### **APPENDIX A**

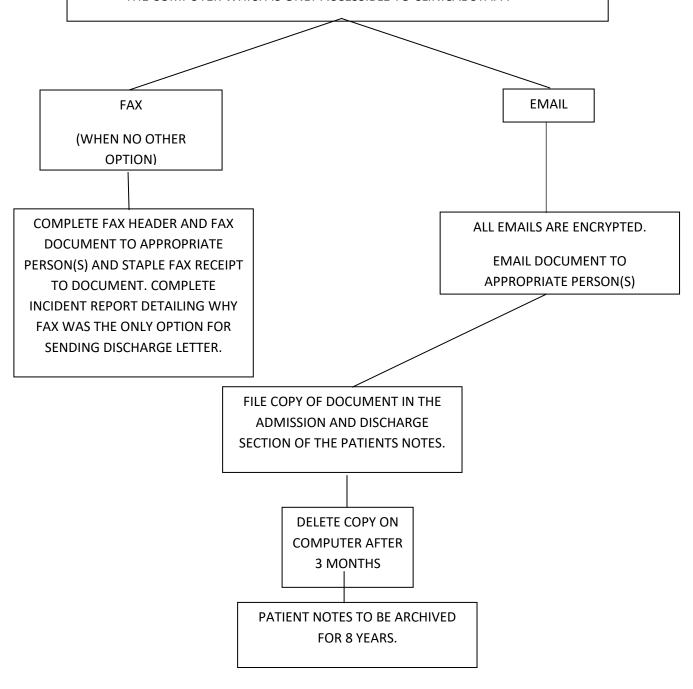
The following documents are provided under this appendix in relation to how Special Category Data is handled:

- Discharge Information
- Referral to Multi-Disciplinary (MDT) Pathway
- Referral Pathway
- Transfer of Hospital Notes

# THE TRANSFER OF DISCHARGE LETTERS BETWEEN SERVICES

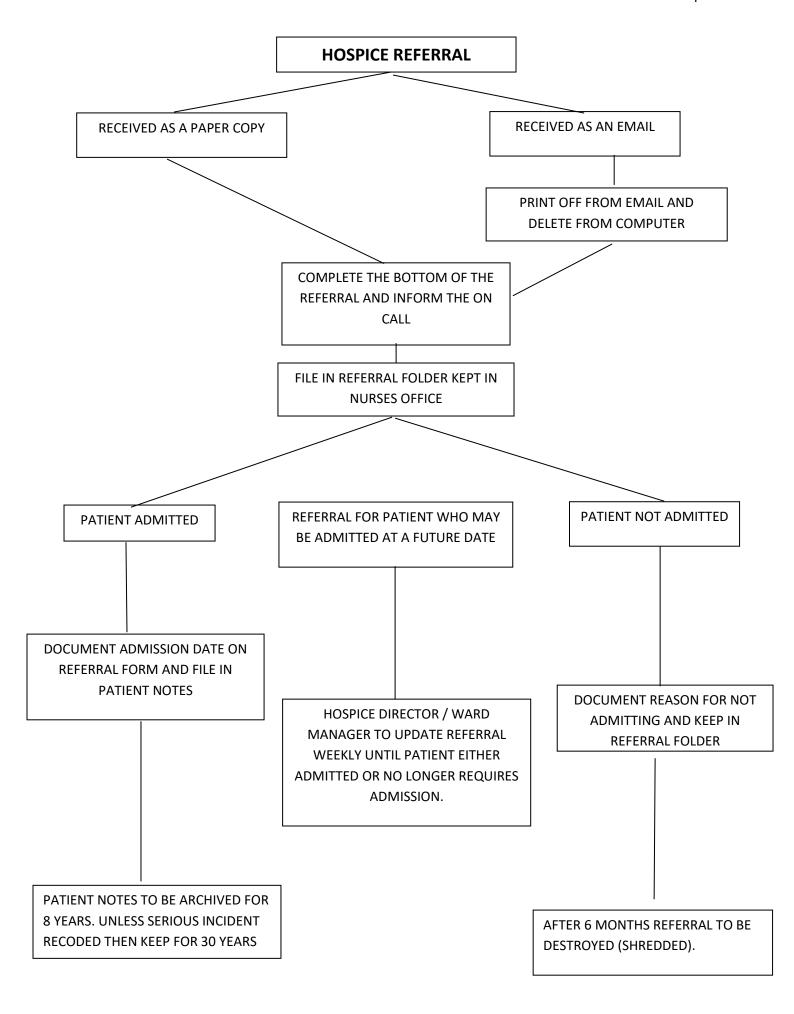
### ON PATIENT DISCHARGE:

- INFORM THE PATIENT THAT YOU WILL BE SENDING A SUMMARY OF THEIR CARE TO THE MDT INVOLVED AND CONFIRM WHO THESE ARE WITH PATIENT AND THEIR FAMILY.
- COMPLETE PATIENT DISCHARGE LETTER LOCATED IN THE NURSES DRIVE ON THE COMPUTER WHICH IS ONLY ACCESSIBLE TO CLINICAL STAFF.



