 33.3: File results in healthcare record



Figure 33.4: ID labels placed on each side of each page

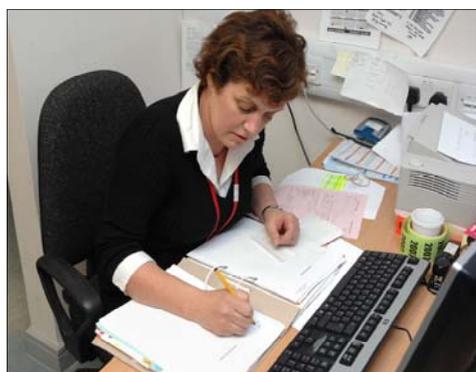


Figure 33.5: Continuation sheets dated

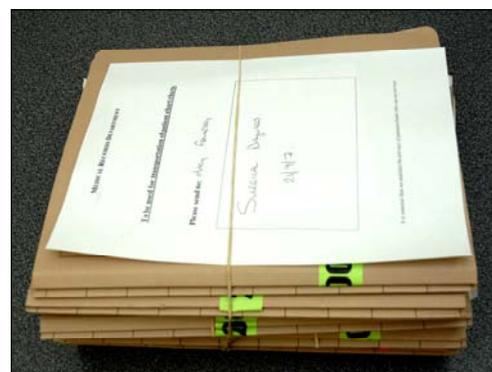


Figure 33.6: Bundle and label healthcare records for clinics



Part 4

Additional Resources and Appendices

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Glossary of Terms

Adult: A person over the age of 18.

Audit: A systematic examination to determine whether activities and related results conform to planned arrangements and whether these arrangements are implemented effectively and are suitable for achieving the organisations policies and objectives.

Child: A person under the age of 18 years unless that person has attained full age through marriage (Section 2 Child Care Act 1991).

Clinical accountability: Refers to the accountability of healthcare professionals to a clinical director for meeting agreed standards of service user safety and quality. Not to be confused with ‘managerial accountability’. The terms ‘healthcare professional’ and ‘clinical director’ can refer to individuals from any clinical profession, including medicine, nursing and health and social care professionals.

Clinician: A professional having direct contact with and responsibility for treating service users. The term clinician can refer to individuals from any clinical profession, including medicine, nursing and health and social care professionals.

Document Imaging: Document imaging is the process of scanning paper documents, converting them to digital images that are then stored on Microfilm, CD, DVD, or other magnetic storage.

Healthcare Professional: A healthcare professional is a person who by education, training, certification or licensure is qualified to and is engaged in providing health care. A healthcare professional is associated with either a specialty or a discipline and belongs to one of the following groups:

- Medical and dental staff (associated with one or more specialties)
- Nurses, midwives and health visitors
- Health and Social Care Professions (HSCPs), e.g. clinical psychologists, dieticians, physiotherapist
- Other professionals who have direct service user contact, e.g. pharmacists.

Glossary of Terms

Healthcare record: The healthcare record refers to all information collected, processed and held in both manual and electronic formats pertaining to the service user and service user care. It includes demographics, clinical data, images, unique identification, investigation, samples, correspondence and communications relating to the service user and his/her care.

Hospital Information System: A hospital information system (HIS) is a comprehensive, integrated information system designed to manage the administrative and clinical aspects of a hospital. This encompasses paper-based information processing as well as data processing machines. The aim of a HIS is to achieve the best possible support of service user care and administration by electronic data processing. It can be composed of one or few software components with specialty specific extensions as well as of a large variety of sub-systems in medical specialties (e.g. Laboratory Information System, Radiology Information System).

Legal Guardian: A person with rights and responsibilities in respect of someone who lacks legal capacity, such as a child. These rights and responsibilities are automatically vested in the parents of a child born within marriage and in the mother of a child born outside marriage and include responsibility for the maintenance, care, education, health and welfare of the child. For adults lacking mental capacity, the only legal guardianship system currently in place is the Ward of Court system.

