Filing Convention for Inpatient blue efolders and Evolve
New trust Casenote structure Proposed – Worthing, Southlands and St. Richards At Worthing, Southlands and St. Richards, history sheets are filed in chronological order and kept in the history section
Order of Content **Cover Sheet** -Surname, Forename, PDT tracking label, Casenote site **DNACPR Form paper** – Electronic folder (place current copy behind cover sheet in Blue efolder) **Patient labels**
Section 0 "Front of notes" **a. "Patient specific care plans"** End of life care plan/Anticipatory care plan Patient specific care plan RESPECT document "Knowing me". Anaesthetic Airway Alert document **b. Medico-Legal** Power of attorney documents Advanced decision to refuse treatment Organ donation Mental health act paperwork (Section papers) Deceased paper docs (Notice of death, property list and last offices)

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Section 1 **Clinical History and Anaesthetic Records** (Filed in strict chronological order most recent at back, exception is the purple communications documentation sheet) Purple Family Communication sheet sits at the front of this section despite chronology. Acute Admission Document (clerking form) A&E CAS card (scanned in-house) E-Patient ward round print-out Specialty clerking document (E.G. Re-clerked if Pt goes to ITU, HDU) Anaesthetic record history sheets Non-Cancer MDT Notes (often a sticker) Paper Social Worker reports Physical / mental assessment paper Acute / Thrombolysis assessment sticker Deprivation of Liberty Safeguards sticker weekly review (DoLS) AHP Notes Mental Health Notes Palliative care printed patient assessment (marked Somerset) Pharmacist notes Tongue tie and Breast feeding assessment Copy of Cancer MDT records during inpatient episode List of medications from patient List of blood pressure results from patient Cardiac arrest audit form Medical Photographs TCI card Oxford hip score Oxford foot score Oxford knee score

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Section 2 **Correspondence** (Filed in strict chronological order most recent at back) Discharge summaries (electronic into Evolve) A&E attendance summary (electronic into Evolve) ACA paper discharge summary Outpatient letters Referral letters External letters to / from other trusts Internal referral letters to teams within the trust Correspondence represented by email – uploaded to Evolve MDT outcome letter (often electronic printed to Evolve) GP correspondence i.e. referral letter into hospital
Section 3 **Investigations / Results** (Filed in strict reverse chronological order most recent at front) Haematology Clinical Chemistry Microbiology X-ray Histology ECG's Exercise Tests Paediatric height measurement External clinical reports Audiology charts Cellular pathology report Visual field maps Patientrack Obs (Sometimes on paper) Patientrack Assessments (if on paper) Skin prick test

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Section 4 **Nursing and Therapies** (Filed in strict chronological order most recent at back) Nursing Notes part A paper Nursing Notes part b paper Yellow Discharge Planner started Paper One to One Activity Log Paper Nursing Care Notes Paper Food Charts Paper Fluid Charts Paper Body Maps Paper Care plans (Depending on patient need) Paper bedside activity log Pain Tool Intentional Rounding Skin Assessment Wound care plan Mouth care chart Ward transfer checklist Night logs Traceability labels (Sterile Services, catheter etc) Ward / OP IV Devices Stickers Batch Number required Adult inpatient discharge planner MAR Chart

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Section 5 Charts and Forms (Filed in strict chronological order most recent at back) Diagnostic test requests paper Paper Assessment Forms Paper or PT Drugs Charts Paper Infusion Pump Chart Paper charts Infusions / transfusions charts (Blood,drugs,fluids) Sliding Scale - variable Insulin infusion Community prescription Adelaide Paediatric coma scale Adult ENT pre assessment chart Adult neuro / Glasgow Coma Scale Invasive procedure safety checklist outpatients WHO Safety checklist Patient outcome form Copy of FP10 Prescription (outpatients) Blood component prescriptions Consent form This section includes all other approved documents not specified elsewhere in this Health record)
Section 6 **Integrated Care Pathways** (Filed in strict chronological order most recent at back) Medical and surgical Integrated Care Pathways e.g. Bariatrics, fractured neck of femur, Cardiac day case Endoscopy Care Pathway Preoperative Assessment Pathway Preoperative Assessment Summary Short Stay Pathway for Elective Surgery Enhanced recovery programme “inpatient pathway colorectal” Main theatres Care Pathway (Anaesthetic record chart is embedded within this) (Device sticker page embedded within this theatre document, continuation device sheets within theatre would be filed here) Anaesthetic record (if not attached to main theatre care pathway)

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Section 7 (electronic only) Cancer MDT folder (Somerset) MDT outcome letter (will be via somerset Cancer registry) MDT meeting notes
Section 8 Unstructured content (electronic only)
Section 9 Summary notes (electronic only – feature in Evolve)
Section 10 Research notes (Electronic only)
Section 11 Safeguarding Electronic only (requested to enter a reason for why you need to access record)