



Storage of Patient Clinical Records Procedure

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1. Introduction

- 1.1. South East Coast Ambulance Service NHS Foundation Trust ('the Trust') depends on the patient data and records it holds to operate efficiently and account for its actions. The Trust has a statutory obligation to maintain accurate records of its activities and to arrange for their safekeeping and secure disposal. All records created in the course of the business of the Trust, of whatever format and medium are public records under the terms of the Public Records Acts 1958.
- 1.2. Clear guidelines are required to ensure that patient care records are handled securely and arrive with the Health Records team in a timely manner.
- 1.3. This procedure is derived from the Storage of Patient Clinical Records Policy and is linked to the Operational Completion and Submission Procedure and the Patient Data and Health Records Management Procedure (Appendix A).

2. Objectives

- 2.1. Eliminate or minimise the chances of Patient Care Records (PCRs) being lost and/or the information contained in the records being inappropriately accessed.
- 2.2. To clarify staff responsibilities, duties and legal obligations relating to care records and patient data.
- 2.3. To ensure patient data and care records are available and can be accessed when needed.

3. Scope

- 3.1. This procedure applies to all staff in a permanent, temporary, voluntary or contractor role acting for or on behalf of the Trust.
- 3.2. This procedure applies to all staff who are responsible for the storage and transportation of care records.
- 3.3. This procedure applies to the storage and transportation of all paper based patient care records created within the trust, inclusive of 'associated forms' such as continuation sheets.
- 3.4. It is the responsibility of all Managers and Clinical Staff within the Trust to ensure that staff within their remit who are involved with patient data or Health Records are made aware of, and fully understand, their roles and responsibilities in relation to patient data and Health Records.



4. Procedure

4.1. Ambulance Crews

4.1.1. A shift log envelope must be completed by the crew on each vehicle for each shift and all PCRs and associated paperwork must be placed in this. Relevant details will be recorded on the front of the shift log envelope. Details include:

- shift date
- call sign letter and number
- station
- shift start time
- crew 1 last name
- crew 1 personnel number
- ePCR trained (y/n)
- crew 2 last name
- crew 2 personnel number
- ePCR trained (y/n)
- incident number
- tick boxes to confirm if paper or ePCR submitted or passed to another crew
- additional forms completed and any further information

4.1.2. If an incident has caused moderate or severe harm or the death of a patient and an IRW-1 has been completed; a RED sticker must be attached to the envelope against that incident and the process flow chart in Appendix B must be followed.

4.1.3. If controlled drugs have been administered at an incident, a YELLOW sticker must be attached to the envelope against that incident and the process flow in Appendix C must be followed.

4.1.4. Shift Incident Log Envelopes that have been completed as per the PCR Operational Completion and Submission Procedure must be posted into the PCR collection box, at a SECAmb site at the end of each shift. (Unless PAP or VAS crews have agreed alternative arrangements with their contract manager.)

4.2. Station Leadership

4.2.1. Any Shift Incident Log Envelopes that have a red or yellow sticker on them must be identified by the designated OTL and the process as described in Appendix B & C must be followed.

4.2.2. The designated OTL must complete a Shift Incident Log Envelope audit of 1 out of 10 envelopes. This may need to be increased to 1 out of 5 envelopes if that operating unit's unreconciled incidents are greater than 10%. The results of this audit will be recorded on the front of the shift log envelope and will show:



- number of forms indicated
- number of forms included
- missing incidents checked (Y/N)
- paperwork completed (Y/N)
- any relevant comments
- OTL name and personnel number
- date of audit
- signature.

- 4.2.3. The OTL must verify that the envelope contains all the PCRs and associated documents that are recorded on the Shift Incident Log Envelope, where the PCRs have not been passed to another crew as per 4.1.1. They must match these against a report from Info.SECAmb on vehicle activity for that shift.
- 4.2.4. Shift Incident Log Envelope audits should be completed in a timely manner so that transportation of forms to Health Records is not delayed.
- 4.2.5. OU leadership must investigate any missing paperwork and record the outcome on the Shift Incident Log Envelope, without delaying sending the paperwork to Health Records. OU leadership must follow SECAmb policy on Information Governance breaches (see 6.1 of this procedure for more information).
- 4.2.6. Once the audit is complete, the shift log envelopes must be placed in the red delivery bags, which are then secured by serial numbered, tamper evident tags.
- 4.2.7. The OTL then completes their section of the PCR collection and delivery log sheet (Appendix D) with:
- ID number of the red bag
 - serial number of the tamper evident tag
 - Number of envelopes in the red bag
 - OTL name
 - OTL signature
 - Date the bag was sealed.
- 4.2.8. The red delivery bag and PCR Collection and Delivery Log must be locked in the designated secondary storage cabinet.
- 4.2.9. PCRs must be transferred from the PCR collection box into red delivery bags and into the secondary storage cabinet as close to the scheduled collection time as possible, but no longer than 24hrs prior.
- 4.2.10. Each individual station/Make Ready Centre (MRC) should have a display of their collection day. It is the responsibility of the designated OTLs to ensure that all bags are ready and accessible.