Mandatory (guidance): Compulsory (guidance) but not required by law.

Microfilming: Microfilm is used to store images that have been reduced for storage convenience. When compared to paper, microfilm is less bulky and weighs less, resulting in lower storage costs. The main problem with microfilm is that it should be magnified to be seen.

Minor: A person who is less than 18 years of age, who is not or has not been married (Section 2 of the Age of Majority Act, 1985).

Monitor: To check, supervise, observe critically, or record the progress of an activity, action or system on a regular basis in order to identify change.

PACS: Picture Archiving and Communications System, more commonly known as PACS, enables images such as X-rays and scans to be stored electronically and viewed on video screens, so that doctors and other healthcare professionals can access the information and compare it with previous images at the touch of a button.

Glossary of Terms

Procedure: The word procedure refers to operations, interventions, investigations, pharmaceutical treatment, examinations and any other situation or procedure in which permission should be sought from the service user/parent/guardian before it is carried out. Also following from the Non-Fatal Offences against the Person Act 1997, section 23 www.irishstatutebook.ie/1997/en/act/pub/0026/sec0023.html#z26y1997s23 “Surgical, medical or dental treatment” includes any procedure undertaken for the purposes of diagnosis, including the administration of an anaesthetic which is ancillary to any treatment.

Risk: The chance of something happening that will have an impact upon objectives. It is measured in terms of the severity of the consequence and frequency.

Risk Assessment: The process used to determine risk management priorities by comparing the level of risk against predetermined standards, target risk levels or other criteria.

Risk Management: The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

Service User: The term ‘service user’ includes:

- People who use health and social care services as patients.
- Carers, parents and guardians.
- Organisations and communities that represent the interests of people who use health and social care services.
- Members of the public and communities who are potential users of health services and social care interventions.

The term service user also takes account of the rich diversity of people in our society whether defined by age, colour, race, ethnicity or nationality, religion, disability, gender or sexual orientation, and may have different needs and concerns.

The term service user is used in general, but occasionally the term patient is used where it is most appropriate.

Abbreviations

A&E	Accident and Emergency (Emergency Department)
CD	Compact Disc
CEO	Chief Executive Officer
CTG	Cardiotocograph
DP	Data Protection
DVD	Digital versatile disc
EEG	Electroencephalogram
e.g.	For example
ELOS	Estimated length of stay
EPAU	Early Pregnancy Assessment Unit
Etc.	etcetera
FOI	Freedom of Information
GIT	Gastrointestinal tract
GP	General Medical Practitioner
gsm.	Grams per Square Meter (paper weight)
HBN47	Health Building Note 47
HIPE	Hospital Inpatient Enquiry
HIQA	Health Information Quality Authority
HCR	Healthcare Record
HCRD	Healthcare Records Department
HCRM	Healthcare Records Manager/Management
HSE	Health Service Executive
ICD-10-AM	International statistical classification of diseases and health related problems, 10th revision
ID	Identification
i.e.	that is
IMC	Irish Medical Council
IT/ICT	Information Technology/Information Communication Technology
MIS	Management Information System
mm	millimetre

Abbreviations

NCHD	Non Consultant Hospital Doctor
NIMIS	National Integrated Medical Imaging System
OPD	Outpatients Department
PAS	Patient Administration System
PATH	Pathology Record
PIN	Personal Identification Number
PPPG	Policy, procedure, protocol or guideline
RIP	Rest in Peace
RNP	Registered Nurse Prescriber
SHO	Senior House Officer
TOE	Trans Oesophageal Echo

