London Ambulance Service NHS
NHS Trust

Procedure for the Management of Health Records

DOCUMENT PROFILE and CONTROL.

Purpose of the document: Provides users with a clear procedure for use, storage and transportation of Health records, both paper and electronic and ensures that the requirements of Clinical Governance, Research Governance, the Data Protection Act 1998 and Caldicott Guidelines are met.

Sponsor Department: Management Information

Author/Reviewer: Head of Management Information. To be reviewed by August 2013.

Document Status: Final

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1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

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Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
	Caldicott Guidelines 1998	
	Data Protection Act 1998	
TP/009	Policy for Access to Health Records, Disclosure of Patient information: Protection and Use of Patient Information'	
TP/012	Data Protection Policy	
TP/018	Suspected Cases of Child Abuse Procedure	
TP/019	Suspected Abuse of Vulnerable Adults Procedure	
OP/014	Procedure relating to the Hand Over of Patients	
OP/031	Policy & Procedure for Consent to Examination or Treatment	
	Assignment Record and Clinical Record Form User Guide	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

Concise, accurate and legible patient care record keeping is an integral part of all healthcare practice. It is a tool of professional practice and one which contributes to the care of the patient. It is not separate from the care process and is not an 'optional extra' to be fitted in if circumstances allow. London Ambulance Service NHS Trust (LAS) staff who have responsibility for creating and/or managing health records are not exempt from these principles.

In accordance with Clinical Governance, Research Governance, the Data Protection Act 1998 and Caldicott Guidelines, the London Ambulance Service has a responsibility to its patients to ensure that personal information recorded about them remains confidential.

Clinical Governance is about a culture shift to a patient-centred, accountable, safe and high quality service in an open and questioning environment.

Research Governance is about enhancing research in health and social care. Research Governance sets a framework within which the public has a right to expect high scientific, ethical and financial standards, transparent decision-making processes, clear allocation of responsibilities and robust monitoring arrangements.

The Data Protection Act is about ensuring that personal data is obtained and processed fairly and lawfully for specified purposes, is adequate, relevant and not excessive, is accurate and up-to-date, held for no longer than necessary, processed in accordance with data subject's rights and is kept secure.

The Caldicott Guidelines reflect the same legal requirements as the Data Protection Act. The Caldicott Guidelines are specific in guiding each organisation in ensuring that safe systems are in place to govern the flow of patient-identifiable information. This includes how documents are completed, stored and transported at a local level. Each member of staff must take every possible precaution to protect each patient's information.

Good record keeping helps to protect the welfare of patients by promoting better communication and dissemination of information between members of the inter-professional health care team and thus the ability to detect problems, such as changes in the patient's condition, at an early stage. The quality of patient care record keeping is a reflection of the standard of professional practice. Good record keeping is a mark of a skilled and safe practitioner.

The principles outlined in this procedure relate to the use, storage and transportation of health records completed by operational staff. Any specific guidance relating to an individual record is attached as an appendix to the procedure. Health records are legal documents that may be produced in both Coroner's and civil courts as evidence and they can be accessed by patients or their representatives where appropriate.

The documents discussed within the procedure provide a medico-legal record of any assessments, observations, treatment or actions undertaken by LAS staff. This information is essential to provide evidence that the crew's duty of care has been fully met. Comprehensive completion of all health records is a contractual requirement.

2. Scope

This procedure applies to electronic data, paper forms, tape recordings and any other formats, containing patient information, completed, generated or handled by operational staff (A&E, EOC, UOC and PTS).

3. Objectives

1. To provide users with a clear procedure for use, storage and transportation of Health records, both paper and electronic.

2. To help ensure that the requirements of Clinical Governance, Research Governance, the Data Protection Act 1998 and Caldicott Guidelines are met.

4. Responsibilities

4.1 AOMs or other appropriate managers have responsibility for ensuring that this procedure is adhered to by staff and for carrying out the monitoring role as defined with the 'Implementation Plan' of this document.

4.2 Staff designated as responsible for dealing with the forms are responsible for processing the records in accordance with the appropriate appendix of this procedure.

4.3 Staff will be expected to ensure that forms remain secure at all times until handed-in and to accurately complete.

4.4 Equipment support personnel and other persons designated the task of transferring forms, will be responsible for ensuring the security of documents during transportation.

4.5 Postholders with responsibilities for the records identified in the appendices are responsible for managing that part of the lifecycle of the document that relates to: access, retention and destruction.

4.6 The Information Governance Manager is responsible for defining the correct retention periods of records defined in the appendices of this procedure.

4.7 The Audit Manager is responsible for developing an annual programme of audits that will enable the monitoring of the intended outcomes of this procedure.

4.8 The Information Governance Group (IGG) is chaired by the Director of IM&T who is the Senior Risk Owner (SIRO) and will monitor the implementation of this procedure.

5. Definitions

5.1 Record

'Recorded information, in any form, created or received and maintained by theTrust in the transaction of its business or conduct of affairs and kept as evidence of such activity'.

5.2 Health Record

The Data Protection Act 1998, describes the Health Record as 'consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual.'

6. Legal and Professional Obligations

All NHS records are Public Records under the Public Records Acts. The Trust will implement all necessary measures to comply with its legal and professional obligations for public records as set out in the Department of Health guidance 'Records Management: NHS Code of Practice', in particular:

- Public Records Acts 1958 and 1967
- Data Protection Act 1998
- Freedom of Information Act 2000
- Caldicott Review of Patient Identifiable information, 1997
- Confidentiality: NHS Code of Practice

and any new legislation affecting records management as it arises.

7. Record creation

7.1 Health records are created to ensure that the business of the Trust is carried out effectively and information is available to:

- support the care process and the continuity of care
- support day to day business which underpins delivery of care
- support sound corporate and managerial decision making and provide evidence of decisions taken
- meet legal requirements, including requests from service users under access to health records legislation
- assist with clinical and other audits and learn lessons from past experience
- support improvements in clinical effectiveness through audit and research
- provide a contemporaneous record for PRFs as outlined in the Assignment Record and Clinical Record Form (PRF) User Guide.

8. Record quality

8.1 All records must be fit for purpose, complete and accurate and the information they contain reliable with its authenticity guaranteed. Failure to ensure that data is of good quality and is up-to-date could have a detrimental effect on the Trust, its employees, its relationship with other Trusts and the community it serves. The LAS aims to ensure that:-

- the right information is created at the right time;
- the information is reliable and accurate;
- the information has been created in an appropriate format;
- information has been captured which describes its purpose, its content, who created it, and when it was created (known as metadata).

8.2 All manually completed paper records must be written clearly and legibly using a black ink ballpoint pen. Records should be dated and signed with time of entry and any alterations should be visible and initialled. When forms are self duplicating, staff must ensure that all written entries are legible on all copies.

8.3 Record keeping standards for PRFs must be followed in line with the Assignment Record and Clinical Record Form (PRF) User Guide (see Appendix 3).

9. Management and Tracking of Paper Health Records

9.1 A secure designated point, which in most instances will be a locked box, is provided for all completed forms. All paperwork must be handed in to the designated point by the end of the shift and not left in vehicles or lockers.

9.2 Forms must be transferred from their secure designated points on a daily basis. If required, Team Leaders may also undertake transfers of forms at the weekend.

9.3 Each working day designated staff responsible for dealing with the forms must empty all the paperwork from the boxes/containers and process in accordance with the appropriate appendix of this procedure.

9.4 All forms designated for Management Information should be promptly processed by station complexes in order that they are received by Management Information within three (Monday to Friday) working days.

9.5 Staff must ensure that forms remain secure at all times until handed in. Documents should never be left on view or unattended in an unlocked vehicle.

9.6 When documents are subsequently transported from one location to another they must be conveyed in designated bags/ containers with an entry made in the appropriate log by the equipment support personnel or team leader (at weekends). In the absence of the equipment support personnel, a specific member of staff should be allocated for this responsibility and to act in accordance with the procedure. All documents destined for Management Information should be taken directly to the department.

9.7 The log will comprise of the equipment support personnel running sheet or the station occurrence book. The log should be dated, timed and signed by the person responsible for the transfer and the recipient. In the absence of a recipient the log should clearly indicate where the forms have been deposited.

9.8 The equipment support personnel, or other designated person transferring the patient related forms should ensure that the bags/ containers are sealed when being put in the vehicle and that they remain secure whilst being transported. The vehicle must not be left unlocked whilst unattended.

9.9 When completed documents are being used for audit or monitoring purposes and are not in a secure container, work must be undertaken in a designated ‘safe haven’ and access restricted to essential staff. A safe haven is a lockable facility within a lockable area.

