East of England Ambulance Service NHS Trust

Patient Care Record Policy (including submission of records)

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DOCUMENT CHANGE HISTORY		
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Version	Date	Comments (i.e., viewed, or reviewed, amended approved by person or committee)
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V7.1	November 2021	Definition of patient contact requiring PCR completion expanded (section 4.2).

Version	Date	Comments (i.e., viewed, or reviewed, amended approved by person or committee)
V7.1	13 January 2022	Approved by Information Governance Group
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V8.1	March 2024	Recommended by IGG
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Linked procedural documents	Data Protection Policy Records Management Policy & Procedures Clinical Audit Policy
Dissemination requirements	All managers and staff via email and intranet
Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust

will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

Contents

1. Introduction

The East of England Ambulance Service NHS Trust (EEAST) recognises its legal and moral duty to ensure that appropriate patient care records are completed for all patients it assesses and treats.

Accurate health records are a tool of professional practice and a contemporaneous account of any care and/or treatment delivered. A patient care record (PCR) is an important medical-legal document which must be completed and submitted for every clinical patient contact.

This policy encompasses all PCRs and their associated documentation currently in use within the Trust. This includes all those completed, whether they are electronic or paper, by any clinician such as: Paramedics, Doctors, Nurses, Emergency Medical Technicians and Emergency Care Assistants (including Ambulance Support Workers), as well as those completed by persons acting on behalf of the Trust such as volunteers and contracted organisations (agency and private ambulance

services). For the purposes of Community First Responders the term 'patient care record' applies to the 'Incident Report Form'. Accurate and timely information is paramount and a PCR may be used for a variety of reasons:

- to provide accurate information which may be transferred to the next health or social care professional
- assesses compliance against quality reporting standards associated with patient records
- improvement in quality of care (through audit and training processes)
- to help defend against complaints or legal proceedings
- as evidence i.e. in criminal cases, HM Coroner etc.

Therefore, all clinicians have a responsibility to complete a PCR with accuracy and clarity to provide a true contemporaneous record of any assessment undertaken and care/treatment delivered.

All PCRs and associated documentation must be treated as confidential documents.

It is the expectation of the Trust that all patient care records will be completed on the ePCR portal when this is available to the member of staff to use. The completion of a paper record should become the exception rather than the norm. If a paper record is completed where ePCR is available a Datix report will be required to identify the reason e.g. a technological failure. Where an ePCR iPad is not functioning the user should contact It at the earliest opportunity so repair or replacement can be arranged.

ePCR has been implemented for a number of reasons;

- Reduce lost patient records, improving our ability to analyse our clinical activity and improve our patient care standards.
- To provide clinicians with a comprehensive range of clinical materials and databases to support their decision making processes in delivering most appropriate care pathway to the patient.
- Improve legibility of patient records which will help to reduce potential transcription and handover errors and improve patient outcomes.
- Improve crew capture activity, to support future PU and enhance training and development standards.
- Enable staff to view their individual record through an online web viewer to support and evidence their personal development.

All staff (whether employed by the Trust, or acting on behalf of the Trust either as volunteers or a contracted service) who complete or handle patient records must follow this policy. Failure to adhere to the contents of this policy could result in formal actions being taken in line with the Trust's Disciplinary Policy.

2. Purpose

This policy outlines the Trust's requirements and processes for the creation, completion, submission, access and storage of all PCRs excluding archiving, retention and destruction processes, which are included within the Trust's Records Management Policy and Procedures. This policy has been produced taking into account relevant legislation, including:

- Health and Social Care Act

- Public Records Act 1958
- Data Protection Act 2018
- Access to Health Records Act 1990
- Access to Medical Reports Act 1988
- Freedom of Information Act 2000
- Common Law Duty of Confidentiality
- NHS Confidentiality Code of Practice 2003
- Records Management Code of Practice

Legal Obligations

To enable the Trust to meet its legal obligations in relation to confidentiality and access to records, it is imperative that staff, who for any reason handles patient records, including the creation of such records, follow the outlined processes contained within this policy. This will be monitored in line with the monitoring section contained within this document and the Trust's Records Management Policy and Procedures.

