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**PROTOCOL FOR STAFF ON THE USE OF THE SINGLE ASSESSMENT  
PROCESS  
PERSON HELD RECORD (PHR) IN WALTHAM FOREST**

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**PROTOCOL FOR STAFF ON THE USE OF THE SINGLE ASSESSMENT  
PROCESS  
PERSON HELD RECORD (PHR) BY STAFF WITHIN THE PRIMARY CARE  
TRUST AND SOCIAL CARE**

**1.0 STATEMENT OF PURPOSE**

Every adult, over the age of 18 years, who is the subject of a multi-disciplinary or multi-agency assessment process, must be provided with a Person Held Record folder. This will allow efficient and safe storage of assessment records and other related documentation by the assessed person. At his or her discretion, it will prevent duplication and support the practice of information sharing between the individual and practitioners of various agencies through provision of a recognisable standardised format.

**The detail of information held in the folder will follow the principle of being proportionate to the individual's needs.**

**Standard needs:** If an individual has only single agency involvement, a simple folder will be issued with a copy of the contact assessment, summary of needs identified by the overview assessment, and a care plan and any relevant information or advice leaflets, such as complaints and access to records.

**Complex needs:** If an individual has multi-agency involvement, including individuals in receipt of a care co-ordination or intensive case management service, a more robust plastic binder will be issued, which will help to organise the more detailed information contained.

The folder and its contents will be the property of the assessed person, although certain clearly identified paperwork within it may remain the property of the issuing organisation (e.g. nursing records, subject to any future changes in PCT procedures). Access to the information within the folder will be covered by the Single Assessment Information Sharing Protocol (version 12 July 2006), and specifically by agreement of the assessed person as.

**2.0 SCOPE**

This policy applies to all clinical and social care staff involved with the assessment, care and treatment of adults and older people who fall within the Single Assessment Process.

**3.0 RESPONSIBILITIES**

### **3.1 Managers of social work assessment and community matron teams**

Operational managers of these teams must ensure that their team or service has administrative processes and documentation in place to comply with the storing and issuing of the integrated person held record folders.

### **3.2 Individual Practitioners**

All members of staff involved with the care of adults have a responsibility to:

- ensure that they understand when a PHR should be provided and can provide one promptly;
- help individuals to understand the benefit to their own care afforded by use of the PHR and encourage them to keep the folder secure;
- ensure that they make every effort to determine whether their patient already has a PHR, and whether consent exists for them to access the information held within it;
- ensure that their own recording takes into account the PHR content, updates and/or supplements it, avoids duplication and is in keeping with evidence based best practice for record keeping;
- ensure that documentation is only removed from the PHR with the assessed person's agreement;
- encourage the patient to take the record with them to relevant appointments, eg with GPs and other health and social care professionals, on admission to hospital etc;
- explain that the ambulance service may request that the record accompanies the patient in the event of an emergency hospital admission from home;
- offer support to people who are unable to manage the upkeep of their record by helping with inserting new documents or removing out of date information.

## **4.0 PROCEDURE**

### **4.1 Issuing the Person Held Record**

4.1.1 The PHR plastic binder will be issued on those occasions when it is clear that:

- more than one professional group will be involved in assessment or delivery of care
- the person has complex health and social care needs, or complex long term conditions requiring intensive case management or care co-ordination.
- the assessed person consents to some level of information sharing between different professional groups or organisations bounded by the provisions of the Single Assessment Information Sharing Protocol, and their agreement is documented on the Contact or Overview Forms.

4.1.2 The PHR will generally be issued by the practitioner who undertakes the overview assessment. However, there will be circumstances when additional practitioners become involved only at a later stage. In these cases the subsequent practitioner should ensure that consent to share information is discussed, the agreed level of consent documented on the Contact or Overview Assessment Forms, and the PHR issued.

## **4.2 Inserting Information**

### **All Person Held Records**

4.2.1 The following documents are included in all PHR's prior to any assessment documentation being issued. These are:

- 'Your Personal Record' which explains to the person receiving services what the PHR is and what it is used for
- Important contact details
- Messages Sheet for the individual, their 'informal' carer(s) and professionals to communicate with each other about ongoing issues with the implementation of their treatment and care plans.