9.10 Copies must not be taken of any documents locally and documents must not be retained by departments for enquiries. If copies of forms are required or any queries are received, these must be channelled through the Operational Information and Archives Department.

9.11 Documents received by MI are logged into a database detailing date, station and number of records. Documents are then scanned into the Scanning system. Ad hoc documents are scanned as attachments to the PRFs. The documents are colour-coded at each stage of the process to demonstrate their current status and the system is checked to ensure that the documents have been correctly processed. A count of expected records and received records is available on the Pulse through the MI Business Intelligence Portal and missing records are chased by Management Information staff.
All records in Management Information are stored in a locked storage system.

10. Management and Tracking of Electronic Health Records

Management of electronic health records is carried out in accordance with Appendix 2. Access to electronic health records is via the MI Business Intelligence Portal and this is controlled by Windows log-in based on rules determined by IGG.

11. Storage, Handling, and Security

Staff must ensure that Health Records are kept secure at all times when being handled and/or transported between Trust locations and externally. All portable devices containing electronic records must be encrypted and the transportation of patient identifiable paper records, particularly externally, must be kept to a minimum and not stored externally except under controlled conditions. (See also TP047 Electronic Information Handling Procedure).

12. Disclosure and Retrieval

12.1 Health records will only be disclosed by the LAS in compliance with TP/009 'Policy for Access to Health Records, Disclosure of Patient information: Protection and Use of Patient Information'. Any information recorded about a patient may not be disclosed without the patient's consent (LA234) or a declaration form (LA413, LA414, LA416) being completed. These forms are available electronically on '*the pulse*', and when completed should be faxed to the Operational Information and Archives Department who control and record details of all access to, and retrieval of, such records.

12.2 Disclosure to a third party will be limited to the minimum information required to satisfy the purposes of disclosure and any bulk or regular transfer of identifiable patient data between the LAS and other Trusts and agencies will be controlled and monitored through an Information Sharing Protocol or Subject Specific Information Sharing Agreement (SSISA). Any secondary use of health records will be anonymised wherever this is sufficient for purpose.

13. Retention, Disposal, and Destruction

13.1 Patient identifiable information will be stored and maintained for differing periods of time and in different locations in accordance with the appropriate appendix of this procedure.

13.2 The length of time records will be stored will take into consideration legislation, best practice and organisational needs.

13.3 Records will be securely stored in conditions and locations appropriate, for the period of time they are to be retained, to ensure preservation.

13.4 The postholder with responsibility for the records, as identified in each appendix, will in each instance ensure that access to records is maintained throughout their lifecycle, and has the responsibility to ensure that a review is carried out at the end of the retention period. Where there is uncertainty about the need for continuing retention the postholder will consult with the Information Governance Manager who will make the final decision on retention.

13.5 The postholder with responsibility for the records is responsible for their secure destruction. Electronic records will be destroyed in compliance with TP/047 Electronic Information Handling Procedure and paper copies will be destroyed on site in compliance with TP/057 Waste Management Policy.

13.6 The following is a list of forms covered in this procedure and their corresponding appendix:

- AS1s, AS3s — Appendix 1
- Electronic patient records — Appendix 2
- Patient Report Form(LA4 & LA4H) (Available from procurement) — Appendix 3
- LA1 Accident and Emergency Journey Summary (Available from procurement) — Appendix 4
- PTS booking forms — Appendix 5
- PTS1 log sheet and PTS1 continuation sheet — Appendix 6
- Other PTS patient identifiable documents — Appendix 7
- EOC and UOC audio tapes — Appendix 8
- LA5 Assessment of Capacity Form, (Available from procurement) — Appendix 9

- LA5a Patient Agreement to Investigation, or Treatment (Available from procurement) — Appendix 9
- LA5b Parental Agreement to Investigation or Treatment for a Child or Young Person (Available from procurement) — Appendix 9
- LA279 Child Protection Report Form — Appendix 10
- LA280 Protection of Vulnerable Adults Report Form — Appendix 10
- LA3 Recognition of Life Extinct (R.O.L.E. leaflet) (Available from procurement) — Appendix 11

All forms, with the exception of those in Appendix 7 which are kept for six months, are retained in their original paper format or in electronic format for 25 years. See individual appendices for details.