Appendix 1 - National Healthcare Records Management Advisory Group membership

Name	Title	Organisation
Ms. Ann Brennan	Quality Manager	St. Michael's Hospital, Dun Laoighaire
Mr. Eddie Byrne	Director of Nursing	Cavan General Hospital
Dr. Joe Devlin	Clinical Director, Quality & Patient Safety Directorate	Health Service Executive
Ms. Ann Duffy	Clinical Risk Advisor	Clinical Indemnity Scheme, State Claims Agency
Ms. Helen Lambert	ICT Security	HSE South East, Kilkenny
Ms. Siobhan Lynch	Hospital Manager	Mallow General Hospital
Ms. Mary Moynihan	Area Physiotherapy Manager	St. Luke's General Hospital, Kilkenny
Ms. Gay Murphy	National Programme Lead for Healthcare Records	Health Service Executive
Ms. Mary O'Connor	Healthcare Records Manager	Mater Hospital, Dublin
Ms. Irene O'Hanlon	Group Risk Advisor	Our Lady of Lourdes Hospital, Drogheda
Mr. Liam Quirke	Consumer Affairs Area Officer	HSE West, Merlin Park, Galway
Ms. Winifred Ryan	Head of Standards & Guidance, Quality & Patient Safety Directorate	Health Service Executive

Appendix 2 List of HSE organisations who participated in the consultation process

Waterford Regional Hospital, Co. Waterford
St. Luke's General Hospital, Kilkenny
Lourdes Orthopaedic Hospital, Kilcreene, Kilkenny
Wexford General Hospital, Wexford
South Tipperary General Hospital, Clonmel, Co. Tipperary
Cork University Hospital, Cork
Cork University Maternity Hospital, Cork
St. Finbarr's Hospital, Cork
St Mary's Orthopaedic Hospital, Cork
Mallow General Hospital, Mallow, Co. Cork
Kerry General Hospital, Tralee, Co. Kerry
Bantry General Hospital, Bantry, Co. Cork
Mercy University Hospital, Cork
South Infirmary-Victoria University Hospital, Cork
Our Lady of Lourdes Hospital, Drogheda, Co. Louth
Louth County Hospital, Dundalk, Co. Louth
Cavan General Hospital, Cavan
Monaghan General Hospital, Co. Monaghan
Our Lady's Hospital, Navan, Co. Meath
Sligo General Hospital, Sligo
University College Hospital, Galway
Merlin Park Regional Hospital, Galway

Appendix 2 cont'd - HSE organisations who participated in the consultation process

Mayo General Hospital, Castlebar, Co. Mayo
Roscommon County Hospital, Roscommon
Portiuncula Hospital, Portiuncula, Ballinasloe, Co. Galway
Letterkenny General Hospital, Letterkenny, Co. Donegal
Midland Regional Hospital, Mullingar, Co. Westmeath
Midland Regional Hospital, Tullamore, Co. Offaly
Adelaide & Meath Incorp National Children's Hospital, Tallaght, Dublin
Naas General Hospital, Naas, Co. Kildare
Coombe Women's Hospital, Dublin 8
Our Lady's' Hospital for Sick Children, Dublin 12
Midland Regional Hospital Portlaoise
Mid Western Regional Hospital Limerick, Dooradoyle, Limerick
Mid Western Regional Orthopaedic Hospital, Croom, Co. Limerick
Mid Western Regional Maternity Hospital, Limerick
Mid Western Regional Hospital, Ennis, Co. Clare
Mid Western Regional Hospital, Nenagh, Co. Tipperary
St John's Hospital, Limerick City
St Vincent's University Hospital, Elm Park, Dublin 4
St Michaels Hospital, Dun Laoghaire, Co. Dublin
St Columcille's Hospital, Loughlinstown, Co. Dublin
National Maternity Hospital, Holles Street, Dublin 2

Appendix 2 cont'd - HSE organisations who participated in the consultation process

St Luke's Hospital, Rathgar, Dublin 6
Royal Victoria Eye & Ear Hospital, Adelaide Road, Dublin 2
St James's Hospital, James's Street, Dublin 8
Mater Misericordiae University Hospital, Eccles St., Dublin 7
Beaumont Hospital, Beaumont Road, Dublin 9
Connolly Hospital, Blanchardstown, Dublin 15
Cappagh National Orthopaedic Hospital, Cappagh, Finglas, Dublin 1
Children's University Hospital, Temple Street, Dublin 1
Rotunda Hospital, Parnell Street, Dublin 1
Adoption Service, Health Service Executive South
National OPD Performance Improvement Project
National Integrated Medical Imaging System (NIMIS) Project, Health Service Executive