This policy sets out the Trust's arrangements for the management of patient care records in all formats and uses, including:

- The need to document the assessment or treatment of a patient across all areas of Trust activity
- Basic requirements for record-keeping standards, which must be followed by all staff
- The description of the minimum set of data which needs to be completed – the minimum data set can be found Appendix A
- The expectations of the Trust in regard to monitoring of PCRs

- The definition of responsibilities for all aspects of the patient record
- The process of reviewing, monitoring and tracking of Trust patient care records

All PCRs and related clinical documents must be stored as per the Trust Records Management Policy and Procedures – these documents also include the data storage requirements for ePCRs. The Trust has a number of forms in place for patient care records, both paper and electronic, these include:

i. Emergency Services: including 999 patients, Health Care Professional assessed calls and transfers. This includes the use of Scheduled Transport and non-Trust resources when working on behalf of the Emergency Service. There is a mandated expectation that the electronic patient care record must be used where it is available.

ii. Emergency Clinical Advice & Triage (ECAT): ECAT clinicians assess patients over the telephone rather than sending a clinician to the patient, or when following up a patient after a visit by a Trust clinician.
The prime PCR for EOC is the electronic record produced within Priority Solutions Integrated Access Management (PSIAM). Where clinical co-ordinators or Extended Triage Clinicians undertake an assessment the patient record becomes the CAD.
Where clinical assessment is undertaken business continuity arrangements must be in place to manage a technological failure.

iii. Community First Responders: Incident Report Form completed when assessing and/or treating patients on behalf of the Trust, for the purposes of this policy the term 'PCR' encompasses this form.

This policy pertains to all staff, not just clinicians, who have access to clinical records for any reason, i.e. audit, complaints, transportation, storage etc.

Limitations of the policy

This policy excludes:

- Staff health records
- The management of patient personal information which does not form a Patient Care Record, for example job lists and planning by Scheduled Transport

3. Duties

3.1 Trust Board

The Trust Board is responsible for ensuring appropriate policies, procedures and resources are in place to provide adequate governance arrangements in relation to Patient Care Records (PCR).

3.2 Chief Executive

The Chief Executive is ultimately responsible for the quality of PCRs and the security and management of such documents, this responsibility is delegated to the Caldicott Guardian.

3.3 Caldicott Guardian

The Caldicott Guardian is supported by additional guardians who are responsible for protecting the confidentiality of patient and

service-user information and enabling appropriate information-sharing ensuring that the Trust adheres to the seven Caldicott Principles.

3.4 Head of Information Governance and Security

The Head of Information Governance and Security is responsible for ensuring appropriate systems for;

- the design and content of PCRs,
- the use of PCRs,
- the quality monitoring of data recorded on them, and
- the secure archiving, retention and destruction of such documents.

3.5 Compliance and Risk Group

The Compliance and Risk Group will receive any escalations regarding issues from this policy from the Information Governance Group.

3.6 Information Governance Group

The Information Governance Group (IGG) has responsibility for receiving any breaches of this policy in respect of the inappropriate release or loss of information and for monitoring any action plans implemented as a result.

3.7 Locality Directors

Locality Directors are responsible for ensuring that PCRs are completed and submitted for every patient, that they are monitored for quality purposes and that, in the case of paper records, that they are stored safely prior to their submission to the relevant locality office.

3.8 Information Governance Manager

The Information Governance Manager is the Trust lead for medical records ensuring all documents meet the retention and

destruction schedules and are stored and managed in line with DH guidance and the Trust's Records Management Policy.

3.9 Clinical Audit Manager

The Clinical Audit Manager is responsible for ensuring that accurate data is extracted from PCRs for quality monitoring purposes in line with the Clinical Audit Policy.

3.10 ePCR Clinical Lead

The ePCR Clinical Lead is responsible for ensuring that the ePCR system is kept up to date with changes to national and local guidelines as well as introducing new functionality to improve the quality of the trust documentation. They will also monitor usage compliance across the region and feed this back to local operations.

3.11 Corporate Records Manager

The Corporate Records Manager is responsible for day to day management of systems and processes for safe archiving, retrieval and retention and storage of paper PCRs when they are received at the locality offices.

3.12 Operational Managers

Operational Managers are responsible for:

- Ensuring staff within their areas are aware of the operating system for ePCR and that this is used as the primary source when it is available.
- Ensuring that PCRs are monitored in line with Trust quality purposes.
- Ensuring that records are packaged in the approved secure envelopes and submitted to their appointed locality office within the Trust 14 day standard.