14. Training

Training on health record-keeping is contained within the Information Governance requirement in the LAS Training Needs Analysis. This document is appended to TP/056 Core Training Policy. Further reference to the Trust's approach to Records Management training can be found in TP/029 Records Management & Information Lifecycle Policy.

IMPLEMENTATION PLAN				
Intended Audience	For all LAS staff who are responsible for creating or managing Health Records			
Dissemination	Available to all staff on the Pulse			
Communications	Revised Procedure to be announced in the RIB and a link provided to the document			
Training	Records Management training to be part of Information Governance training developed by E&D/L&D and Information Governance Manager and other IG staff.			
Monitoring:				
Aspect to be monitored	**Frequency of monitoring AND Tool used**	**Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported**	**Committee/ group responsible for monitoring outcomes/ recommendations**	**How learning will take place**
Duties, including basic record keeping standards which must be used by all staff (Sections 4 and 8)	Responsibilities will be checked at each Procedure review period. Record quality will be checked on a monthly basis by auditing a percentage of PRFs (CPI reports)	Head of MI - reports to Information Governance Group CARU – reports to CARSG	Risk Compliance and Assurance Group	Staff advised of any changes. Training, PDRs etc.
Legal obligations that apply to records (Section 6)	Annual review of IG legislative agenda	IG Manager reports to Information Governance Group		Staff advised of any changes through RIB notification etc.
How a new record is created and the process for making sure a contemporaneous record of care is completed (Section 7)	Record completion is checked on a monthly basis by auditing a percentage of PRFs (CPI reports) Receipt of completed PRFs	CARU – reports to CARSG Head of MI - reports to		Training, PDRs etc. Notifications to managers and

	is continuously monitored by MI and available through their BI Portal.	Information Governance Group		staff as required
How health records are tracked when in current use (Section 9)	Receipt of completed PRFs is continuously monitored by MI and available through their BI Portal.	Head of MI - reports to Information Governance Group		Notifications to managers and staff as required.
How health records are retrieved from storage (Section 12)	Annual review of access arrangements and retrieval process – report produced.	Head of MI - reports to Information Governance Group		Any report recommendations communicated to relevant staff.
Process for retention, disposal and destruction of records (Section 13)	Retention arrangements to be checked at each Procedure review period. As records are kept for 25 years the disposal and destruction process will be reviewed prior to the first review period.	Head of MI - reports to Information Governance Group IG Manager reports to Information Governance Group		Notifications to managers and staff as required.

Appendix 1

AS1s & AS3s

Introduction

If the CTAK system is unavailable in EOC a paper AS1/AS3 is completed for all emergency and non-urgent calls.

Specific Procedure

1. AS1s and AS3s must be placed in the filing box in EOC. The box will be collected daily (Monday to Friday) and taken to Operational Information & Archives Department for processing and filing.

3. The forms must not leave the control room until they are collected by a designated person for delivery to MI. If there are any requests from an outside agency regarding these forms, section 2.10 of this procedure should be adhered to.

4. AS1s are filed chronologically.

5. AS3s are filed in alphabetical order by date of travel and patient surname

6. Retention and Disposal: It is the responsibility of the Operational Information & Archives Manager to ensure that:

    - Original copies are transferred onto CD and then securely destroyed.

    - The CDs are stored for 25 years in the Management Information Department, then reviewed and securely destroyed if no longer required.

Appendix 2

Electronic patient records

Introduction

For all calls taken in EOC and UOC through the 999 system, an electronic record is generated.

Specific Procedure

1. All calls are stored in a secured database on a centrally managed server.

2. The database is managed by Management Information.

3. The database is automatically backed up every four hours by internal IT services.

4. Access to records is controlled and managed by Management Information

5. Retention and Disposal: Records are retained for 25 years.
   It is the responsibility of the Deputy Head of Management Information to ensure that electronic patient records are reviewed after 25 years and securely destroyed if no longer required.

Appendix 3

Patient Report Form & Handover Report Form

Introduction

The Patient Report Form – LA4 (PRF) provides a record of a resource's response to a call, patient observations and treatment. This information recorded on the PRF is important because:

- It contains details about the patient that may assist in their care, both in terms of changes in their condition, where changes in the vital signs show a trend, and the environment in which the patient was found.

- It may contain elements of the history that the hospital or alternative pathway would not otherwise know which may affect the patient's care and the decision to discharge.