4.3. Logistics

- 4.3.1. The logistics driver must collect the red delivery bags on the planned day (Appendix E) and complete the PCR Collection and Delivery Log. By signing the collection and delivery log, the delivery driver confirms that the tag serial number recorded matches the serial number recorded on the collection and delivery log.
- 4.3.2. If the station collection day falls on a public holiday the next collection will be the following working day, where possible, otherwise the logistics team will communicate a revised collection schedule.
- 4.3.3. The logistics driver must not collect any red bags that have not been tagged and logged on the PCR Collection and Delivery Log or any bags where the serial number on the tag does not match the number on the collection and delivery log. They must record any bags left on station and the reason for leaving them on the relevant section of the PCR Collection and Delivery Log. This information must be reported to the Health Records team at the time of delivery. The Health Records team will investigate this and complete an IRW1 if required.
- 4.3.4. When stored overnight by Logistics prior to delivery to Health Records, the red delivery bags and the collection and delivery log must be stored securely in the designated locked cabinet at the local stores, until they are transported to the Health Records department.
- 4.3.5. Care records must be delivered to the Health Records team on the following days:
- Surrey - Monday and Wednesday
 - Sussex - Wednesday and Friday
 - Kent – daily (Monday to Friday).
- 4.3.6. If the delivery day falls on a public holiday, delivery will take place the next working day.

4.4. Health Records

- 4.4.1. Health records staff must confirm that:
- The red bag IDs & tag IDs match those on the PCR Collection and Delivery Log
 - The bags contain the number of envelopes specified on the PCR Collection and Delivery Log
 - There have not been any untagged bags left on a MRC/station.
- 4.4.2. They must sign the PCR Collection and Delivery Log to confirm that all of the points in 4.4.1 are present and correct.



- 4.4.3. If there are any discrepancies at 4.4.1, the Health Records team must investigate these and complete an IRW1 if an IG breach has occurred or there is evidence of practice outside of this procedure.
- 4.4.4. The Health Records team retain a copy of the PCR Collection and Delivery Log and the original is returned to the delivery driver. The driver takes this copy back to their base, to be stored securely. This ensures a log of all collected/received bags is maintained.
- 4.4.5. The Health Records team will record the total number of PCRs in each red bag and the percentage of those received within 14 days of the incident occurring.
- 4.4.6. The Health Records team track and record all shift log envelopes that have been audited in the delivery record database. The Health Records Manager updates a weekly delivery spreadsheet (located on SharePoint), which tracks the ambulance stations/MRC from which deliveries took place and highlights any stations/MRCs failing to do so.
- 4.4.7. Any station that fails to deliver completed PCRs on two consecutive weeks will be contacted by the Health Records Manager to prompt a delivery. These incidents will be recorded on an IRW1 form.
- 4.4.8. PCRs will then be processed as per the Patient Data and Health Records Management Procedure.

5. Responsibilities

- 5.1. The Chief Executive Officer (CEO) has overall responsibility for the secure storage of PCRs in SECamb.
- 5.2. The Executive Director of Operations, through delegation by the CEO, has overall responsibility for the local implementation, operation and assurance of this procedure.
- 5.3. The Executive Director of Operations delegates local responsibility and accountability for this policy to the Regional Operation Managers, Operating Unit Managers, Operational Managers, Specialist Managers and where relevant the Head of Fleet and Logistics.
- 5.4. The Regional Operation Managers, Operating Unit Managers, Operational Managers, Specialist Managers and where relevant the Head of Fleet and Logistics delegate local responsibility and accountability for this policy to their staff including the Operational Team Leaders, Logistics Manager, and others.
- 5.5. The Executive Medical Director, through delegation by the CEO, has overall responsibility for secure storage of PCRs.



- 5.6. The Head of Clinical Audit supports the Executive Medical Director in the provision of assurance around the secure storage of PCR's within the Trust.
- 5.7. The Executive Medical Director and Head of Clinical Audit escalate unresolved concerns to the CEO.
- 5.8. The Executive Director of Finance, through delegation by the CEO, has overall responsibility for Security and Estates. Security and estates staff provide professional advice to the Medical Director and Head of Clinical Audit for the secure storage of PCR's in the trust.
- 5.9. All staff who handle PCR's are accountable for complying with this policy, for reporting any concerns and for the secure storage of all PCR's.

6. Audit and Review

- 6.1. Any information governance breach must be reported immediately to the Trust's Information Governance Lead by the relevant manager. Details must also be recorded on the Trust's incident reporting system (Datix). Once this has taken place, the action plan will need to be agreed and the incident investigated. The Head of Clinical Audit will review Datix and audit records quarterly to ensure compliance with this policy.
- 6.2. The Head of Clinical Audit and staff will complete quarterly PCR Security and Storage Audit to assess:
 - 6.2.1. PCR's stored in Shift Log Envelopes and deposited into PCR collection box.
 - 6.2.2. 1 in 10 Shift Log Envelopes are audited and the results acted upon.
 - 6.2.3. Shift Log Envelopes are stored securely in the secondary storage cabinet in tagged red bags ahead of the scheduled collection day.
 - 6.2.4. Collection and Delivery Logs are completed consistently and accurately.
 - 6.2.5. Red bags held at stores are locked securely in the designated storage cabinet.
 - 6.2.6. Health Records Team accurately record receipt of care records.
 - 6.2.7. Private and Voluntary services are submitting PCR's to a SECAmb site at the end of each shift, unless otherwise agreed with their contract manager.
- 6.3. Any deviations or other concerns will be reported to the Clinical Audit and Quality Sub-Group. Unresolved concerns will be escalated to the Trust executive.
- 6.4. Ad hoc inspection of PCR security and storage will also take place as part of the crime reduction surveys and quality assurance visits.



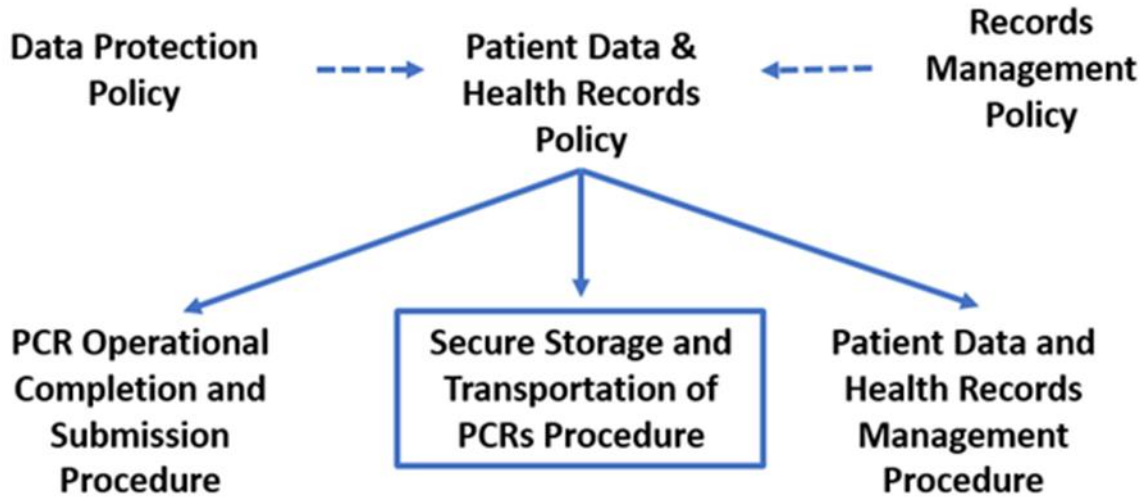
- 6.5. Quality issues arising from these inspections must be escalated to the Head of Clinical Audit and Medical Director via quality assurance reporting or the Datix reporting system.