3.13 Community Partnership Managers

Community Partnership Managers (CPMs) are responsible for ensuring that PCRs completed by Community First Responders are monitored monthly for quality purposes and that CFRs within their respective areas are aware of standards for completion and submission.

3.14 All Staff

All staff, including employees, volunteers and contractors of the Trust, have a duty to complete PCRs where appropriate, either paper or electronic, in line with this policy. The forms must be completed accurately and in a legible manner.

All staff who complete or handle PCRs for other purposes, such as archiving or audit purposes, must ensure that the records are secure and protected at all times in line with the Data Protection Act 2018 and the Caldicott Guardian principles.

3.15 Clinical Staff – Emergency Services

In relation to paper PCRs completed by the Emergency Service staff, these must be submitted to the relevant locality office within 14 days of the incident. In relation to ePCR records should be finalised as soon as possible following the end of the patient interaction. All records must be finalised prior to the end of the shift.

Clinicians have a responsibility to act upon the results of any documentation or clinical audits in order to effectively learn from and improve practice as part of their professional responsibilities and development

3.16 Organisations assessing or treating patients on behalf of the Trust.

Organisations acting on behalf of the Trust must abide by all Trust and NHS policies and guidance on PCRs. The Trust will include completion of PCRs and the security of PCRs as part of any inspection or audit carried out on such organisations.

Such organisations must ensure that all PCRs reach the nominated Trust office within 14 days of the incident, using the stipulated transfer method.

4. Basic Record-Keeping Standards and High-Quality Record-Keeping

To ensure that information contained within the record is correctly recorded legible, and factual, the following guidance from the Confidentiality: NHS Code of Conduct: Record Keeping Best Practice document should be followed:

Patient records should be:

- factual, consistent and accurate
- completed as soon as possible after an event has occurred, providing current information on the care and condition of the patient;
- completed clearly, legibly and in such a manner that they cannot be erased;
- written in such a manner that any alterations or additions are dated, timed and signed in such a way that the original entry can still be read clearly;

- accurately dated, timed and signed or otherwise identified, with the name of the author being printed alongside the first entry;
- readable on any photocopies (for paper records)
- completed, wherever applicable, with the involvement of the patient or carer;
- clear, unambiguous, (preferably concise) and written in terms that the patient can understand. Abbreviations, if used, should follow common conventions;
- be written so as to be compliant with the Equality Act
- consecutive; (for electronic records) use standard coding techniques and protocols;
- relevant and useful, the use of pertinent negatives should be limited to selections that are pertinent to the patients presenting complaint and relate to specific item ruled out during the assessment
- A PCR must be completed in a clear and legible way using the relevant Trust approved minimum data set as defined in Appendix 1 for any patient assessed and or treated.

Erasers, liquid paper, or any other obliterating agents must not be used to cancel errors

They should also:

- identify problems that have arisen and the action taken to rectify them;

- provide evidence of the care planned, the decisions made, the care delivered and the information shared including exceptions where care and or treatment cannot be provided e.g. due to patient refusal, allergy etc;
- provide evidence of actions agreed with the patient (including consent to treatment and/or consent to disclose information).

And include

- medical observations: examinations, tests, diagnoses, prognoses, prescriptions and other treatments;
- relevant disclosures by the patient – pertinent to understanding cause or effecting cure/treatment;
- facts presented to the patient;
- correspondence from the patient or other parties.

Patient records should not include

- unnecessary abbreviations or jargon;
- meaningless phrases, irrelevant speculation or offensive subjective statements; irrelevant personal opinions regarding the patient.

4.1 Governing Body Requirements

All clinicians must also take into account the guidance issued by their relevant governing body in relation to patient records.

4.1.1 Paramedics: Health and Care Professions Council (HCPC) Requirements

Registrant paramedics must:

(2b.5) Be able to maintain records appropriately:

- be able to keep accurate, legible records and recognise the need to handle these records and all other clinical information in accordance with applicable legislation, protocols and guidelines
- understand the need to use only accepted terminology (which includes abbreviations) in making clinical records

(10) You must keep accurate patient, client and user records

Making and keeping records is an essential part of care and you must keep records for everyone you treat or who asks for professional advice or services. All records must be completed and legible, and you should write, sign and date all entries.

If you are supervising students, you should also sign any student's entries in the notes. Whenever you review the records, you should update them and include a record of any arrangements you have made for the continuing care of the patient, client or user.