- It contains timings that are vital for the Service to monitor, both for response times, but also times at which vital signs were taken and when interventions were undertaken.

- It allows the Service to audit / research various aspects of our work. By doing so we can link our care with patient outcomes and work toward improving patient care and evidence based practice.

    - It is an essential element of the documentation required in answering queries and complaints and undertaking investigations into reported incidents.

It is therefore extremely important that the PRF is always completed giving as much information as possible, especially when patients are not transported.

Specific Procedure

1. This guidance must be read in conjunction with the Assignment Record and Clinical Record Form User Guide.

2. A PRF must be completed for every emergency, urgent and non-urgent call where the vehicle has arrived at a given location, regardless of whether a patient is present or not, including self activated and running calls. Self activated calls are when a responder hears of an emergency call, informs EOC and is then asked to attend. A running call is when a responder comes across a call for which they have not been allocated and there is no other resource on scene.

3. If the vehicle is cancelled en route to a call and therefore does not arrive at the scene of the incident a PRF is not required. In these circumstances an entry must be made on the LA1 to show that the call was cancelled.

4. Where a vehicle arrives on scene but can not find a patient a PRF is still required. IN these circumstances the PRF is used to document fully what steps were taken to locate the patient.

5. Where a single responder attends a call and the patient is conveyed by another vehicle, a handover form (LA4H) may be completed instead of a full PRF. The exceptions to this are when attending a cardiac arrest call or where the patient is not conveyed. In these circumstances a full PRF must always be completed.

6. A single form must be completed for every patient and, in situations where there are multiple patients, an individual form will be required for each patient.

7. Resources attending an incident who do not transport the patient must ensure that the call sign of the vehicle that transported the patient is clearly printed in the additional information box of their PRF/LA4H

8. Information passed concerning a call must be written directly onto the PRF, and that form completed and placed in the designated box by the end of the shift for secure onward transmission to the main station office. Some forms will inevitably be ‘spoiled’ during completion and in this case it is permissible to begin again on a new form. Spoilt forms must be clearly marked as such and lined through; they must then be managed as per section 1.4 of this procedure.

9. The fullest possible explanation of assessment and treatment must be recorded for each patient. It is equally important to make clear why care/treatment required by clinical guidelines, protocols and procedures has NOT been administered as it is to record what has been done (this helps to justify clinical decisions).

10. Any information that cannot be detailed adequately elsewhere on the form must be recorded in the Additional Incident / Treatment Details box.

11. The second white copy of the PRF is designed to be left at the hospital or alternative pathway to form a permanent record of the care given by the LAS. It must be left with the receiving clinician prior to leaving the patient in accordance with the Procedure relating to the Handover of Patients. The smaller fourth page at the back of the form is left with hospital reception staff to reduce the need for passing over details verbally.

12. When the patient is not conveyed the second white copy of the PRF must be handed to the patient or carer.

13. A written record must be made on the PRF of the advice that the crew have given the patient regarding their condition, including a recommendation where appropriate that the patient allow the crew to convey them to hospital or utilise an alternative pathway.

14. The crew must ensure that the patient or carer has been advised of how to proceed should they wish to be conveyed to hospital at a later time. This information must also be noted on the PRF.

15. When the patient is not conveyed, the patient must be asked to sign the PRF indicating that they have understood the advice given to them. If the patient is unable to sign, then a responsible adult may sign on their behalf and a note of this made on the PRF. If the patient is a young child, the parent/guardian may sign, indicating their parental responsibility.

16. The white copy of the PRF must be placed in the designated box by the end of each shift.

17. Following calls where there is no patient, the second white copy must be placed in the designated box by the end of the shift with the first white and yellow copy.

18. Administrative staff on station must ensure that all PRFs are accounted for against the LA1.

19. The white copies of the PRFs should be open and batched by date.

20. Continuation sheets, additional forms, separate notes, ECG traces, etc. must include references to allow the information to be matched with the appropriate PRF. The reference must include all of the following; Date, CAD, Call sign and PRF ID. The additional paperwork must NOT be attached to the PRF but filed behind the corresponding PRF.

21. Each day's forms must be placed in a secure bag, sealed with a white numbered seal and placed in the internal post box. A record of the seal number and PRF batch dates must also be placed in the bag. Sealed bags will be collected by equipment support personnel, the seal number recorded on the running sheet, and taken to the Logistics Support Unit where they are placed in secure, sealed containers for onward transmission to Management Information.

22. Retention and Disposal: It is the responsibility of the Deputy Head of Management Information to ensure that:

    - Original forms are scanned as images onto a centrally controlled server and automatically backed up every day through internal IT services.

- The original copies are securely destroyed.

- Electronic records which are stored for 25 years in the Management Information Department are reviewed after 25 years and securely destroyed if no longer required.

23. Attention is drawn to section 1.7 and 2.5 of this procedure to ensure that the LAS maintains patient confidentiality within the Data Protection Act (1998) and Caldicott Guidelines (1998).

Appendix 4

LA1 Accident and Emergency Journey Summary

Introduction

The LA1 provides a shift summary of all patient and non-patient vehicle movements for all A&E resources.

Specific procedure

1. At the commencement of every shift, the top section of the LA1 must be completed for the service vehicle in use.

2. Every journey undertaken by a crew during their shift must be recorded on the front of the LA1. Each separate patient journey or service run must be recorded on the next new line. This will include all responses to emergency, urgent and non urgent calls, standbys, service runs, vehicle refuelling and any other activity during the shift. Calls which are subsequently cancelled before arrival are also recorded on the LA1.

3. For every separate journey, whether patient related or not, the following information must be accurately recorded:
   - all journey times
   - the odometer reading at the end of the journey

4. Details of any equipment left at hospitals must be recorded in the relevant box.

5. The person(s) carrying out the vehicle daily inspection (VDI) and equipment check must sign in the relevant box to indicate that each has been completed.

6. Any losses/defects must be reported to the appropriate local manager and EOC and recorded on the form.

7. A final odometer reading must also be completed on the form at the end of the shift.

8. If staff are required to change on to another vehicle at any point throughout their shift, a new LA1 must be completed for the Service vehicle.

9. All completed LA1s must be signed on the front of the form by the crew and where applicable the supervisor or observer on the vehicle.

10. All completed LA1s, with their corresponding PRFs, must be placed in the designated box as detailed in 2.1 of this procedure.

11. Any ‘spoilt’ forms must be managed as detailed in 1.4 of this procedure.

12. Administrative staff on station must ensure that all LA1s are accounted for against staffed vehicles.

13. Retention and Disposal: LA1 forms are stored on station for 25 years .It is the responsibility of the Station Administrator to ensure:

- They are kept securely
- A review of the records is undertaken with the Head of Records Management after 25 years
- They are securely destroyed if no longer required.

Appendix 5

PTS Booking Forms

Introduction

A PTS Booking Form is a form generated for the purpose of booking a patient to travel. Once the booking has been entered onto the computer system, the PTS booking form is stored at the appropriate PTS control. The forms are stored for enquiries and as a manual back up in case of computer failure.

Specific procedure

1. The forms are filed in date order and stored securely at the PTS site for one month for queries. They are then sent off for scanning onto CD Rom. The CDs are sent to MI for archiving while the forms are securely destroyed by the contractor.

2. Booking forms processed by hospital staff remain the responsibility of the hospital concerned.

3. Retention and Disposal: The CD Roms are stored securely for 25 years by MI. It is the responsibility of the Deputy Head of PTS to ensure that secure storage is in place and the CD Roms are reviewed and securely destroyed if no longer required at the end of the 25 year retention period.

Appendix 6

PTS1 Log Sheet and PTS1 Continuation Sheet

Introduction

PTS1 log sheets are generated by the PTS computer system and they detail the journeys to be undertaken by PTS staff. The sheets are updated during the shift with times, whether the patient was conveyed and any other appropriate information. Additional journeys are hand-written onto the form or entered onto the PTS1 continuation sheet.

Specific procedure

1. At the end of each run, the PTS1 log sheets and continuation sheets must be handed in to the designated location and stored in accordance with section 2.1 of this procedure.

2. The sheets must then be collected by the PTS Operations Manager for updating the computer system at any PTS control.

3. All designated information from the PTS1 log sheets and continuation sheets must be entered onto the PTS computer system. Any PTS1 log sheets and continuation sheets which have information recorded about the incident or treatment of the patient other than the times must be retained. All other PTS1 log sheets and continuation sheets are disposed of in accordance with section 1.4.