Appendix 3 - List of external organisations who participated in the consultation

Consultees (external)	Consultees (external)
Irish Directors of Nursing and Midwifery Association	Association of Physical Scientists in Medicine
Royal College of Physicians of Ireland	Irish Society of Audiologists
Academy of Medical Laboratory Science	Information Commissioner
Dublin Hospitals Group Risk Management Forum	Data Protection Commissioner
HSE Safety & Advisory Group, Irish Public Bodies	Clinical Indemnity Scheme
Royal College of Surgeons of Ireland	Health Care Risk Managers Forum
Association of Occupational Therapists of Ireland	Freedom of Information Officers Association
Psychological Society of Ireland	Department of Health and Children
Irish Association of Speech & Language Therapy	Health Policy & Information Division, ESRI
Pharmaceutical Society of Ireland	National Archives of Ireland
Head Medical Social Workers Group	An Bord Altranais
Irish Chiropodists/Podiatrists Organisation	National Council for Nursing & Midwifery
Association of Clinical Biochemists in Ireland	Patient Focus
Irish Society of Chartered Physiotherapists	Irish Advocacy Network
Irish Institute of Radiotherapists	Patients Together
Irish Nutrition and Dietetic Institute	Patient Partnership
Irish Patients Association	

Appendix 4 - Legislation, guidance, regulations and standards

Advance Healthcare Decisions Bill, 2010

Age of Majority Act, 1985

Child Care Act 1991 and related regulations

Civil Partnership and Certain Rights and Obligations of Cohabitants Act, 2010

Civil Liability and Courts Act, 2004

Data Protection Acts, 1988 and 2003 and related regulations

Freedom of Information Acts, 1997 and 2003

Health Acts, 1947, 1953, 1970 and related regulations

Mental Health Acts, 1945 to 2001

Statute of Limitations Act, 1957

Statute of Limitations Amendment Act, 1991

Appendix 5 - Consent documentation referenced

Consent for Anaesthesia, Revised Edition 2006, Published by The Association of Anaesthetists of Great Britain and Ireland, 21 Portland Place, London W1B 1PY

Good Medical Practice In Seeking Informed Consent To Treatment, Medical Council, February 2008.

Guidelines in Relation to Obtaining Patient Consent, Revised Edition May 2007, Dublin Hospitals Group, Risk Management Forum.

Guidelines in relation to obtaining consent to Clinical Treatment in an Acute Hospital setting, June 2006, Hospital Network Dublin North East.

Guidelines for Consent to Clinical Examination and/or Treatment, HSE Mid-West Area Acute Hospitals, May 2009.

Guidelines for Consent to Clinical Examination and/or Treatment, Hospital Group South East, November 2008.

Staff Guidelines in Relation to Obtaining Consent for Children and Young People, The Children's University Hospital, Our Lady's Children's Hospital, The National Children's Hospital AMNCH, October 2007.

Appendix 6 - Name change request form

Name Change Request Form

(To be completed using black pen and BLOCK CAPITALS)

Healthcare Record Number:

Surname:

Forename:

Address:

.....

.....

.....

Date of birth:

Please update the name on the above healthcare record as per the details provided below:

Change **surname** fromto

Where applicable:

Change **forename** fromto

Change **gender** fromto

Request made on behalf of:

- Self Child (specify relationship to child, i.e. parent/legal guardian)

Supporting legal evidence provided:

- Birth Certificate Marriage/Civil Partnership Certificate Adoption Certificate Deed Poll Certificate

Service user signature:

Date:

Office Use Only:

Details updated on IT System including any stand-alone systems

Healthcare record updated

Staff member signature:

Date:

