

## **GUIDELINES FOR INFORMATION-SHARING AND CONSENT SIGNING WITH THE SINGLE ASSESSMENT PROCESS (Draft 1:Sept 04)**

To be used in conjunction with the Guidelines for FACE use (Draft 1:Sept 04)

### **Information Sharing Guidelines:**

Camden Protocols – At present we are all bound by Coldicott regulations (there are Coldicott guardians for health, social services and mental health). An information-sharing protocol is being developed across the trusts and a statement of good practice is imminent.

One of the key principles of SAP is that professionals in a service user's life have access to core information about the client to enhance communication between professionals, reduce duplication of assessments and documentation, and facilitate a more cohesive system of care provision.

Signing the '**Consent to Information-sharing**': The principle here is that the staff member will ensure the client is aware that professionals work in a team and not in isolation – referrals are routinely made from one profession to the next and the SAP information will be shared in order to prevent the client having to be asked these same questions over again.

If the client states that they do not want their SAP details shared with one or more professionals, the only implication is that they will be asked this information by each separate professional using the same paperwork. *They will not be excluded from access to services if they choose not to engage with the Single Assessment Process on information sharing.*

### **SAFETY**

- If the professional assessor identifies issues of safety to the client or others, they are under an obligation to inform appropriate others even if consent has not been obtained.
- This can include if the client cannot communicate for themselves through ill health or inability to give informed consent. The professional assessor may also have to share client information if a delay in providing services may endanger the client or others.
- A simple statement explaining these principles of information sharing will accompany the patient held record.

## **Writing, keeping and sending records**

Information can be gathered through Documentation Training available through the Trust. Key issues are as follows:

### Writing:

- Black biro pen to be used for hand-written documentation
- No tipex to be used
- Errors to be corrected by single line deletion followed by signature and date.
- No lines to be left blank in continuation sheet documentation and all input to be chronological
- Each page of paperwork has to be client identifiable – name and date of birth.
- All client ID numbers will, in the future, be their NHS numbers as this is the only unique identifier allocated from birth.

### Storage:

Each profession has its own professional code of conduct relating to documentation and holding client-identified information

Key issues are as follows:

- notes to be kept in lockable files
- notes should not be left on open desks.
- Faxes should be standard paper as ink on fax paper fades
- No client-identified information should be left unattended in areas open to the public

### Delivery of client-identifiable information:

- Faxes to be sent with cover sheet stating confidentiality disclaimer
- Fax machines receiving patient identifiable information are within offices which are not accessed by the public.
- External post is sent in sealed envelopes with a return address clearly marked.
- Using the telephone - not divulging any personal information regarding a named person without having established the professional or legal status of that person.
- There are no firewalls or safety systems in place for the transference of client-identifiable information across different IT systems in Camden. No information can therefore be delivered via email at present, unless it is within the same safeguarded system.