

Health Records Policy

Date	Version
April 2016	4.4

Purpose

To ensure that health records management, both paper and electronic, complies with regulatory and operational requirements.

Who should read this document?

All staff who handle the paper health record and/or view and amend electronic health records

Key messages

This document details Trust policy on the completion, use, tracking, storage, retrieval, archiving and disposal of clinical records and details the responsibilities of all users to ensure that all records are:

- secure
- retained and disposed of appropriately
- available when needed
- can be interpreted
- can be trusted
- can be appropriately maintained through time

Accountabilities

Production	Head of Health Records and eNotes Implementation
Review and approval	Paper Records Transformation Group
Ratification	Director of Planning & Site Services
Dissemination	Head of Health Records and eNotes Implementation
Compliance	Caldicott and Information Governance Assurance Committee

Links to other policies and procedures

Clinical Record Keeping Policy
 Information Governance Formal Documents
 System Level Security Policies
 APNs
 Release of Patient Case-notes
 Filing of Loose Sheets
 Moving Patient Case-notes (Patient Documents)
 Notification of Additional Health Records
 Patients who want to access or obtain a copy of their own Hospital Records
 Restricted Access and Site Security Central Records Library (Bush Park)
 Retention and Destruction of Case-notes
 Splitting Oversized Case-note Folders (Excess Folders)
 Storage and Tracing of Sensitive Case-notes
 Raising a New Case-note Folder
 How to Request Notes from the Central Records Library (CRL)
 Checking patient details and reception of patients
 Registration of Patients on iPM

Version History

Draft 1.2	April 2011	1 st Draft – Associate Director of Patient Administration.
Draft 1.2	May 2011	2 nd Draft – Records Services Manager
1.2	June 2011	Approved by the Paper Records Transformation Group
1.3	Feb 2012	Reviewed and amended by Records Services Manager
2.1	May 2012	Reviewed by Records Services Manager

3	April 2015	Reviewed and amended by Head of Health Records and eNotes Implementation to include changed roles, reference to the Records Management Code of Practice Review and to the eNotes Programme.
3	April 2015	Ratified by the Director of Planning & Site Services
3	April 2015	Approved by the Paper Records Transformation Group
4	April 2016	Reviewed by Central Records Library Manager
4.1	December 2018	Extended to March 2019
4.2	April 2019	Extended to July 2019
4.3	September 2019	Extended to September 2019
4.4	November 2019	Extended to December 2019
Last Approval		Due for Review
April 2016		Extended to December 2019

PHNT is committed to creating a fully inclusive and accessible service.

Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff.

We will treat people with dignity and respect, actively promote equality and diversity, and eliminate all forms of discrimination regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/ maternity.

An electronic version of this document is available on the Trust Documents. Larger text, Braille and Audio versions can be made available upon request.

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1 Introduction

- 1.1. All NHS health records are public records under the terms of the Public Records Act 1958. The Trust needs robust records management policies and procedures to meet legal, regulatory and NHS requirements.
- 1.2. Accurate, up to date and accessible information is essential to the planning and delivery of high quality patient care and so effective records management is vital.
- 1.3. All NHS staff have a responsibility to manage health records in line with this policy, from the creation of a record to its ultimate disposal.

2 Purpose, including legal or regulatory background

2.1 To ensure that health records management complies with regulatory, legal and best practice requirements (encompassed by the *Records Management: NHS Code of Practice 2006*)¹ and that records:

- Are secure
- Are retained and disposed of appropriately
- Are available when needed
- Can be trusted
- Can be maintained through time

And that staff are trained in health records management in accordance with the Policy.

2.2 The Trust is required to meet various regulatory standards relating to records, these include:

- NHSLA Risk Management Standards²
- Care Quality Commission (CQC) standards
- Information Governance Toolkit Compliance

These standards apply to any member of staff who handle or enter information into the Health Record.