4.2.2 When documentation is completed by the practitioner and given to the assessed person to keep as their own property, the practitioner must also retain a copy of that information (either on paper or electronically within their own recording keeping system).

### **Standard Person Held Records**

4.2.4 The Standard PHR will contain dividers for the following documents:

- The Contact assessment and basic personal information
- Summary of needs from the Overview assessment or re-assessment
- Care Plan

- Home care documentation
- Other documentation.

The practitioner responsible for the assessment/re-assessment will send the folder out by post following the completion of the care plan with as much information inserted into the relevant sections as is possible at the time of sending. The standard PHR will be checked with the individual service user at the initial Fair Access to Care Services (FACS) statutory review meeting.

- 4.2.5 If the individual is in receipt of a home care service, the home care provider is responsible for inserting their service plan and accompanying documentation into the relevant 'home care' section of the Standard PHR.
- 4.2.6 If Specialist assessors, such as District nursing or Occupational Therapists become involved at a later date the practitioner responsible for the specialist assessment must insert a summary of their specialist assessment, together with their action plan or summary of intended action in the 'other' section of the PHR.
- 4.2.7 The specialist practitioner is also responsible for inserting the name of their speciality and contact details in the 'Important Contact Details' page and for deleting it when their involvement is ended and the person discharged from their service.

### **Complex Person Held Records**

4.2.8 The complex PHR will contain dividers for the following documents:

- Shared Care Timetable
- The Contact assessment and basic personal information
- Summary of needs from the Overview assessment or re-assessment
- Joint Care Plan
- District nursing
- Home Care
- Medical
- Therapies
- Shared Reviews
- Other

The practitioner responsible for co-ordinating the comprehensive assessment and care co-ordinating (social worker) or case managing (community matron) will be responsible for ensuring the PHR has all of the relevant documents inserted. Due to the complex nature of the situation it is unlikely that the PHR will be able to be completed at a particular point in time and is more likely to be a process than a one-off event. The PHR should be started as soon as the assessment is

completed and reviewed as an integral part of the review of the care co-ordination or case management service.

If the practitioner responsible for delivering the care co-ordination or case management is not the same as the practitioner who had co-ordinated the comprehensive assessment the responsibility for completing the PHR should be formally handed over as part of the case transfer arrangements.

### **4.3 Ownership and Responsibility**

4.3.1 The folder is the person's own property, but practitioners should help by filing information or removing outdated material if requested or necessary.

4.3.2 While a practitioner holds the role of care co-ordinator or case manager, that person would be assumed to be the person primarily responsible for assisting with the maintenance of the PHR. If a co-ordination role is not required, each practitioner involved with the person's care should adopt a proactive approach to helping the person maintain the record in a useful manner.

4.3.3 Any inserted record which remains the property of an issuing organisation (e.g. nursing record) must not be removed by anyone other than the appropriate practitioner. Such records will be removed when the episode of care terminates, and a discharge summary left to show the care delivered. All other records should remain in place.

4.3.4 The remainder of the PHR remains the property of the assessed person, who is free to use it as he/she wishes.

### **4.4 Access to the Person Held Record**

#### **Consent.**

4.4.1 The individual will have already given consent to sharing their information at

the assessment stage. If they have given consent and placed no restrictions on the scope of information sharing a PHR should be issued and the individual encouraged to share it with all professionals involved in their individual care.

4.4.2 If an individual has refused for information to be shared with other professionals it will be inappropriate to issue a PHR to this individual. Instead any relevant documentation that services are statutorily required to send a service user, for example, summary of needs and care plan for Community Care service users, should be sent directly to the individual but not put in a PHR.

4.4.3 If an individual has placed limitations on the sharing of information this should be clearly recorded on the consent form in the PHR.

4.4.3i If the individual has out a limitation on **what** information can be shared, the “limited” information should not be included within the PHR and should not to be shared as specified by the person.

4.4.3ii If the individual has placed a limitation on **who** information can be shared with this should also be clearly recorded on the consent form in the PHR.

The individual service user should limit access to their PHR to the professionals specified by them on their consent form. The service user and practitioner when discussing consent should consider the practicality of achieving this. If it is agreed that this would be unworkable for the individual to control in practice it may be inappropriate to use a PHR in these situations.

Instead any relevant documentation that services are statutorily required to send a service user, for example, summary of needs and care plan for Community Care service users, should be sent directly to the individual but not put in a PHR.