You must protect information in records against loss, damage or use by anyone who is not authorised. You can use computer-

based systems for keeping records but only if they are protected against anyone tampering with them (including other health professionals). If you update a record, you must not erase information that was previously there, or make that information difficult to read. Instead, you must mark it in some way (for example, by drawing a line through the old information).
Note – the above requirements have been adopted by EEAST. Emergency Medical Technicians, Student Ambulance Paramedics, Emergency Care Assistants and any other persons either voluntary or contracted must adhere to these requirements.

4.1.2 Nurses – Nursing and Midwifery Council (NMC) Requirements

As a registered nurse or midwife, you must co-operate with others in the team:
(4.4) Health care records are a tool of communication within the team. You must ensure that the health care record for the patient or client is an accurate account of treatment, care planning and delivery. It should be consecutive, written with the involvement of the patient or client wherever practicable and completed as soon as possible after an event has occurred. It should provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.

4.1.3 Doctors – General Medical Council (GMC) Requirements

In providing care you must:
(3.f) keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information

given to patients, and any drugs prescribed or other investigation or treatment
(3.g) make records at the same time as the events you are recording or as soon as possible afterwards

4.2 Creation of a Contemporaneous Patient Care Record

With the exception of any cohorting patients or a multi-casualty incident there will be a single care record for each patient interaction and/or scene attendance. This is required for all patients treated or formally assessed and for all CAD generated incidents resulting in a scene attendance.
All Patient Care Records should be completed as soon as possible after an event has occurred, providing current information on the care and condition of the patient and in line with the basic record keeping standards as defined in Appendix 1.
Other records may be created in support, such as a, PPCI checklist, and non-conveyance form, etc. ROLE forms and Mental Capacity assessments are available as part of the ePCR and should be created within the ePCR software where this is available and applicable. Any paper documents must be kept together with the relevant Shift Log Summary. Do not stick document wallets on the patient care record to hold these supporting documents.
All PCRs and their related clinical documents such as checklists and consent forms etc, must be submitted and stored in line with the Trust's Records Management Policy and Procedures.

All clinicians acting on behalf of the Trust (including Voluntary Aid Society members and staff of private services) have responsibility for the care of a patient, including the transfer or

referral of a patient have responsibilities for creating and handling PCRs.

A PCR is required from the clinician for every patient assessed or treated and for every incident generated by a CAD dispatch that results in a scene attendance, whether a patient is found or not. An exception to this rule is if the attending resource is stood down on route.

A patient is anyone contacting the Trust who requires healthcare assistance from the Trust. This can either be anyone attended by the Trust or spoken to by a clinician following contact with the Trust. A patient may also have been identified to the Trust by a third party as needing assessment or treatment and so a PCR should be completed in this instance. A patient has the right to refuse assessment and treatment, but a PCR should be completed documenting discussions had, scene findings and decisions made.

A PCR should also be completed when attendance has been made at the scene of a CAD generated dispatch even if there is no patient found. The PCR in this instance becomes an incident log of actions taken, scene findings, interactions with other professionals at scene and decisions made. When using ePCR the 'No Patient Found' outcome can be used which does not enforce the usual mandatory fields associated with patient assessment.
PCRs with patient identifiable data visible must not be copied or printed under any circumstances unless with the express

permission of the Trust's Caldicott Guardian or nominated staff acting on their behalf.

Shift Log Summaries and paper PCRs and any other paperwork completed by staff, (including volunteers and non-Trust resources) must be submitted to the relevant locality office within 14 days of the incident.

Where a Corpuls monitor is used, the incident number must be recorded on the device and an ECG print out handed to the receiving hospital or given to the patient if they are not conveyed. A copy must not be retained with the Trust's copy of the PCR. If a crew is not using the Corpuls ECG machine, then a printout will need to be retained PCR.

Electronic records must be completed and finalised securely and timely.

All clinical records (including patient records, ECGs, ROLE forms, thrombolysis forms etc) must be treated in accordance with the Data Protection Act 2018, Caldicott Principles and the NHS Code of Confidentiality.

In the event of a multi-casualty incident, such as Persons in Transit and building evacuations, a Multi-Patient Form can be used and referenced using a e/PCR as an incident log.

Should an ePCR be created by a first arriving resource and the transport resource not be fitted with ePCR then a paper record

should be created. The ePCR should be completed with details up until the point of handover and finalised by the clinician. The contents of the ePCR should be transferred to the paper record, as a minimum the observations first recorded by the first resource and details of any medications administered must be transferred to the paper PCR. The back-up crew should clearly mark the paper PCR as a continuation record and the ePCR identification number should also be recorded on the paper PCR for future reference. The identification number on the paper PCR **must be recorded** on the ePCR log to ensure that records can be linked at a later occasion if required and a comment added stating that all information has been transferred to this paper PCR.

If the first resource is not equipped with ePCR than a paper PCR should be completed. The top copy should be retained by the RRV and processed as per this policy, the carbon copy travelling with the patient. The transporting resource, if equipped, should then complete an ePCR for the purposes of recording any further assessment and treatment, including the handover of care to the receiving facility. The photo capture facility on the ePCR should be used to capture the RRV's initial paper record as part of the ePCR document.

When a call has been reprioritised, if the first resource is equipped with ePCR this should always be used and to start and finalise an ePCR, leaving any pertinent information documented on a non-conveyance form. The conveying resource should then create their own patient care record as this is a second patient

contact. Within the notes on the record it should be noted that this is an ambulance clinician booked urgent.

When a Trust clinician is attending a patient on behalf of an organisation contracting Trust services or on behalf of a GP under local agreement, the attending clinician should record their assessment and treatment using the Trust PCR system. The clinician should also make any records required by the contracting organisation.

It is acceptable for a record to be completed on behalf of an organisation be that for primary care or another organisation providing clinical support to the Trust. Such a record is not to be regarded as the PCR. Except for primary care records, such records will not contain any readily patient identifiable information.

Exclusions not requiring a PCR:
Patients cared for by Scheduled Transport (PTS) as 'routine' which unexpectedly require emergency care from PTS staff.
If a PTS crew transport a patient at the request of a Trust clinician who has assessed the patient, the clinician will complete a PCR. The clinician will split the paper PCR and the non-clinical crew will hand the original (bottom) copy to the receiving HCP. When using an electronic system, the PCR will be made available to the receiving facility (through selecting the appropriate destination) via the Siren Notification Board

Clinicians should ensure they have followed the Safe Discharge care bundle, and this is documented fully on the PCR. More information on this can be found in the Safe Non-Conveyance and Discharge Policy.

4.3 Transfer of record

When a patient is handed over to another healthcare facility:

- **ePCR** – the PCR will be made available to the receiving facility electronically via the use of Siren Notification Board.

- **Paper** – the bottom copy of the must be given over as part of the continuing care process.

Non-conveyed patients:

- **ePCR** – the PCR should be finalised and a 'leave at home' form completed.
- **Paper** – the bottom copy should be handed to the patient or may be passed to someone other than the patient with the permission of the patient.

Paper:

If the patient is deceased, keep the top copy and process as normal, and leave the bottom copy with the patient, this will be available to the police if required.

It is important to ensure that a referral is made where appropriate and no documentation takes the place of a verbal clinician to clinician discussion

The top copy of the paper PCR must be retained and sent to a locality office in accordance with the guidance within this policy.

Electronic

Electronic systems retain the information automatically.

Electronic systems have their own system of producing a version of the record which does not contain any PI data.

Cohorting

Contemporaneous records are vital, and documentation of the patient's condition should be maintained at least hourly, even if the patient appears stable and there have been no visible or obvious changes to their condition. This should be completed on an EEAST patient care record (PCR) and have the date, CAD number, crew, and patient details documented on the PCR. Number the pages accordingly, i.e. 1 or 2, 2 of 2 etc. and state that this is a cohorted patient. This documentation should be sent through to stations, where the courier will deliver the PCRs to the relevant locality offices.

Where ePCR is available the record transfer process should be utilised so that the cohorting crew can continue to document the care as part of the same record

Under no circumstances are clinicians or their managers to photocopy or download any part of the PCR without express permission of the Caldicott Guardian or staff acting on their behalf.

4.4 Submission of patient records

As part of the complete PCR process, staff working under the auspices of Emergency Services must also complete a 'Shift Log

Summary' sheet and submit this with any completed paper records to their appointed area office as soon as possible and always within 14 days of its creation. This is to help reduce risk and permit efficient retrieval of records. Guidance on completing the 'Shift Log Summary' sheet can be found in appendix 2.

Until the Trust has completely moved to electronic patient care records, tracking of individual records remains difficult for the Trust, however it has implemented the following systems to ensure that records are safely transferred between stations and the main locality offices which should be followed at all times:

Ensure any paper patient care records are stored securely within the 'Shift Log Envelope' at all times during the shift, storing securely in the vehicle and not taking the envelope when attending other emergency calls. Paper care records are not to be kept in view of the public when storing in the ambulance vehicle, they are to be stored in the secure locked area of the vehicle.

When handing the patient over at hospital or to another healthcare provider, the record stays in your possession until the record is safely placed in the shift log envelope in the vehicle.

Remember it is your professional responsibility to look after this record.

Individual Clinician (emergency operations):

Paper:

- Complete record in accordance with training against patient needs.
- Sign record
- Bottom copy to follow patient.
- Top copy placed inside Shift log envelope with completed Shift Log Summary and VDI.
- Secure safely in the vehicle until back at station
- Envelope placed unsealed in identified store at local station.

Electronic:

- Individual clinician creates record using their log on.
- Mandatory fields completed.
- Record finalised.
- End of shift ensure all records are finalised and deleted from tablet.
- .
- Unsealed envelope placed in identified store at local station.

Supervisor / manager (for paper):

- Feedback to clinicians as felt appropriate based on accuracy (also includes clinical care and assessment) and legibility.
- Information relating to a late finish copied for GRS purposes
- PCR contents collated against Shift Log Summary prior to the envelope being sealed.
- Place PCRs in the approved secure zipped bags and seal ensuring that they are marked 'Confidential Medical Records', with the address of the receiving location and the name of the station submitting.
- Post bags should be conveyed to the local Area Office: Bedford, Chelmsford, or Norwich.

- Transportation of post bags containing PCRs should be transported by Trust Courier Services or nominated Trust staff only.

Courier:

- Ensure each post bag is sealed
- Transport the post bags in a secure and confidential manner
- Handover all the post bags to the nominated responsible team at the receiving Area Office – localities will be informed of their nominated team directly as this will depend on area and time of delivery.

Receiving location:

- Receive the post bags from the courier
- Return empty post bags via courier or internal post service
- Record receipt of records from specific station on the 'Delivery Log'
- Date stamp PCRs to ensure offices are receiving PCRs within the 14 day standard
- Prep and scan PCRs at each locality office
- The originals of scanned PCRs will be held within a secure area for one week post scanning and back up of the servers have been completed before being placed in the blue 'confidential waste'
- Maintain and archive PCRs in accordance with Trust Records Management Procedure and Records Management Policy.
- Any stations submitting PCRs that exceed the 14 day standard will be contacted by the relevant locality office

and the Records Manager notified of any outcomes.

Operational management will be informed of any reoccurring late or inappropriate arrivals. The Trust's formal reporting system will be used for repeated or serious problems.

4.5 Archiving

Archiving of PCRs will be conducted in line with the Trust's Records Management Policy.

4.6 Access and release of records

Access to patient records will be restricted for specific purposes on a 'need to know' basis, in accordance with the Trust's Records Management Policy and Data Protection Policy.

All PCRs and their related clinical documents must only be released externally from the Trust by the Patient Experience and Subject Access Request teams in line with the Trust's Data Protection Policy. This does not relate to the handover of PCR during transfer of care.

All PCRs and any related clinical documents required for internal use e.g. for use in investigation complaints, claims, incidents etc. must be requested from the Patient Services, Safeguarding, Patient Safety or Subject Access Request teams.

4.7 Data security and confidentiality

The duty of confidentiality arises out of the common law of confidentiality, professional obligations, and also staff employment contracts (including those for contractors). Breach

of confidence, inappropriate use of health records or abuse of computer systems may lead to disciplinary measures, bring into question professional registration and possibly result in legal proceedings. Staff should ensure that they are aware of the requirements and standards of behaviour that apply.

Voluntary staff who are not employees, and students are also under obligations of confidentiality, and must sign an agreement indicating their understanding when helping within the NHS.

Records of the NHS are subject to the Public Records Act 1958, which imposes a statutory duty of care directly upon all individuals who have direct responsibility for any such records.
All PCR's must be treated as confidential documents at all times. Processes pertaining to the creations, use, storage and retrieval of all PCR's must be in accordance with the NHS Information Governance arrangements and associated Trust's policies and procedures.

All PCRs and copies of PCRs, both paper and electronic, requiring destruction must be carried out under confidential conditions in line with the NHS Retention Schedule.
Copies of all PCRs come under the same regulations as original documents; this policy applies equally.

5. Training

Training for all clinicians, including voluntary responders, will be included as part of their core training or induction. Further training is delivered to individuals and groups as identified within

the Training Needs Analysis and as part of an individual's personal development or as a result of any concerns raised through learning from an incident or complaint.

All staff receive training within their mandatory corporate induction on aspects of information governance, including:

- Confidentiality
- Data Protection Act 2018
- Freedom of Information Act (2000)
- Caldicott Guardian Principles

All attendance at training, both specific and generic is monitored through the Learning and Development Unit.

ePCR training will be undertaken to include the actual system and security.

6. Monitoring Compliance with the Document

The monitoring of compliance can be found in appendix E

6.1 Clinical Audit

The Trust has in place an annual clinical audit programme which takes into account both nationally and locally driven priorities and which is used as a basis to measure the standard of both documentation standards and quality of care.
Clinicians are responsible for recording accurate and legible information.

Patient care records will be subject to regular audit. The objectives of such audit are:

- To aid in effective management of the Trust patient care record system
- To help ensure patient care records are retrievable when required
- To help ensure patient care records contain appropriate information

To assist in controlling risks associated with non-compliance to the patient care record system. Trust wide monitoring and audits of the completion of records will measure each of the audit indicators listed within the Minimum Data Set (Appendix 1) and audit reports will completed in line with the Trust's Clinical Audit Policy. Results should be analysed for patterns of non-compliance and reported for each operational area and service type including Private Ambulance Service providers.

Full information relating to the Trust's processes and systems for clinical audit can be found in the Trust's Clinical Audit Policy.

7.0 References

- Data Protection Act 2018
- Access to Health Records Act 1990
- Freedom of Information Act 2000
- Access to Medical Reports Act 1988
- Caldicott Guardian Principles
- Confidentiality: NHS Code of Practice. (2003)
- Records Management Code of Practice

Appendices

A Trust Patient Care Record Minimum Data Set (Basic record keeping standards) and Audit Standards

B Shift Log Summary Sheet

C PCR / Shift Log Summary data fields

D Shift Log Summary Process

E Monitoring Table

F Equality Impact Assessment form

Appendix D: Shift Log Summary Process

Commence shift – start Shift Log Summary

Start at a Shift Log Summary envelope at the start of every shift

⇩

Patient Care Record completed

An ePCR should be completed for every occasion that a clinician assesses a patient where it is available.

All PCRs should be clinically coded and include the incident number

⇩

PCR / Shift Log incident row completed

Every incident to be recorded; even if stood down

Finalise EPCR

Ensure any paper patient care records are stored securely within the 'Shift Log Envelope' at all times during the shift ensuring that, when handing the patient over at hospital or to another healthcare provider, that the record stays in your possession until the record is safely placed in the shift log envelope

⇩

Complete PCR / Shift Log

At the end of each shift complete any final information and check for accuracy ensuring any paper PCRs are placed inside the Shift Log Summary envelope – top copies only. Check all completed paper PCRs are inside the Shift Log Summary envelope. Ensure all PCRs have been finalised when completed

⇩

Submit Shift Log Summary Sheet and any paper PCRs

At the end of each shift, the clinician should submit them in line with locally agreed processes i.e. direct to supervisor/ identified receptacle etc.

⇩

Transfer of records from station / depot

Make sure all corresponding paper PCRs are included within the shift log envelope as well as other paper documents relating to the incident, e.g. ROLE Witness statement, ECG, patient consent form). Place in zipped post bag and seal. Post bags should be labelled with the ambulance base and addressed as Confidential Medical Records, local Area Office full address ready for collection by a Trust Courier.