7. References

- 7.1. IGA Records Management Code of Practise for Health and Social Care 2016



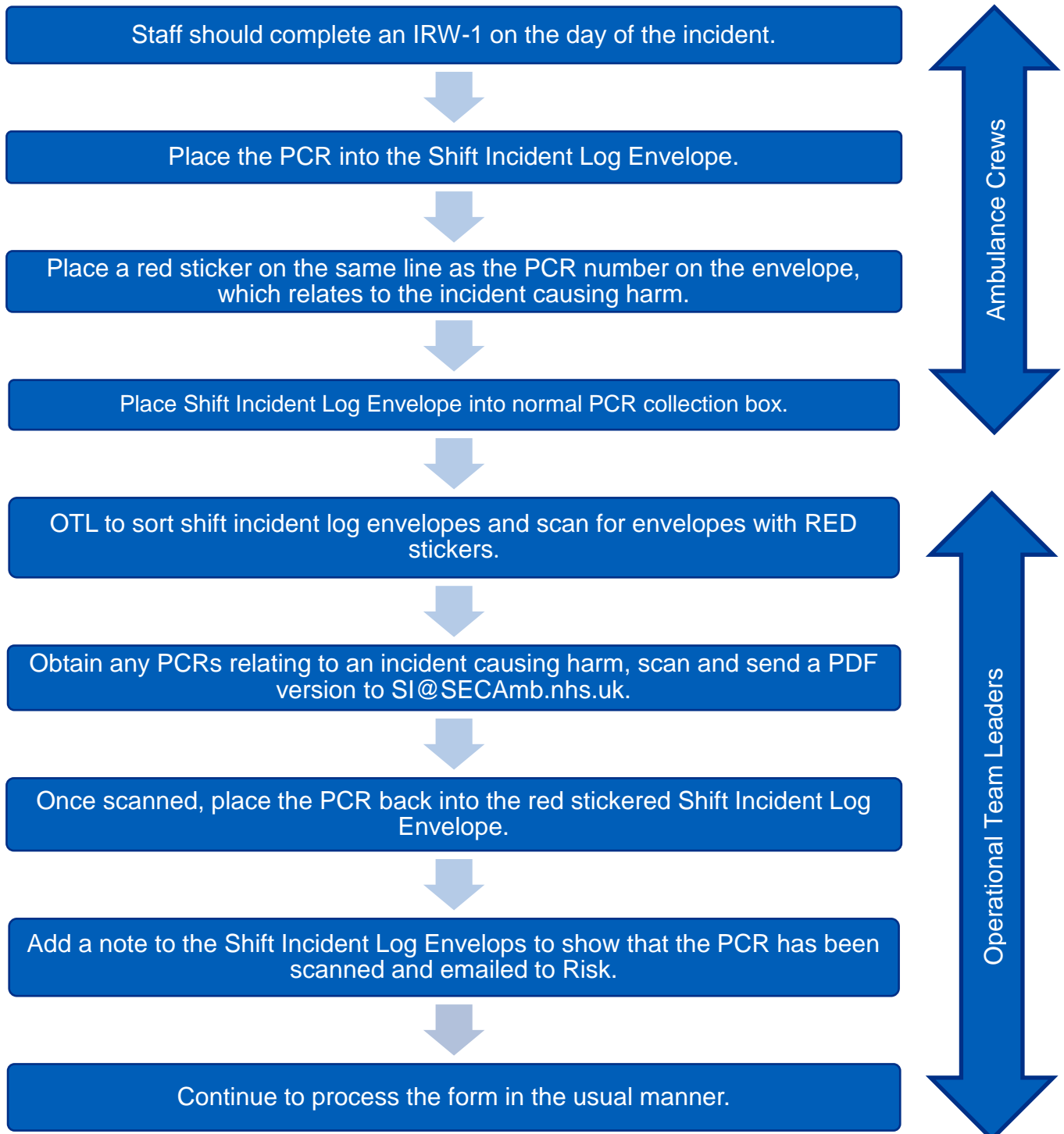
Appendix A: Procedure Structure





Appendix B: Incidents Causing Harm

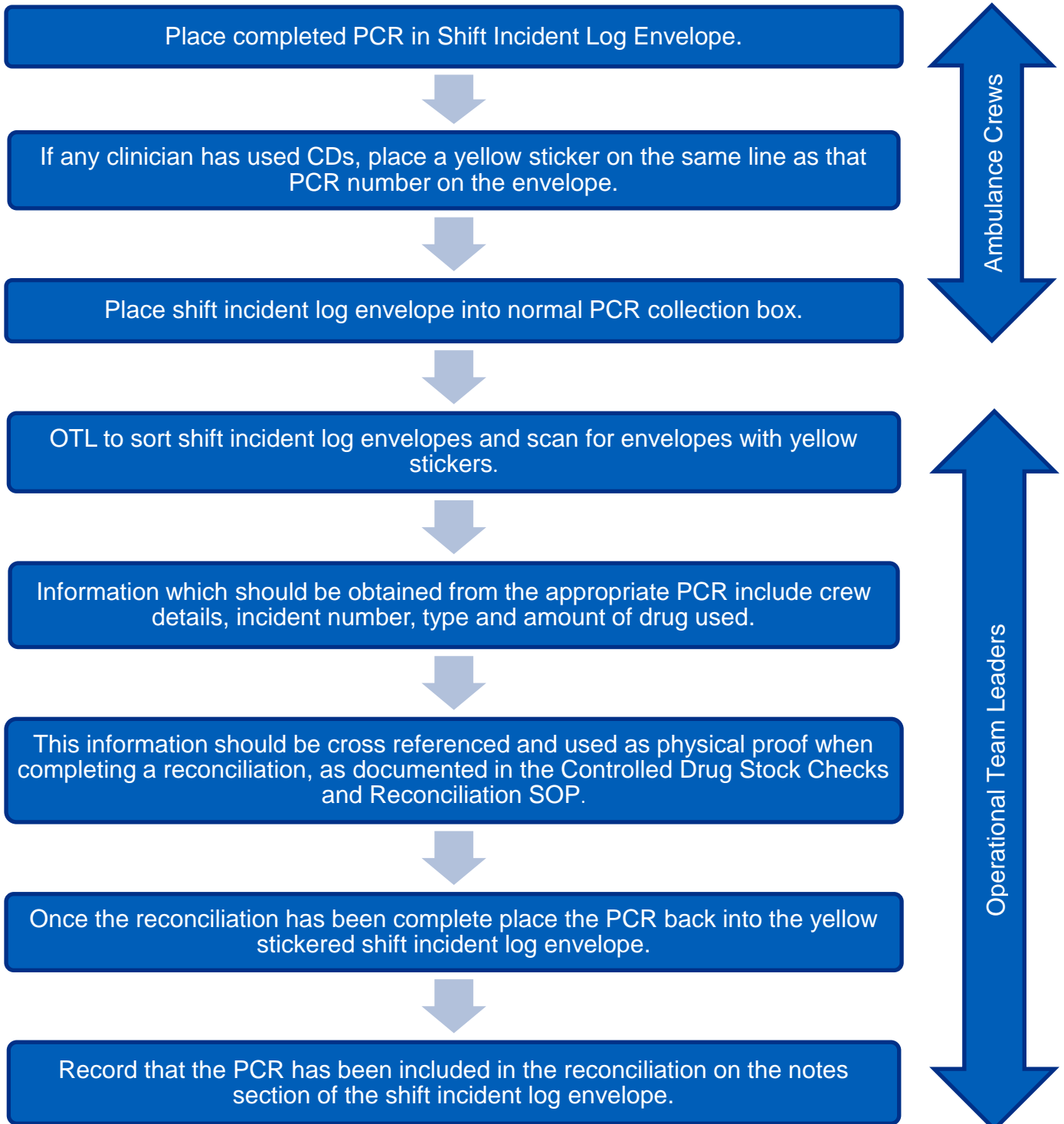
This flow chart shows the process to follow when reporting any incident (Datix IRW1) that a crew report involving concerns for a patient. This process is required to ensure that investigators, the coroner, patients and their family receive vital information as soon as possible.





Appendix C: Incidents with Controlled Drugs

Where Controlled Drugs have been administered (morphine, diazepam, ketamine & midazolam), Shift Incident Log Envelopes will be marked with a yellow sticker. This allows OTLs to reconcile CD usage against the CD registers and Omnicells more efficiently.





Appendix E: PCR Collection Schedule

	Surrey Collection	Sussex Collection	Kent Collection
MONDAY	Caterham Redhill St Johns Godstone	Littlehampton Tangmere	Ashford Sheppey
TUESDAY	Esher Walton Staines Woking Chertsey	Burgess Hill Haywards Heath Gatwick MRC Gatwick HART	Medway Sittingbourne
WEDNESDAY	Guildford Godalming Haslemere Tongham	Shoreham Hove Brighton	Dartford Thameside
THURSDAY	Epsom Leatherhead Dorking	Polegate Lewes	Thanet
FRIDAY	Chertsey Woking Farnborough Tongham	Worthing	Hastings