4.4.4 Where the assessed person lacks either mental or physical capacity to control access to the record, the care co-ordinator/case manager or practitioner having the most significant involvement should organise PHR access in the best interests of the assessed person. The principles of both person-centred care and risk assessment, together with policies of Health and Safety, and Data Protection should be adhered to.

4.4.5 The issue of capacity should be addressed and recorded within the risk assessment episode of the overview assessment.

4.4.6 If the practitioner professionally judges that it is not safe to leave a PHR in the person’s home, the evidence should be clearly documented on the person’s risk assessment and the decision agreed with their supervisor and recorded in the person’s case notes.

#### **Access by Personnel in a Provider Role**

4.4.7 Personnel acting only in the role of ‘provider’ may refer to the information contained in the PHR only with the agreement of the person concerned, provided that the consent agreement does not preclude this.

### **Access outside of the Person's home**

- 4.4.8 Individuals should be encouraged to take their folders to appointments with GPs, at hospitals and other health settings, and make them be available during in-patient admissions.
- 4.4.9 With the individual's consent, the existence and whereabouts of the PHR will be made known to emergency services via "The Message in a Bottle" system in order that if the person is unconscious or otherwise unable to give information at the time of the arrival of an emergency service information in the PHR will be available.
- 4.4.10 When any subsequent practitioners access the PHR they should carefully check the current accuracy of the information.
- 4.4.11 In any future episode of care, the PHR should be updated with fresh, or clearly amended, documentation.
- 4.4.12 In any future episode of care the issue of agreement to share information should be revisited and reviewed and any changes recorded and acted upon in relation to information contained in the PHR as outlined in sections 4.5.1 to 4.5.4 above.

### **Access by family members and friends**

- 4.4.13 Family members, carers and friends do not have an automatic right to read information about the individual contained in the PHR without the consent of the individual.
- 4.4.14 The service user and practitioner when discussing consent should consider the practicality of achieving this. If the individual does not want their family and friends to have access to their PHR AND it is agreed that this would be unworkable for the individual to control in practice it may be inappropriate to use a PHR in these situations.
- 4.4.15 If the individual has a care co-ordinator or intensive case manager, the practitioners can offer to keep the PHR and bring to review meetings for the individual to access.
- 4.4.16 In other situations any relevant documentation that services are statutorily required to send a service user, for example, summary of needs and care plan for Community Care service users, should be sent directly to the individual but not put in a PHR.

## **4.5 Terminating Use of the Person Held Record**

- 4.5.1 When delivery of all care or treatment ceases, the folder and record remain the property of the assessed person with the exception of nursing or other clinical records (c.f. 4.4.3).
- 4.5.2 If it is not thought necessary, prior to the completion of care or treatment, for the role of care co-ordinator/case manager to continue, and if the assessed person lacks either mental or physical capacity to control access to the record, the practitioner should use their professional judgement to consider whether or not the PHR should be left in the person's home at all.
- 4.5.3 Following the death of the assessed person, the folder becomes part of that person's estate.

## **5.0 SUCCESS INDICATORS and GOVERNANCE ARRANGEMENTS**

- 5.1 It is the responsibility of relevant line managers to monitor compliance with this policy and procedures within their area, and to ensure actions are taken to address non-compliance issues.
- 5.2 Auditing PHRs should be built into existing quality assurance frameworks to identify and provide evidence that
- Users understand the purpose of their PHR.
  - Users are satisfied that their PHR comprehensively reflects their experience.
  - Agreement exists for information sharing between professionals and agencies.
  - Duplication of basic personal information in peoples' homes is reduced.
  - PHR available to professionals at appointments with the individual.
  - Copies of summary of needs, care plans or statements of service delivery are available and filed appropriately within the PHR.
  - Best practice in record keeping is maintained.
- 5.3 The outcomes of the auditing will be reported to the Single Assessment Project Board and the Long Term Conditions Boards. These Boards will recommend any change action to be implemented by operational teams.

**6.0 REFERENCES**

This policy should be read in conjunction with the following documentation:

- The Waltham Forest Single Assessment Process Information Sharing protocol.

This policy and procedure will be reviewed in .....

Signed (following approval by and on behalf of the SAP Board):

.....

Date:

Review Date:

Person responsible for review: