Shifa Medical Practice

Scanning Documents Protocol

**Document Control**

**A. Confidentiality Notice**

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**B. Document Details**

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**Purpose**This protocol aims to create a process which should be followed when scanning clinical  
documents for inclusion into patients’ records, and for non-clinically-related documentation.  
The purpose of this protocol is to ensure an accurate depiction of the original document is  
obtained, and to ensure the security, ease-of-storage and accessibility of the information in the future.

**Protocol**•Date stamp all items of post arriving at the Practice. Original documents to be retained  
after the scanning process should also be marked as ‘retained’ (see separate section  
‘Retaining Original Documents’ for exceptional reasons to retain documents).  
•Quality proofing of each original document must take place prior to the scanning process  
(see ‘Quality Proofing of Original Documents’, below). Clinical documents must be  
attached to the patient record as an image within the clinical system. Where a single  
patient document contains multiple pages, or is printed on both sides of paper, it is  
essential that every single page of the document is scanned, then the images of those  
pages are combined into one image file and attached as one multiple-page document  
image. Where more than one complete document is received for the same patient  
(whether single or multi-page documents), each must each be scanned as a separate  
image file and not be compiled together as a single image file.  
•Each document will be named in accordance with the following headers, depending  
whether the document is clinically-related or not:  
⮚Specialism (e.g. Gastro, ENT), or Consultant name (if specialism unknown), then;  
⮚Date (of the procedure itself), or episode (clinic date or consultation date). If the  
document is non-clinical or the above two dates are not apparent, the date of the  
letter should be used.  
•All documents must be scanned prior to distribution to ensure that all records are as upto-date as possible should any enquiry be made about, or relating to them.  
•Scanning takes place daily.  
•After the batch of documents has been scanned it will be marked ‘scanned’ also stating  
the doctor to whom the batch of documents has been electronically sent.  
•The clinical staff member will then highlight appropriate information for coding and pass  
the electronic document to a trained coder. The clinical staff member will also highlight  
appropriate actions that need to be taken and pass the electronic document/information  
to the appropriate team member.  
•The coder will enter appropriate Read Codes (please see Read code protocol).  
•The original document should be filed and kept for 1 complete calendar month before  
being disposed of through a confidential waste shredding and collection process.

**Quality Proofing Original Documents**

Documentation arriving at the Practice will be received in a wide variety of formats, including  
letters and photographs. The quality of this documentation may vary greatly, with various font  
sizes, colours, paper quality and inks. These may incorporate alterations, lines-through and  
misprints. Any defect in quality of an original document received may mean that a scanned  
image taken of it will not be a true representation, or reflect all of the original information.

Any quality proof undertaken must identify any potential problems in reproducing the original information on the scanned image.

The person who has responsibility for scanning documents also bears the responsibility of  
ensuring they are legible and that they contain all the information from the original.  
Original documents that show a lack of clarity should be placed together for quality checking and scanning at the end of the process, after all clearly legible documents have already been  
scanned.

The person responsible for scanning should review every scanned image, comparing each back to the original to ensure that all the information is legible. Where a good image cannot be reproduced, a further copy should be sought from the originator.   
advice should be sought from Dr Y Rashid

**Retaining Original Documents**

The following reasons can be used as a benchmark to judge whether an original document  
should be retained after the scanning process (this list is not exhaustive).  
The decision to on whether to retain documents will be made by either a GP, or the Practice  
manager.  
•Originals which are unclear to such a degree that information has not been copied across  
during the scanning process.  
•Originals which have been altered in any way, either using lines-through or correction  
fluid, where the scanned image cannot prove that the alterations had been made by the  
author on the original document.  
•Documents which contain an original signature of a patient or third party, where the  
purpose of the signature is to provide a legal authority for an act or process (e.g. Medical  
Procedure).  
•Other documents where it is determined it would be prudent to retain these.

**Third-Party Information**

Patient documents that contain information about a non-related third party (e.g. another  
patient) must be identified and, where appropriate, reference to the additional persons will be  
blanked out using black marker pen. Where this occurs, this will be indicated on the document  
immediately prior to the scanning process by the person with responsibility for scanning,  
including the nature of the edit.  
**Pre-registered, or De-registered Patients**

**Pre-registered**

Patient-related documents may be delivered to the Practice when a patient is due to register  
with the Practice, but has not yet done so. In this case, documents should be retained securely  
and checked on a daily basis against the patient list to see if registration has taken place.

**De-registered**

Where a patient-related document has been received by the Practice, but the patient is shown as being no longer registered on the patient list, the document must be clearly marked as ‘Deregistered’.

The patient’s former GP at your Practice review the document and indicate any actions to be taken. The document should then be sent to the patients new GP and originator.