Digitalised Health Records

As you will now be aware, NUH has now gone live with rolling out the first phases of moving towards paperless medical records. The Digital Health Record (DHR) project is aimed at replacing a patient's current paper casenote with an electronic version. This electronic copy will be viewable by clinical and administrative staff on PCs, Computers on Wheels, and mobile devices.

The objectives of the programme are to improve patient care (for example by allowing more than one member of staff to simultaneously view a record and to eliminate the risk of records being lost), reduce operating costs (by eliminating casenote tracking for example) and also to support the Trust's objective to become more paper-light. The Trust's scanning programme is fully compliant with the requirements of the British Standard BS 10008 evidential weight and legal admissibility of electronic information, which sets the Legal standards for the admissibility of electronic evidence and ensures all records after scanning are admissible in a court of law.

More information about the project including a set of frequently asked questions can be found on the Trusts intranet page http://nuhnet/ict_services/ecr/Pages/DigitisationoftheHealthRecord.aspx

How will this affect my research project?

The new digitised medical records will read in an identical manner to the current paper medical records but will see the introduction of a ‘research’ tab. The DHR team are teaching the software to recognise the Trust’s approved casenotes documentation. All research specific documents that would be retained in the medical records as research source data or essential information would be housed within the research tab. Templates provided by R&I now contain a unique code specific to that template which when scanned, will automatically be entered into the research tab. The research specific templates which will contain the code can be downloaded from the R&I website (http://nuhrise.org/standards-procedures-and-guidance/templates-and-forms/).
What about records without the unique code?

Documents which need to be entered into the medical records that do not have the unique identifying code (such as research specific lab reports, ECGs etc.), will not be entered into the research tab and will be placed in an episode/group in the back of the patients notes or in an 'unclassified' section making them less easy to locate. Two solutions are available to enable the documents to be scanned into the research tab.

1. Documents which can be edited (such as those where the NUH header has to be applied) can be edited to contain the specific research code. This code must go in the footer of the document with a suggested font of Arial 12 with a 1cm clear space around the code for best results. The code must read NUH03004S in order for the record to be scanned into the research tab.

2. For those documents which do not contain the code and cannot be edited, a research 'sticker' has been designed that can be affixed to the document to ensure the document is filed correctly. The sticker contains the unique code which relates to research and will ensure that the document is placed within the research tab when scanned.

Where will the sticker go?

The sticker has been designed with a white border which is essential for the scanner to read the code. The sticker should be placed in the bottom right corner of the document as shown below on every page. If the document is two sided, a sticker must be placed on both sides.
If the sticker cannot be affixed as shown, for example if it is covering text or essential information, the sticker should be placed as close to this area as possible in a clear space.

How do I order the stickers?

The stickers can be ordered through procurement by your directorate using the order code NUH03004S.

Continuation Sheets

Continuation sheets have also been designed for use within the digitised medical records and already have the unique research identifying code embedded in the bottom right corner. These can also be ordered through procurement using the order code NUH03318S.

Retention of Records

During the transition to digital records and for those records which will not be digitised, in order for the records of a patient taking part in a study to be retained for the correct retention period, a label has been designed to be affixed to the front cover of the patient’s casenotes. Records management do not open the notes to check for such information, so if the detail is not provided on the cover of the notes, the records will be destroyed after 8 years (if not digitised sooner). The majority of notes will be scanned however, and the electronic copy retained indefinitely. The labels can be printed from the website using 12 page label sheets (http://nuhrise.org/standards-procedures-and-guidance/templates-and-forms/).

If you have any queries regarding research documents and the scanning of medical notes for research patients, please contact Teresa O’Leary, Head of Regulatory Compliance for Research and Innovation NUH on extension 70673 or Melanie Boulter, QA Auditor on extension 70120.