Shropshire Community Health NHS
NHS Trust

Document Details	
Title	**Procedure for Scanning and Shredding of Clinical Documents in Prison Health**
Trust Ref No.	1318-29579
Local Ref (optional)	N/A
Main points the document covers	Information Governance
Who is the document aimed at?	HMP/YOI Stoke Heath - Primary Care Team
Owner	Wendy Sweeney
Approval Process	
Approved by (Committee/Director)	Quality & Safety Committee
Approval Date	18/02/2016
Initial Equality Impact Screening	Yes
Full Equality Impact Assessment	No
Lead Director	Director of Nursing and Operations
Category	Information Technology
Sub Category	Prisons
Review Date	February 2019
Distribution	
Who the policy will be distributed to	All clinical and administrative staff working in Shropshire Prison Health
Method	Meeting with staff
Document Links	
Required by CQC	No
Required by NHLSA	No
Other	None

Amendment History		
No	Date	Amendment
1	07/12/2015	Updated to include definitions
2	19/02/2016	Included definitions and duties
3		
4		

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Introduction

This policy will outline the basic procedure for scanning patient related clinical documents into the clinical record. The aim of the procedure is to ensure that the scanned image is a true representation of the original document saved in an electronic format. Once a document has been scanned and stored in an appropriate format, and subject to the appropriate system safeguards, then the paper original can be shredded.

Purpose

To provide a safe system of work for destruction of clinical documents following scanning into electronic notes.

Definitions
Systm One – medical computer system

Duties

Senior healthcare administrator – records management
Prison administration assistant – post coordinator.

Body of Policy

Scanning procedure

On opening of postal delivery, all items of correspondence are immediately date stamped with the date of receipt. All documents relating to individual patients will be placed in the scanning “in tray” to be scanned prior to distribution. (This will ensure that the patient record is immediately up to date should the patient attend the healthcare department or an enquiry be made, and will also ensure that the document is not lost or overlooked before scanning).

All documents will be scanned and attached to the medical record following the clinical system instructions and according to the following rules;

The date will be recorded as the date of the letter and not the date of entry.
The speciality and location (hospital) will be recorded.
Medication will be recorded where the GP will continue to prescribe.
Medication issued in secondary care and already completed or discontinued by the patient will also be recorded in order to demonstrate a complete and accurate record, and assigned to ‘outside agency’ as the issuer.
The person making the attachment will be identified.
All attachments will be linked to an appropriately Read coded entry.
Where these codes are entered by a non-clinician a clinician will identify what will be recorded and this information will be periodically validated by the clinician concerned.
All appropriate members of the healthcare team will be able to see and comment on the document.
Actions will be completed, for example, patient follow up.

Department Process

All mail delivered or collected by primary care staff will be opened on the same day.
All post will be date stamped.

Hard copies of documentation will be signed and posted to the appropriate individual or to specific clinician for them to action.
It is the responsibility of each individual to whom the documentation is addressed to ensure actioned post is scanned into Systm One records.
The GP's will not be expected to complete own scanning. This responsibility will be that of the HCA staff/administrator carrying out this activity on the day.
If any urgent action is required from documentation the nurse in charge will be informed. This communication will be documented in the patients' clinical record.

Processes will be in place for the following;

Staff training and adequate provision will be made to cover the scanning process in the event of holiday or sickness.
Managing scanning software updates – these will be discussed at the Clinical Governance and staff meeting forums and all relevant staff with scanning responsibility will be informed of and trained in any changes to process.

Under no circumstances will Optical Character Recognition (OCR) or automatic clinical coding software be used due to the risk of misreading data if clinical terms are similar, and coding risks.

When a patient is transferred to the non Systm One establishment the whole record will be printed off including all letters. Attachments will be sent to the transferring prison in hard copy. No CD's or floppy disks or other removable media will accompany the medical record in transfer.

Clinical system instructions will be followed in order to view, print or remove scanned documents.

Any attachment to the electronic clinical record is regarded as having equal medico-legal weight as the patient record and will be accorded the same stringencies around audit trail and back up.

Shredding

The Good Practice Guidelines for General Practice Electronic Patient Records published by the Department of Health in June 2005 states "once a document has been scanned and stored in an appropriate format, and subject to the appropriate system safeguards detailed in these guidelines, then the paper original can be shredded".

The department will validate content and replication of accuracy of all scanned images. It is accepted that all scanned documents must be exact replicas of the original documents and will be saved in an electronic format. The original must not have been cut and the scanned image should not have had the 'white space' removed. The identity of the original author of any document (attribution) must be preserved in the scanned document.

Scanned documents will be placed in appropriately marked confidential waste containers in date order. On receipt of the quarterly external data verification (verified by the clinical system supplier) and letter/email of confirmation that verification was successful for the date range concerned, the confidential waster can be shredded. This will usually be three months after the document is scanned.

Documents will not be left lying around on desks and in public areas and will be stored securely in an office/room until they can be disposed of.

Compliance

Compliance with this policy will be assessed by clinical audit and monitored by the Clinical Lead for Shropshire Prisons.
Consultation List

Mark Goodfellow	Informatics Department
Wendy Sweeney	Service Manager Shropshire Prison and Community Substance Misuse Team
Andy l'Anson	IT Programme Manager
Helen Oakley	prison senior administrator

References

NHS connecting for Health www.connectingforhealth.nhs.uk

Shropshire Community Health NHS Trust Information Governance Strategy 1273/11717

Review

This procedure will be reviewed at 3 yearly intervals, when there is a change in national policy or when there is a significant change to the application, or hosting functionality.