Trust Naming Convention

Contents

Overview

It is important that all documents are saved in the Client's record in a specific format. This should include the Division, Service ID, a hyphen & a meaningful succinct descriptor of the document.
e.g. "C&F CCNPC - Letter to GP"

Document Upload Guidance	
Author	Enter the name (or Service) of the author of the document
Document Title	Follow the Trust Naming Convention (see examples below)
Document Date	Date entered on the document – it is not the upload date
Document Type	BCHC Document Type (see examples below)
Description	Non-mandated (use as required)

Examples of Trust Naming Convention

	Division Initials	*SPACE*	**Service Abbreviation**	**-**	**A short, succinct descriptor**
BCHC documents Admin/Clinical					
"CF CCNPC - Letter to GP" "R ACT - Appointment letter"	CF R		CCNPC ACT	-	CCNPC Appointment Letter
External documents					
"Client - Food diary " "HH - Orthopaedics discharge summary"			Client HH	-	Food diary Orthopaedics discharge summary

BCHC Document Type Examples

Type	Description
BCHC Admin	Documentation relating to non-clinical correspondence originating from BCHC (appointment letters; billing; financials; labels; not specified; other correspondence)
BCHC Clinical	Documentation relating to clinical correspondence originating from BCHC (Clinical summary; body map; care plan & crisis plan; case notes; charts; clinic letters; clinical community screening notes; discharge summary; medication; MHA documents; other correspondence; referral document; referral letter; reports/assessments; restricted documents; waiting list letter; X-ray reports)
BCHC/SCR-Clinical Docs	Clinical assessments /clinical letters/summaries that would benefit from being shared more widely with other Healthcare Professionals across the ICS via the Shared Care Record
BCHC/SCR – Discharge Docs	D/C summaries that would benefit from being shared more widely with other Healthcare Professionals across the ICS via the Shared Care Record
BCHC/SCR – Care Plan	Patient Care/Intervention /Action Plans which would benefit from being shared more widely with other Healthcare Professionals across the ICS via the Shared Care Record
BCHC/PP – Apt Letter	Patient appointment letters to be shared with the Patient via the Patient Engagement Portal (PEP)
BCHC/PP - Info	Patient information leaflets/documents to be shared with the Patient via the Patient Engagement Portal (PEP)
Consent	Documentation relating to Consent (Copies of signed consent forms; consent to photograph; consent to share information; consent to treatment; best interest)
External Documents	Documentation relating to Clinical correspondence originating from outside of BCHC (Hospital notes; other correspondence; self-assessment; police report; received documents; refugee status; student visa; visitor permit; work permit)
Genogram	Documentation genogram
Historic Documents	Documentation relating to historic records (Transfers in; historic paper records; temporary notes)
Images	Images to include equipment etc, NB this **excludes** Photo ID for the purpose meds administration
Lab Results	Documentation relating to TEST RESULTS (Test/investigation results)
Photo ID	Documentation Photo ID (specifically for the purpose of ID during Meds administration)

Trust Naming Convention

Type	Description
Safeguarding	Documentation relating to safeguarding (Risk related to safeguarding; safeguarding adult; safeguarding children; TAC documents)
Children in Care	Documentation relating to adoption & fostering only
EHCP – Education Healthcare Plan	Documentation relating to EHCP
Early Years / Early Help	Documentation relating to Early Years Service (Children's Centres)
PSAS (Confidential)	RESTRICTED ACCESS - named staff (PSAS STAFF ONLY - NAMED USERS ONLY)
Psychiatric Confidential Documents	RESTRICTED ACCESS - named staff (RESTRICTED ACCESS - NAMED USERS ONLY)