Essex Partnership University
NHS Foundation Trust

HEALTH RECORDS DOCUMENTATION – FORMS MANAGEMENT PROCEDURE

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OPERATIONAL POLICY SUMMARY

This procedural guideline document ensures that documentation used within electronic health records is appropriately developed, standardised, implemented and reviewed in a controlled and consistent way. This will minimise risk and contribute to good quality care records.

The Trust monitors the implementation of and compliance with this operational policy in the following ways;

The Clinical Audit Department will ensure that annual audits of health records are undertaken across Trust specialities, both inpatient and community as per agreed policies and procedures

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this policy is Medical Director

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HEALTH RECORDS DOCUMENTATION – FORM MANAGEMENT PROCEDUURE

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HEALTH RECORDS DOCUMENTATION – FORMS MANAGEMENT PROCEDURE

1.0 INTRODUCTION

1.1 This procedure outlines the process for managing the documentation which will form part of the electronic care records of patients using Mental Health, Learning Disabilities, Adolescents inpatient Services and Community Services.

1.2 For the purpose of this procedure there will be reference to documentation via different terminologies either in paper or electronic:-

- Forms / eForms
- UDF – User Defined form
- Templates

1.3 It is important that consistency of content and format is introduced for all produced, therefore the creation of any new eforms/UDFs/Templates for use needs to be via a managed process.

1.4 A significant number of forms and templates are produced and used by the Trust. This procedure sets out the arrangements in place to standardise development of the electronic and paper forms.

1.5 The use of Trust approved documentation will add clarity and professionalism to the work undertaken and allow patients to benefit from records that demonstrate effective communications, which support and inform high quality care.

1.6 The control and management of documentation will ensure the Trust works in a consistent and standardised manner, ensuring compliance with Care Quality Commission standards, Audit, Risk Management Standards and other necessary guidance.

1.7 Recording information on Trust Approved documentation is part of the care process and not an optional extra.

2.0 SCOPE OF THE PROCEDURAL GUIDELINE

2.1 This document applies to all professional staff and those associated with the designing and implementation of new forms and or templates.

2.2 Across Mental Health/Learning Disability and community services, Mobius, Paris and SystmOne have been implemented as the core Electronic Patient Records and the electronic recording of documents will be added and viewed via these systems. In addition, Theseus, Excelicare and IAPTUS are used for specific services.

2.3 The standards set out in this document apply across all care settings within the Trust. Its aim is therefore to provide clear and concise guidance for the development and management of documentation used in electronic systems.

2.4 Only approved forms should be used and staff must not develop their own. Any forms required for trials must be discussed with either the Clinical Change Manager and / or Head of Electronic Systems and IG prior to any use; as it will need to be determined where the form best sits within the electronic record.

3.0 RESPONSIBILITIES

Clinical Staff –

- All suitably qualified staff are responsible for the amendment and creation of documents for clinical practice, where inclusion is required in the patients' health record providing this procedure is followed.
- Any staff using documents for clinical purposes is responsible for ensuring the correct documents are used and any old documents highlighted to the Clinical Change Manager and / or Head of Electronic Systems and IG so that they can be removed and destroyed.

Managers –

- All clinical managers will need to ensure staff are using the correct forms. This can be monitored via team meetings, 1:1's, supervisions, appraisals and audits.
- Managers will also need to ensure when approving new local documentation and / or changes required to existing e forms/UDFs/Templates, they follow the process as set out in this procedure

Directors –

- All associated clinical directors will need to approve new documentation and / or changes at their key committees prior to passing onto the relevant project board for discussion / approval.

EPR Project Boards –

- The project boards are responsible for reviewing and either approving or rejecting any e forms/UDFs/Templates development or changes.
- The project boards are responsible for deciding on the priority of each form, taking into account the risks and mitigation as described on the development request form

The Systems Team –

- The systems team is responsible for helping and advising any of the above staff members in their development and / or change to forms.
- Once forms are approved the development team will make necessary amendments to the forms master sheet.
- Any form required in paper whilst awaiting development will be given a unique form number/name to help aid scanning and retrieval.

4.0 KEY ASPECTS OF STANDARDISATION

4.1 All Trust electronic documents must be developed using the relevant standard Trust models.

4.2 The layout of text within a document will depend on what is being produced, its purpose and the preferred style of the author.

4.3 All Trust approved documents, whether in paper or electronic form, must include document rules for referencing, titling, indexing and if appropriate, protective marking. These must be easily understood to enable the efficient maintenance of information, retrieval of records and to maintain security and confidentiality.

4.4 The NHS Trust logo should be used carefully and correctly.

4.5 The version control of a form / template is very important as it outlines the history of consultation, amendments that have taken place to produce the final form and ensures that the correct version is used to amend or distribute. This version control is held by the development team within Mental Health / Learning Disabilities (MH/LD) or Community Teams which is automatically controlled by the system.

4.6 Format

- Electronic documents on the different systems will follow a standard template which has already been pre-determined. (All systems)
- Each electronic document will need to be uniquely named/numbered. This is to aid easy retrieval. The number of pages will also be aligned at the top of the document. (All systems)
- Headers and footers must be put on all documents within the appropriate format, depending on which system the form is being developed on and form part of the standard electronic template being used.

    - The header should contain the core patient details
    - The footer should contain the details of the person completing the form including the date and time – this will be via an electronic stamp from the PC / laptop being used. (All systems)

5.0 TYPES OF FORMS / TOOLS

5.1 **Paper**

When the electronic patient record is not available due to maintenance etc. then all paper forms should only be accessed / downloaded from InPut as only the current version is valid at any point in time. These forms are only to be used in emergency situations. These forms will then be scanned to the patient's record.

Where trials are taking place, these forms will remain in paper until the trial has been concluded. Please refer to section 2 for further guidance on trials. If at this point it is deemed necessary to create a new form then the process as outlined in this procedure will need to be used.

5.2 E-Forms /UDF's /Templates

Users of all EPRs will be able to access the same forms from each system. These forms can be typed into directly and stored electronically on the EPR system.

All eForms/UDF's/Templates will need to be defined in terms of what features and functionality they contain, and must be considered during initial development locally. When existing forms are being reviewed the same principles will need to apply.

A list of features is detailed below for consideration:-

- **Mandatory fields** – where staff have to complete certain criteria prior to submitting/authorising, forms cannot be submitted until these are completed (all systems)

- **Soft Mandatory fields** – UDFs can be saved if soft mandatory fields are not completed but it cannot be authorised until soft mandatory fields have been completed. Soft mandatory allows UDFs to be saved to continue later. (Paris only)

- **Intelligent forms** – workflow to support notifications including expiry dates e.g. risk assessments / care plans. (Mobius only)

- **Dynamic forms** – the ability to open or collapse sections of a form

- **Auto save** – ability to save the document as you type, especially useful for lengthy forms (Mobius, SystmOne)

- **Dropdowns** – that take a list of options e.g. ward names from the PSD. (All systems)

- **Trending forms** - enabling previous versions to use as a 'starter' for the new form and also for a document to be built up over a period of time e.g. physical monitoring over 24 hours etc. (Paris and Mobius)

6.0 EXTERNAL FORMS (COPYWRITED, LOCAL AUTHORITY, 3rd PARTIES)

6.1 There are a number of forms that the Trust uses that have been produced and supplied by outside agencies. Some of these forms are copywrited which means they cannot be replicated or reproduced in any format. However in some circumstances the originator will give permission and allow replication, therefore allowing the Trust to create e Forms/UDFs/Templates. There may be restrictions aligned to the replication i.e. use of logos, crediting the originator etc.

6.2 Where these forms have been identified, they need to be passed to the Clinical Change Manager and / or Head of Records & Senior Program Manager; they will advise where these should be scanned to. They will then endeavour to seek permission to allow replication and or reproduction.

6.3 In instances where the Trust does have permission to replicate copywrited forms the evidence of permission will need to be appended to the master form log for future reference.

6.4 Where permission is not granted or unable to obtain, the form will have to remain in paper and be scanned.

7.0 SIGNATURES

7.1 The Trust has agreed the principle that actual patient signatures are rarely required within the electronic patient record, therefore where possible these have been removed and replaced with a statement that this form (i.e. care plan) and its content have been fully written and discussed with the patient.

7.2 Evidence of the above patient engagement within the record will be subject to audit.

7.3 Where it is necessary and or a legal requirement to have a signature, clear rationale to be documented.

7.4 In paper forms it was easy to be able to add a space to capture the patient's signature; however in electronic systems this is more challenging. With the Trusts vision of least scanning, the printing of documents for signing and scanning is not an option going forward.

Currently only the following forms require signatures:-

- Consent Forms
- Personal Items Record
- Medicine Management Records

7.5 Where a signature is required it will need to be presented to the respective project board using the Development Request form.

8.0 PROCESS FOR THE DEVELOPMENT AND APPROVAL OF NEW / REVIEWED FORMS

8.1 From time to time forms will need to be either developed because of new requirements and service specific needs or updated due to changes within the service. The change could also be around national contractual changes i.e. NHS England, Secure Services (MHSDS) and CQUIN requirements etc. All of these changes including, trust policies, procedures and staff feedback must be considered as part of the review of the pending approval of forms.