Post bags should be delivered each weekly to the locality Office as a minimum

⇩

Received by Locality Office

Check for receipt of post bags daily. Sort and scan records. For those PCRs that exceed the Trust 14 day standard, follow up with the relevant station and advise Records Manager and Information Governance Manager of the outcome

Archive

Archive in accordance with the Trust's Records Management Procedure

Appendix E: Monitoring Table

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
Duties	Line Managers Including Trust Board level	Monitored through PDRs	Annually	EADR forms Identified Training Needs submitted to LDU	Review by Information Governance Group Decisions of the Group will be formally recorded in minutes. Formal approval by	Information Governance Manager with support from the IG team and IAAs and IAOs	Review of the IAR system and processes, review of assets with IAA & IAOs – any updates or learning to be shared at IG

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
					SIRO		workshops held for the IAA/IAOs and IG team
	Line Managers including Trust Board level	As a result of concerns raised following an investigation of a	As required	Documentation included on Datix Risk Management System			

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
		complaint or incident					
Basic record keeping standards which must be used by healthcare professionals	Operational Managers and Clinical Audit Team when part of the programme	Monitoring of records against the Minimum Data Set	Monthly	Local submission reports/ National Quality reporting	Review by Information Governance Group Decisions of the Group will be formally recorded in minutes.	Records Manager	

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
for the completion of a contemporaneous health records							
Creation and submission of PCRs	Medical Records Team	14 day standard	Monthly	Emails, delivery logs PCR Submission audits	Escalation to IG Manager and escalated to Information Governance	Information Governance Manager and Medical Records Team	Any changes to be shared with whole team and stations/co

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
					Group Decisions of the Group will be formally recorded in minutes.		uriers who drop records off
Retrieval and archiving	Records Manager	Monitoring of Release of Information requests and SARs	Monthly	Documentation included on Datix Risk Management System	Review by Information Governance Group Decisions of the Group will be formally	Information Governance Manager	

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
					recorded in minutes.		
Retention, destruction and disposal	Corporate Records Officer/IG Manager	Review of archiving databases	Annually	Emails Minutes: Meetings Destruction certificates	Review by Information Governance Group Decisions of the Group will be formally recorded in minutes. Formal approval by	Information Governance Manager with support from Corporate Records Manager	

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
					SIRO and Caldicott Guardian		

Appendix F: Equality Impact Assessment

<table>
<tr><th colspan="2">EIA Cover Sheet</th></tr>
<tr><td>Name of process/policy</td><td>Patient Care Record Policy (including submission of records)</td></tr>
<tr><td>Is the process new or existing? If existing, state policy reference number</td><td>POL021</td></tr>
<tr><td>Person responsible for process/policy</td><td>Information Governance Manager</td></tr>
<tr><td>Directorate and department/section</td><td>Corporate Affairs and Performance</td></tr>
<tr><td>Name of assessment lead or EIA assessment team members</td><td>Information Governance Manager</td></tr>
<tr><td>Has consultation taken place? Was consultation internal or external? (please state below):</td><td>Internal</td></tr>
<tr><td>The assessment is being made on:</td><td>
<table>
<tr><td>Guidelines</td><td></td></tr>
<tr><td>Written policy involving staff and patients</td><td>X</td></tr>
<tr><td>Strategy</td><td></td></tr>
<tr><td>Changes in practice</td><td></td></tr>
<tr><td>Department changes</td><td></td></tr>
<tr><td>Project plan</td><td></td></tr>
<tr><td>Action plan</td><td></td></tr>
</table>
</td></tr>
</table>

	Other (please state)

Equality Analysis					
What is the aim of the policy/procedure/practice/event? To maintain a quality assured evidence base and measure compliance with guidelines to ensure patient safety and enable quality improvement.					
Who does the policy/procedure/practice/event impact on?					
Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐
N/A					
Who is responsible for monitoring the policy/procedure/practice/event? Information Governance Manager					

What information is currently available on the impact of this policy/procedure/practice/event? There is no impact of this policy upon any specific protected characteristics
Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? ~~Yes~~/No
Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? ~~Yes~~/No, If yes please provide evidence/examples: **Race** ☐ **Religion/belief** ☐ **Marriage/Civil Partnership** ☐ **Gender** ☐ **Disability** ☐ **Sexual orientation** ☐ **Age** ☐ **Gender re-assignment** ☐ **Pregnancy/maternity** ☐ Please provide evidence: The Policy is E&D neutral and has no impact, positive or negative.
Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? ~~Yes~~/No, if so please provide evidence/examples:

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence:

The Policy is E&D neutral and has no impact, positive or negative.

Action Plan/Plans – SMART

Specific

Measurable

Achievable

Relevant

Time Limited

Evaluation Monitoring Plan/how will this be monitored?

Who: Records Manager and Information Governance Manager

How: Escalation of issues

By: Managers and staff members

Reported to: Records Manager, IG manager & IGG