Standards specifically relating to the content of health records in case-notes are detailed within the **Clinical Record Keeping Policy**.

3 Definitions

3.1 Health Record

The Data Protection Act 1998, describes the Health Record as “consisting of information about the physical and mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual”. The Trust stores health records in paper format within

¹ The Records Management NHS Code of Practice 2006 is currently under Review. This policy will be updated and amended once the review and recommendations are published. A National working group has been formed under the Information Governance Alliance (IGA) banner and is looking at streamlining the retention schedule, developing a business classification scheme for the NHS and producing guidance where the existing Code could not have foreseen developments in technology.

² NHSLA Records Standards. Whilst these standards continue to reflect good practice they are no longer updated or monitored by the NHSLA.

case-note folders and on various electronic systems. The key electronic system is iPM which is the main Patient Administration System for the Trust.

3.2 Administrative Procedure Notes (APN's)

Are a series of procedural documents that detail the way staff should carry out certain duties. The APN's, referred to, throughout this policy, are available to all staff via Trust Documents on Staffnet (which is the Trusts Intranet).

3.3 System Level Security Policies

These are documents that detail the technical and operational Information governance components of the various key electronic patient record held by the Trust. These documents are maintained and held by the respective System Managers

3.4 Records Management

This is the process by which an organisation manages records in any format or media type, from their creation to their eventual disposal. The key components of records management are:

- record creation
- record accuracy
- record keeping
- record maintenance (including tracking of record movements)
- access and disclosure
- closure and transfer
- appraisal
- archiving
- disposal

4 Duties

4.1 The Trust Board

The Trust Board will seek assurance relating to the management of the Health Record via the Director of Planning and Site Services.

4.2 Chief Executive

Is ultimately responsible for the quality of the health record delegated via the:

4.3 Senior Information Risk Owner (SIRO)

Is the Director of Corporate Business and takes ownership of Information Risk on behalf of the Trust. .

4.4 Head of Clinical Systems Governance

Is responsible for:

- Information Governance within the Trust.

4.5 Head of Health Records & eNotes Implementation

Is responsible for:

- developing health records policies and procedures for case-notes

- coordinating audit activity relating to health records management of case-notes in conjunction with Directorate managers
- providing assurance in relation to the CQC Records Standards to the Paper Records Transformation Group and the Caldicott and Information Governance Assurance Committee.

4.6 Central Records Library (CRL)

CRL staff will support departments with the retrieval, storage and re-filing of the health record but are not responsible for the security, maintenance (including filing into the records) and completeness of the record whilst outside of the Central Records Library.

CRL staff will ensure that records stored within the CRL facility are traced and filed appropriately, are available when needed and dispatched in a timely manner to avoid undue delay to the assessment of patient needs by health professionals.

4.7 All Directorate Managers and Heads of Department

Are responsible for promoting health records management and ensuring there are operational systems in place within their teams to fulfil the requirements of this policy. This includes ensuring staff receive appropriate training, in the management of health records and developing, implementing and monitoring any action plans required as a result of spot-checks and audits on wards and in departments and feeding back all actions to the Paper Records Transformation Group.

4.8 Clinical Systems Manager

Is responsible for providing the Paper Records Transformation Group with biannual information on the existence of duplicate health records.

4.9 Legal Department

The Legal department deal with all subject access requests both by data subjects and solicitors.

4.10 Data Quality (DQ) Team

The Data Quality Team is responsible for reviewing and monitoring the quality of information regarding the creation, accuracy and management of electronic records on the Trust's Patient Information System (iPM) using the suite of DQ Reports. These reports are discussed at a monthly Data Quality Steering Group and the action plan relating to compliance and effectiveness is managed monthly by this Group. Reports are discussed and major issues are escalated via the Caldicott and Information Governance Assurance Committee.