8.2 All new and reviewed forms will need to be submitted to the Systems Change Board (SCB) for Approval. The Systems Change Board is tasked with assessing the perceived impact of the requested changes to the clinical systems

8.3 SCB will ensure that standardised methods and procedures are used for efficient and prompt handling of all change requests in order to minimise the impact of change on our services, ensure efficient usage of resources, and to support the clinical day-to-day operations of the Trust. This will be done through a formal process of recording, assessment/triage/sizing, authorisation, testing, scheduling and with comprehensive communications around all changes, including authorisation by the relevant project board.

8.4 The following form development process will need to be followed for any new and / or existing forms that require a review, redevelopment or any changes.

Stage 1: Form Requirement	
Justification (Author)	• Define the need for the form • Align to service needs and or statutory requirements • Check to ensure that this form is not duplicating work elsewhere in the Trust or Nationally • Obtain approval from the relevant Service Management team meetings • Obtain final approval from the relevant Service Director
Stage 2: Draft Form Process *including current operational form changes*	
Process	• The author will be responsible for presenting the draft form with confirmation of approval from stage 1 to both the Clinical Change Manager and / or Head of Head of Electronic System and IG • The Clinical Change Manager and / or Head of Electronic System and IG will review the form and make any necessary adjustments to ensure certain words align (using the data dictionary) and discuss with the author other requirements around the forms needs i.e. mandatory fields, trending etc. as per Section 5 • The form will be sent to SCB for discussion and either approval or rejection • The SCB lead will liaise with the development team to determine an estimated time for development.

Priority	• Once the estimated time for development is determined the author is advised • The author will then need to fully complete the Development Request Form (Appendix 1) for Mobius and Paris and (Appendix 3) for SystmOne. • Each new form development request will need to have the rationale and the mitigation completed • The prioritisation scoring matrix* will need to be completed, scoring each category out of 5 (1 low and 5 high) and adding the score up in the last column. This development request form will need to be given to SCB lead to ensure its fully completed • Changes to an existing form will need to follow the same process. • The estimated time for development will be added along with the date. **The matrix will give a score which will determine the priority and need of the form and if this requires prioritisation over other already approved work. The matrix will also contain the current and proposed mitigation along with a risk assessment which will both aid with the scoring.*
Stage 3: Project Board Consultation	
Process	• The whole request (development request (Appendix 2) and form) will be circulated to the relevant EPR project Board members at least 7 days in advance of the meeting for consideration. *(It needs to be noted if the forms are not circulated in advance it is unlikely Board approval will take place)* • Urgent requests that cannot wait for the next Board can go for Chair's action. The steps above will still need to be followed. • Circulation to the Board members can still take place asking for comments by a defined date. • Once comments are returned and the date surpassed this can be presented to the Chair. • 7 days will need to be allowed for Chair's action. • The decision will be fed back to the author. • All approvals following Chair's action will be presented as information only to the next Board • If the request for a change is to an existing operational form and is small and falls within the timescales allowed for quarterly changes the board will approve the request

Stage 4: Approval	
Process	• A decision from the Board will be reached and will be fed back to the author via email along with a predicted development timescale. • The request will be added to the master form development schedule. • If the form is not approved it will be sent back to the author with the reason for rejection added to the request. • Any approved quarterly changes will be added to the forms log and identified as such • Once changes are applied, the Clinical Change Managers will check and advise the author accordingly.
Stage 5: Communications	
Process	• The Board will as part of its commitment on communications, advise all associated staff of the changes using the usual communication methods. • Any urgent communications needed will go out to the associated staff via email or snap comms. • The Clinical Change Manager will notify the relevant Heads of Service / Directors when forms are developed and ready for use. • There may be the need to offer advice, guidance and training to which the systems team will help facilitate in conjunction with the nominated Champions.

9.0 DATA REQUIREMENTS

9.1 In conjunction with the guidance given above (Section 7) in the process for the development and approval of new / reviewed forms there will be the need to update forms for statutory needs where this information needs to be gathered electronically to meet the required information collections and returns.

9.2 These requirements are usually given in advance; therefore the System team will work in conjunction with the Compliance and Information team to best determine where this information can be gathered from or which form it would need to be placed on.

9.3 The forms will be manually updated to reflect the changes; however the Clinical Change Managers will discuss and agree with the relevant service/s prior to any development

9.4 The agreement will be any data requirements needed will be mandatory, therefore the fields will be developed as mandatory fields as in 5.2 above

It is anticipated these changes will take place every six months, therefore allowing time for these to be approved at Project Board.

10.0 REMOVAL OF FORMS FROM SERVICES

10.1 Any form that requires removing from the electronic system will require Project Board sign off. This will need to be presented in the same way as new forms (Section 7 above)

11.0 MONITORING AND REVIEW

11.1 The Executive Medical Director will be responsible for reviewing this procedural guideline in association with the Electronic Records Project Board.

11.2 The Clinical Audit Department will ensure that annual audits of health records are undertaken across Trust specialties, both inpatient and community as per agreed policies and procedures.

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