4. The retained PTS1 log sheets and continuation sheets are filed in date order for each PTS control.

5. Retention and Disposal: The retained PTS1 forms are stored locally within a safe haven for one month. They are then sent off for scanning onto CD Rom. The CDs are sent to MI for archiving while the forms are securely destroyed by the contractor. The CD Roms are stored securely for 25 years by MI. It is the responsibility of the Deputy Head of PTS to ensure that secure storage is in place and the CD Roms are reviewed and securely destroyed if no longer required at the end of the 25 year retention period.

Appendix 7

Other PTS Patient Identifiable Documents

Introduction

A number of other forms containing patient identifiable information are generated from the PTS computer system. These include alphabetical lists, 'missed' lists and copies of PTS1 log sheets or any spoilt sheets with patient details.

Specific Procedure

1. Retention and Disposal: These sets of information are kept securely for up to six months at Becontree, New Malden and UOC. It is the responsibility of the Deputy Head of PTS to ensure that at the end of this period the local Transport Operations Centre manager arranges for these documents to be securely shredded on site in accordance with section 1.4 of this procedure.

Appendix 8

EOC and UOC Audio Tapes

Introduction

All incoming and outgoing calls received or made by EOC and UOC are recorded. Radio transmissions are recorded onto Dat tapes. All other calls are held on a central server at HQ.

Specific Procedure

1. Calls held on a central server are backed – up.

2. The Dat tapes are changed by the radio engineers. Each day the tapes are sent to Operational Information and Archives department in a locked box.

3. Retention and Disposal: It is the responsibility of the Operational Information & Archives Manager to ensure that Dat tapes are logged and stored for 25 years in the Management Information Department, then reviewed and securely destroyed if no longer required.

Appendix 9

LA5 – Assessment of Capacity Form, LA5a – Patient Agreement to Investigation or Treatment, LA5b – Parental Agreement to Investigation or Treatment for a Child or Young Person

Introduction

OP31 Policy for Consent to Examination or Treatment details the LAS approach on patient consent to examination or treatment. The above forms are used as part of that approach where appropriate.

Specific Procedure

1. For specific guidance on the above forms please refer to OP31 Policy for Consent to Examination or Treatment

2. The forms when completed must be filed behind the corresponding PRF and sent to Management Information for filing

3. Retention and Disposal: It is the responsibility of the Deputy Head of Management Information to ensure that:

    - LA5 forms are scanned as images with the appropriate PRF onto a centrally controlled server and automatically backed up every day through internal IT services.

    - The original copies are securely destroyed.

    - Electronic records which are stored for 25 years in the Management Information Department are reviewed after 25 years and securely destroyed if no longer required.

Appendix 10

LA279 – Child Protection Report Form
LA280 – Protection of Vulnerable Adults Report Form

Introduction

TP 18 and TP19 are the procedures for ambulance crews who attend a child or vulnerable adult and are concerned that the child or vulnerable adult may have been either physically, sexually, emotionally abused, or neglected. The above forms are used as part of that procedure where appropriate.

Specific Procedure

1. Please refer to TP 18 (Suspected Cases of Child Abuse Procedure and Recognition of Abuse Notes) for specific information on LA279, and TP19 (Suspected Abuse of Vulnerable Adults Procedure and Recognition of Abuse Notes) for specific information on LA280.

2. Forms LA279 and LA280 are faxed to the Emergency Bed Service (EBS) at HQ who will scan into the DATIX system.

3. Retention and Disposal: EBS will securely shred forms on site. It is the responsibility of the Head of Patient Experiences to ensure that the scanned LA279 and LA280 forms are stored for 25 years and reviewed after 25 years and securely destroyed if no longer required

Appendix 11

LA3 Recognition of Life Extinct (R.O.L.E. leaflet)

Introduction

In certain circumstances, and in accordance with the National Clinical Guidelines, ambulance staff are authorised to recognise patient death. Form LA3 must be completed for all patients where death has been recognised.

Specific Procedure

1. Please refer to LA3 booklet for specific guidance on how and when to complete the form.

2. The white copy is retained by the LAS and filed with the corresponding PRF.

3. Retention and Disposal: It is the responsibility of the Deputy Head of Management Information to ensure that:

    - LA3s are scanned as images with the appropriate PRF, onto a centrally controlled server and automatically backed up every day through internal IT services.

    - The original copies are securely destroyed.

    - Electronic records which are stored for 25 years in the Management Information Department are reviewed after 25 years and securely destroyed if no longer required