HANDOVER SHEET THE HANDOVER SHEET IS A LIVE DOCUMENT KEPT ON THE NURSES DRIVE OF THE COMPUTER AND **ONLY CLINICAL STAFF HAVE ACCESS** THE HANDOVER SHEET TO BE UPDATED DAILY BY NIGHT STAFF AT START OF SHIFT ALL CLINICAL STAFF MUST WRITE THEIR NAME AT THE TOP OF THE HANDOVER SHEET HANDOVER SHEETS MUST REMAIN WITH THE STAFF MEMBER FOR THE DURATION OF THEIR SHIFT. IF THE HANDOVER SHEET IS MISLAID OR FOUND UNATTENDED AN INCIDENT FORM MUST BE COMPLETED. THE HANDOVER SHEET MUST BE SHREDDED AT THE END OF THE SHIFT.

IF THE HANDOVER SHEET IS FOUND OUTSIDE OF THE HOSPICE THIS WILL BE A BREACH OF DATA REPORTABLE TO THE DATA PROTECTION OFFICER AND WILL BE TREATED AS A SERIOUS INCIDENT LEADING TO DISCIPLINARY PROCEEDINGS.



REFERRAL NEEDED TO SERVICE **OUTSIDE OF HOSPICE** DISCUSS WITH PATIENT AND OR FAMILY (IF APPROPRIATE) TO GAIN **VALID CONSENT** COMPLETE REFERRAL **DOCUMENTATION AS PRESCRIBED** BY THE INDIVIDUAL SERVICES' PROTOCOL SCAN DOCUMENT TO NURSES EMAIL AND EMAIL TO APPROPRIATE SERVICE. DELETE DOCUMENT FROM COMPUTER FILE ORIGINAL DOCUMENT IN ADMISSION AND DISCHARGE SECTION OF THE PATIENTS NOTES DOCUMENT TO REMAIN WITH PATIENTS NOTES AND WILL BE **ARCHIVED FOR 8 YEARS BEFORE** BEING DESTROYED.

# THE TRANSFER OF HSC MEDICAL RECORDS

MEDICAL NOTES ARE REQUESTED WHEN PATIENT ADMITTED FROM AN ACUTE INPATIENT SETTING

PATIENT TRANSFERRED VIA
AMBULANCE

AMBULANCE STAFF TO BRING
MEDICAL NOTES IN A SEALED BAG

HOSPICE RECEIPT/RETURN OF MEDICAL NOTES FORM TO BE SIGNED BY BOTH PARTIES.

PATIENT TRANSFERRED USING OWN TRANSPORT

HOSPICE STAFF COLLECT NOTES IN PERSON FROM PRINCESS ELIZABETH HOSPITAL.

HOSPICE PHOTOGRAPHIC ID REQUIRED.

HOSPICE RECEIPT/RETURN OF MEDICAL NOTES FORM TO BE SIGNED BY BOTH PARTIES.

MEDICAL NOTES TO KEPT IN THE NOTES TROLLEY WHICH IS KEPT SECURELY IN THE NURSES OFFICE.

RECEIPT/RETURN OF MEDICAL NOTES FORM TO BE FILED IN PATIENT NOTES.

PATIENT RETURNS TO ACUTE SETTING

PATIENT IS DISCHARGED OR PATIENT DIES

VIA AMBULANCE? VIA OWN TRANSPORT?

AMBULANCE STAFF TO TAKE NOTES
BACK USING ORIGINAL BAG

RECEIPT/RETURN OF MEDICAL NOTES FORM TO BE COMPLETED AND SIGNED BY NURSE IN CHARGE AND AMBULANCE STAFF MEMBER HOSPICE STAFF TO RETURN NOTES
TO MEDICAL RECORDS/WARD
USING ORIGINAL BAG

RECEIPT/RETURN OF MEDICAL
NOTES FORM TO BE COMPLETED
AND SIGNED BY HOSPICE
DIRECTOR/WARD MANAGER AND
MEMBER OF STAFF IN MEDICAL
RECORDS

COMPLETED RECEIPT/RETURN OF MEDICAL NOTES FORM TO BE FILED IN PATIENT NOTES AND THESE TO BE ARCHIVED FOR 8 YEARS.

# Patron: HRH The Prince of Wales





## Help our Hospice

# Receipt/return of HSC Medical Records

Patient name:			DOB:	
	Date			
Records received from		Name	Designation	Signature
Records Received by Les Bourgs Hospice		Name	Designation	Signature
Records returned from Les Bourgs Hospice		Name	Designation	Signature
Records received by		Name	Designation	Signature