4.11 All staff

All staff who handle records have a duty to:

- Protect patient confidentiality and records security.
- Take all reasonable precautions to ensure that the records entered are accurate
- Ensure that notes in their care are in a good physical condition ensuring that the folder is robust and that all relevant documentation is filed securely within the record.
- Ensure that records held within their department are traced and filed appropriately, are available when needed and dispatched in a timely manner to avoid undue delay to the assessment of patient needs by health professionals.

- Report records / information related incidents on the Datix System

5 Key elements

5.1 Storage of Health Records

5.1.1 Central Records Library, Bush Park

The Central Records Library is the Trust's primary off-site store for Health Records. CRL staff will ensure that records stored within the CRL are traced and filed appropriately, are available when needed and dispatched in a timely manner when needed to avoid undue delay to patient care.

5.1.2 Storage of case-notes in other areas

All staff that handle records must ensure that records held within their department are:

- Secure (i.e. never left unattended in public places and accessible on a strictly need to know basis)
- Traced in on receipt and out on dispatch on iPM
- Are available when needed and dispatched in a timely manner to avoid undue delay to patient care

5.1.3 Information Governance

Please refer to the Trust's suite of formal Information Governance documents for further details on the security and governance of personal information.

5.2 Health Records Creation and Identification

5.2.1 A new patient record (paper case note and an electronic iPM record) will be created by the receiving department when a new patient is referred to the hospital and is not already registered on iPM with a current set of notes. This may be when the patient attends the hospital for an Inpatient/Day-case or an Outpatient Appointment.

5.2.2 Each patient registered on iPM is allocated a unique identification number (the Hospital Number) and this will be used in conjunction with the NHS Number. All other electronic systems use the NHS number as well as other identifiers.

5.2.3 Emergency admissions, not registered, will have case-notes created either by the Emergency Department (if being admitted to the hospital) or by the admitting Ward. If the patient cannot be identified then staff should refer to the 'Registration of Unidentified Patients Policy' available on Trust Documents on Staffnet.

5.2.4 New Electronic Health Records will be created on other Trust electronic systems, aside from iPM, as required to support the patient care.

5.2.5 It is essential that new episodes of care for existing Patients are always added to the existing Patient Record. Creating a new record will lead to duplication and compromise the integrity of the Patient's record.

5.3 Management of Patient Records

5.3.1 For iPM and casenotes, this is governed by Administrative Procedure Notes (APN's) which are held on Trust Documents on Staffnet.

5.3.2 Other electronic Patient Record Systems are managed by the respective Systems Managers who detail the governance in the System Level Security Policy.

5.4 Retention, Disposal and Destruction of Case-notes

5.4.1 The Trust adheres to the minimum retention periods set out in the Records Management NHS Code of Practice 2006 (part 2).³ There are three principal options regarding how to process a record that has exceeded its minimum retention period:

- **Destroy**

When a record meets its minimum retention time it would usually be destroyed in accordance with agreed Trust procedures (see APN) unless the Paper Records Transformation Group has agreed that the records should be retained for a further period.

- **Dispose** (i.e. by passing on to another organisation)

This only applies to records belonging to Service Personnel. These are retained until the appropriate retention period expires and are then sent securely to MOD Shoeburyness to be processed.

- **Retain for a further period**

Where a record type is not listed or a health professional requires that specific records be retained beyond the minimum retention time, then this should be brought to the attention of the Trust's Head of Health Records & eNotes Implementation.

5.4.2 The Paper Records Transformation Group will make the final decision on such matters in order to balance the interests of professional staff, the resources available for storage and give consideration to the fifth principle of the Data Protection Act, i.e. that 'Personal data ... shall not be kept for longer than is necessary for that purpose or those purposes'. Such decisions will be clearly documented in the minutes of the meeting.

5.4.3 The Trust has a Records Maintenance and Archive Service based within the Central Records Library. Members of this team have been specially trained to process Health Records according to agreed national and local requirements and are therefore the only members of Trust staff authorised to undertake the archiving, destruction and/or disposal of Health Records.

5.4.4 The Records Maintenance and Archive Service will ensure that a permanent record of the destruction and disposal of patient case-notes is entered onto iPM and that secure destruction certificates are obtained whenever notes are taken away to be destroyed.

5.4.5 Retention, Disposal and Destruction arrangements for records held on electronic systems are detailed in the respective System Level Security Policy.

5.5 Health Records Training

5.5.1 All staff who trace records on iPM will be required to attend mandatory Case-note Training. Attendance is recorded on the Electronic Staff Record Learning Management System (OLM).

5.5.2 Information Governance training is mandatory and is incorporated in Trust Induction and Mandatory Training. Completion is recorded on OLM.

³ See Footnote 1

5.5.3 All staff who use iPM in the course of their work are required to attend the relevant modular systems training before access is given to the system. Attendance is recorded on OLM. Comprehensive manuals and eLearning are available for each iPM module.

5.5.4 Training to use other electronic systems will be provided by the relevant system managers.

5.6 Electronic Case notes

In February 2015 the Trust embarked on a programme of work that will include:

- The replacement of the PHNT paper case note, on a phased basis, whilst ensuring continuation of current patient services.
- Deployment of the eNotes software, scanning solution software and all related hardware.
- An informed decision relating to the most appropriate scanning strategy for the Trust. This will be scaled appropriately to deal with bulk uploads of current folders and include scanning of new paper generated on an on-going basis.
- An on-going process for uploading newly created documents to the digitised Health Record.
- Each document in use will then have a unique bar code showing the form type, patient identity and encounter reference. Forms will be held in temporary folders until the patient encounter is over and will then will be scanned and uploaded within 24 hours of the attendance. The unique bar codes enable the form to be automatically indexed.
- Management of all Health Records related issues which will result from the administrative changes to the management of electronic records instead of paper.
- Training of all clinical, administration and managerial staff in the use of the eNotes system.

As the eNotes programme gains momentum this policy will be reviewed and updated to include any significant changes to the Health Records process.

6 Overall Responsibility for the Document

6.1 The Caldicott and Information Governance Assurance Committee (chaired by the Trust SIRO)

Receives assurance from the **Paper Records Transformation Group**. This group's Terms of Reference state that they will assure The Caldicott and Information Governance Assurance Committee, via monthly updates to that meeting, that effective systems and processes are in place to manage the Trust's information assets, in particular:

- IG Toolkit Assurance
- CQC Records Management Assurance
- Policy Control
- Freedom of Information (FOI)
- Risk Management Assurance for all of the above.

6.2 The Paper Records Transformation Group is responsible for:

- Approving the pilot stage of all newly developed or amended documents and approving documents for official use in the case note across the Trust. This will include suggesting standardisation (logo, format etc) of design and production and maintaining a master list of approved documents.
- Overseeing compliance with Health Records Audit action plans and providing assurance to the Caldicott and Information Governance Assurance Committee.

7 Consultation and Ratification

The design and review process of this policy document will comply with The Development and Management of Trust Wide Documents.

The review period for this document is set at three years since the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the policy described.

This document will be approved and reviewed by the Paper Records Transformation Group (PRTG) and ratified by the Director of Planning and Site Services.

Non-significant amendments to this document may be made with delegated authority from the Head of Health Records and eNotes Implementation, to the nominated author. These must be ratified by the Director of Planning and Site Services and reported retrospectively to the PRTG.

Significant reviews and revisions to this document will include a consultation with all sub-groups of the Caldicott and Information Governance Assurance Committee. For non-significant amendments consultation will be restricted to the PRTG.

8 Dissemination and Implementation

Following approval and ratification this policy has been

- Rolled out across the Trust.
- Publicised in Vital Signs the Trusts weekly staff news briefing.
- Made available on Trust Documents on Staffnet.
- The Policy will be highlighted in the Records Management and the Information Governance Training and at Trust wide Induction and mandatory training.

9 Monitoring compliance and effectiveness

Compliance with this policy will be monitored as follows:

- a. **The process for tracking and availability of records is monitored by:**
 - i. A twice yearly audit of random tracings on the iPM System. This is carried out by the Head of Health Records and eNotes Implementation, who reviews the current tracings of 50 Hospital case-notes and reports the results to the Paper Records Transformation Group.
 - ii. A yearly review of misfile searches within the CRL will be conducted by the Head of Health Records and eNotes Implementation and reported to the Paper Records Transformation Group.
 - iii. A twice yearly review of record availability for planned appointments and emergency admissions will be conducted by the Head of Health

Records and eNotes Implementation and reported to the Paper Records Transformation Group

- iv. A twice yearly review of records required for internal and external patient transfers will be conducted by the Senior Operations Manager responsible for patient transfers and reported to the Paper Records Transformation Group. This will involve conducting random spot checks to ensure that all regulatory requirements have been met and talking to other health providers to review their experience of information transfers.
- b. **The physical condition of case-notes and filing of loose sheets** will be reviewed by the Head of Health Records and eNotes Implementation and reported to the Paper Records Transformation Group on a twice yearly basis. This review will be based on intelligence gathered from ward spot-checks and audits.
- c. **Duplicate and /or mixed patient registrations** will be reviewed by the Deputy Clinical Systems Manager on a regular basis with an update to each Data Quality Steering Group. This will in turn be reported to the Caldicott & Information Governance Group by the chair of the Data Quality Steering group as part of regular reporting.
- d. **The creation, accuracy and management of electronic records** is monitored and reported on by the Data Quality Team and relevant Systems Managers. These reports are presented to the monthly Data Quality Steering Group (DQSG) as part of a rolling programme designed to assure the group that the data quality arrangements described by relevant system level policies are appropriate, effective and implemented in practice. The Data Quality Steering Group will report levels of compliance / non-compliance to the Caldicott and Information Governance Assurance Committee.
- e. **The Process for retrieving records** is monitored by an annual audit conducted by the Clinical Audit Department. The results will be reported to the Paper Records Transformation Group who will review and action the results.
- f. **The processes for retention, disposal and destruction** of case-notes are monitored via quarterly spot-checks within the Central Records Library and reported directly to the Head of Health Records and eNotes Implementation who will in turn report to the Paper Records Transformation Group. The processes for retention and destruction of electronic health records are monitored by the Head of Clinical Systems Governance who reports any associated compliance issues to the Caldicott and Information Governance Committee. The process for subject access requests will be reviewed yearly by the Head of Health Records and eNotes Implementation and reported to the Caldicott and Information Governance Assurance Committee.
- g. **The process for reporting incidents and complaints** related to the physical and electronic patient record will be reviewed by the Head of Clinical Systems Governance on a yearly basis and reported to the Head of Health Records and eNotes Implementation and reported to the Paper Records Transformation Group.
- h. In order to monitor the effectiveness of the processes relating to case-notes the Paper Records Transformation Group agenda will include an annual audit by the Clinical Audit Department of compliance with this

policy. This will encompass all of the above monitoring and consider other local knowledge based on feedback from staff and service users.

- i. The Paper Records Transformation Group will commission ad hoc Audits when issues relating to paper record keeping are brought to their attention.
- j. Ongoing review and implementation of recommendations and actions will be overseen by the respective steering group. This will be managed in accordance with the severity and priority of the issues and reported to Caldicott and Information Governance Assurance Committee as necessary.

NB: The Quality of Clinical Record Keeping is monitored by the Clinical Audit Department who will conduct an annual audit and report to the Paper Records Transformation Group. (Please see the Clinical Record Keeping Policy for more detail)

10 References and associated documentation

- *The Data Protection Act 1998*. London: The Stationery Box. Available at: www.opsi.gov.uk
- *The Access to Health Records Act 1990*. London: The Stationery Box. Available at: www.opsi.gov.uk
- Connecting for Health (England). *Website resources*. Available at: www.connectingforhealth.nhs.uk
- Department of Health. (1999). *For the record – managing records in NHS trusts and health authorities*. London: Department of Health. Available at: www.dh.gov.uk
- Department of Health. (2006). *Records Management NHS Code of Practice. Part 1*. London: Department of Health. Available at: www.dh.gov.uk
- Department of Health. (2009). *Records Management NHS Code of Practice. Part 2. (2nd edition)*. London: Department of Health. Available at: www.dh.gov.uk

Core Information				
Document Title	Health Records Policy			
Date Finalised	02/04/2015			
Dissemination Lead	Head of Health Records and eNotes Implementation			
Previous Documents				
Previous document in use?	Electronic versions only			
Action to retrieve old copies.	Old version superseded on Trust Documents Network Share			
Dissemination Plan				
Recipient(s)	When	How	Responsibility	Progress update
All Staff	Within 4-weeks of ratification	Vital Signs	Head of Health Records and eNotes Implementation	
All Staff	Within 4-weeks of ratification	Trust Documents on Staffnet	Head of Health Records and eNotes Implementation	
All Staff	Within 4-weeks of ratification	Trust induction and mandatory training	Head of Health Records and eNotes Implementation	

Review		
Title	Is the title clear and unambiguous?	Yes
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Yes
	Does the style & format comply?	Yes
Rationale	Are reasons for development of the document stated?	Yes
Development Process	Is the method described in brief?	Yes
	Are people involved in the development identified?	Yes
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Yes
	Is there evidence of consultation with stakeholders and users?	Yes
Content	Is the objective of the document clear?	Yes
	Is the target population clear and unambiguous?	Yes
	Are the intended outcomes described?	Yes
	Are the statements clear and unambiguous?	Yes
Evidence Base	Is the type of evidence to support the document identified explicitly?	Yes
	Are key references cited and in full?	Yes
	Are supporting documents referenced?	Yes
Approval	Does the document identify which committee/group will review it?	Yes
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes
	Does the document identify which Executive Director will ratify it?	Yes
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Yes
	Does the plan include the necessary training/support to ensure compliance?	Yes
Document Control	Does the document identify where it will be held?	Yes
	Have archiving arrangements for superseded documents been addressed?	Yes
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes
	Is there a plan to review or audit compliance with the document?	Yes
Review Date	Is the review date identified?	Yes
	Is the frequency of review identified? If so is it acceptable?	Yes
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes

Core Information	
Manager	Vanessa Bennett
Directorate	IM&T
Date	02/04/2015
Title	Health Records Policy
What are the aims, objectives & projected outcomes?	<p>To support the provision of high quality care by ensuring health records management complies with the relevant legislation and regulatory requirements and that health records are:</p> <ul style="list-style-type: none"> • Secure • Retained and disposed of appropriately • Available when needed • Can be interpreted • Can be trusted • Can be maintained through time • And that staff are trained in health records management in accordance with the policy
Scope of the assessment	
<p>This policy has limited equalities and human rights impact, all staff have been consulted and this policy is available in all forms of communication upon request and contains no restriction or prejudice to any group</p>	
Collecting data	
Race	N/A
Religion	N/A
Disability	N/A
Sex	N/A
Gender Identity	N/A
Sexual Orientation	N/A
Age	N/A
Socio-Economic	N/A
Human Rights	N/A
What are the overall trends/patterns in the above data?	N/A
Specific issues and data gaps that may need to be addressed through consultation or further research	N/A
Involving and consulting stakeholders	
Internal involvement and consultation	N/A
External involvement and consultation	N/A
Impact Assessment	

Overall assessment and analysis of the evidence	N/A			
Action Plan				
Action	Owner	Risks	Completion Date	Progress update