Policy Document

Reference: Re01

University Hospitals of North Midlands NHS Trust

Multidisciplinary Health Records

Version:	**9.1**
Date Ratified:	**June 2022 by Executive Digital and Data Security & Protection Group**
Minor Amends:	**February 2023**
To Be Reviewed Before:	**June 2025**
Policy Author:	**Health Records Manager**
Executive Lead:	**Director of Digital Transformation**

Version Control Schedule

Version	Issue Date	Comments
1	October 2006	
2	July 2008	The key changes surround the storage and safeguarding of notes, EPR usage and individual responsibilities. Monitoring arrangements have also been included around Casenote availability.
3	July 2009	
4	October 2011	Approved by the Quality and Safety Forum 11/10/2011
5	January 2013	Reviewed regarding compliance with NHSLA ,CQC and internal audit requirements in line with new role of the Compliance Steering Group and G01 Trust Policy for the Development and Control of Procedural Documents.
6	November 2014	Amendment to reflect the introduction of the Clinical Information System (CIS) and Ward spot check audits
7	October 2016	Amended to reflect the introduction of iPortal
8	January 2018	Amended to incorporate the roll out of the Digitalisation Programme and new General Data Protection Regulations
9	June 2022	Reviewed and amended to reflect the new Records Management Code of Practice 2021 for the identification of records that meet the minimum retention period.
9.1	February 2023	Amended to include reference to the Standard Operating Procedure for recording of Next of Kin

Statement on Trust Policies

The latest version of 'Statement on Trust Policies' applies to this policy and can be accessed here

NHS
University Hospitals of North Midlands
NHS Trust

Review Form / Equality Impact Assessment (EIA)

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Analysis Form is designed to help consider the needs and assess the impact of each policy. To this end, EIAs will be undertaken for all policies.

Policy Reference, Title and Version Number	RE01 Multidisciplinary Health Records Policy V9
Summary of changes made on this review	Updated to incorporate the requirements of the Records management Code of Practice 2021 and IHRIM guidelines for correction of misfiled information in records.
Please list which service users, staff or other groups have been consulted with, in relation to this	Health Records team Data Security and Protection (Records Management Working Group) . Clinical Audit
Were any amendments made as a result? If yes, please specify	No
Does this policy involve the administration or control of medicines? If yes, have the Safe Meds Group been consulted with?	N/A
Which Executive Director has been consulted on?	Director of Digital Transformation

Does this policy have the potential to affect any of the groups listed below differently - please complete the below. Prompts for consideration are provided, but are not an exhaustive list

Group	Is there a potential to impact on the group? (Yes/No/Unsure)	Please explain and give examples	Actions taken to mitigate negative impact
Age (e.g. are specific age groups excluded? Would the same process affect age groups in different ways?)	No		
Gender (e.g. is gender neutral language used in the way the policy or information leaflet is written?)	n/a		
Race (e.g. any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)	n/a		
Religion & Belief (e.g. Jehovah Witness stance on blood transfusions; dietary needs that may conflict with medication offered)	n/a		
Sexual orientation (e.g. is inclusive language used? Are there different access/prevalence rates?)	n/a		
Pregnancy & Maternity (e.g. are procedures suitable for pregnant and/or breastfeeding women?)	n/a		

Group	Is there a potential to impact on the group? (Yes/No/Unsure)	Please explain and give examples	Actions taken to mitigate negative impact
Marital status/civil partnership (e.g. would there be any difference because the individual is/is not married/in a civil partnership?)	n/a		
Gender Reassignment (e.g. are there particular tests related to gender? Is confidentiality of the patient or staff member maintained?)	n/a		
Human Rights (e.g. Does it uphold the principles of Fairness, Respect, Equality, Dignity and Autonomy?)	n/a		
Carers (e.g. is sufficient notice built in so can take time off work to attend appointment?)	n/a		
Socio/economic (e.g. would there be any requirement or expectation that may not be able to be met by those on low or limited income, such as costs incurred?)	n/a		
Disability (e.g. are information/questionnaires/consent forms available in different formats upon request? Are waiting areas suitable?) Includes hearing and/or visual impairments, physical disability, neurodevelopmental impairments e.g. autism, mental health conditions, and long term conditions e.g. cancer.	n/a		
Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities? (e.g. allow extra time for appointments, allow advocates to be present in the room, having access to visual aids, removing requirement to wait in unsuitable environments, etc.)			**No**
Will this policy require a full impact assessment and action plan? (a full impact assessment will be required if you are unsure of the potential to affect a group differently, or if you believe there is a potential for it to affect a group differently and do not know how to mitigate against this - please contact the Corporate Governance Department for further information)			**No**

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1. INTRODUCTION

The aim of this policy is to ensure that all healthcare workers employed by the University Hospitals of North Midlands produce and handle records which are:

- Accurate
- Unambiguous
- Legible
- Contemporaneous
- Chronological
- Un-altered
- Relevant

The records should

- Enable the patient to receive effective care
- Allow another healthcare professional to assume the care of the patient at any time.
- Enable the patient to be identified without risk of error and in accordance with NHS standards
- Facilitates the collection of data for research , education and audit
- Provide documentary evidence in cases of legal or disciplinary action
- Comply with legal and ethical requirements
- Complies with the requirements for clinical record keeping issued by relevant professional bodies
- Complies with the requirement of the NHS Litigation Authority

2. SCOPE

This policy will apply to all areas of the Trust and all individuals employed by the Trust including contractors, voluntary workers, students, locum, bank and agency staff and those holding honorary contracts. The Policy also applies to neighbouring Trusts who utilise the medical record, (e.g. MPFT)

Clinical records may be held on both paper and electronically. The Trust's iPortal is now widely used by Clinicians across many specialties. The iPortal has the functionality to enable detailed clinical information to be recorded and therefore as such is now being used to record clinical notes in many areas particularly in Outpatient Clinics where the Digitalisation Programme has been implemented.

For the purpose of this policy, health records include:

- Notes made by doctors, dentists, nurses, midwives, allied healthcare professionals, social workers, technical and scientific staff and students
- Care plans, patient/parent held records, triage notes, charts, prescriptions, transfer/ referral records, patient property forms/books, adverse incident forms (notwithstanding that they are kept separate from the medical records and medical notes).
- Electronic records such as those held in the iPortal Clinical Information Portal and the Electronic Document Management System (EDMS)

3. DEFINITIONS

IHRIM- Institute of Health Records Information Management
EDMS – Electronic Document Management System
HTA – Human Tissue Authority
SAR – Subject Access Requests

4. LEGAL REQUIREMENTS

There are a number of statues which impact on the overall management of Health Records. These statutes place responsibilities on both the Trust and individual staff whilst also providing patients with rights relating to access to records

Data Protection Act 1990 /General Data Protection Regulations 2018

In accordance with the Data Protection Act 1998 (and GDPR from May 2018))all users of the Health Record have a legal obligation to ensure that sensitive information is processed only for the healthcare purpose in which it was generated and only accessible by those authorised to access the information.

NHS Records Management Code of Practice 2021

The code of practices outlines the range of legal and professional obligations in respect of the management and use, disclosure, retention and disposal of Medical records.

Public Records Act 1958

Medical Records are also subject to the Public Records Act 1958 which imposes a statutory duty of care directly upon all individuals who have direct responsibility for records.

In addition to the specific responsibilities previously stated, **every** member of staff who generates, handles or processes health records is responsible for:

- Correctly filing documents, they have received or generated
- Replacing folders found to be in poor condition
- Having a justifiable requirement for accessing /processing the records.

Subject Access Requests / Access to Health Records

The Data Protection Act 1998 /General Data Protection Regulations 2018 provides patients (or their specific representatives) with legal rights of access to their Health Record. Where a request is received by a patient, their representative, or organisation acting on behalf of the patient, the process to facilitate this access is managed by the Health Records Department. Where there are pending legal matters between the applicant and the Trust, such requests are usually processed by the Legal Team.

All Subject Access Requests must be processed in accordance with the General Data Protection Regulations and within the required timeframe (1 calendar month) Health Records staff involved with the processing of requests should follow the guidance with the standard operating procedure for Subject Access Requests.

Applications for access to the records of deceased patients are still processed in accordance with the Access to Health Records Act 1990 although the general principles of disclosure are applied as those processed as a Subject Access Request.

Compliance with the SARS timescales is reported monthly to the Records Management Working Group

Recording of Next of Kin within a Medical Record

There is no definition in law regarding who is next of kin to a hospital patient. A next of Kin dan be anyone they chose and may change. The purpose of recording a next of kin is primarily to know who to keep informed about a patient's condition and treatment.

The next of kin has no legal rights in relation to the patient's care and treatment. For full details please refer to the Trust's Standard Operating Procedure for Next of Kin

5. ROLES AND RESPONSIBILITIES

5.1 Unqualified Clinical staff

5.1.1 Clinical Support Workers

Clinical Support workers do not record nursing assessments, patient care plans or evaluations unless they have reached agreed levels of competence. Any documentation made to clinical notes must be countersigned by a registered practitioner. Once competent they can:

- Complete forms/charts/documentation as determined by their ward manager as appropriate.
- Record tasks undertaken as determined by their Directorate.
- Ensure patients admitted to the ward are admitted on to the Patient Administration system, ensuring that all demographic information has been obtained from the patient and verified.

5.1.2 Therapy Support Staff

Therapy assistants and technician instructors are not required to have entries countersigned by qualified staff.

5.2 Students

5.2.1 Technical /Scientific Students

Technical and Scientific Students do not make entries in health records.

5.2.2 Student Nurses and Midwives

Student Nurses and Student Midwives must always formulate care plans under the direction of a registered practitioner. Entries must be checked and countersigned.

5.2.3 Medical Students

Medical students may sign entries but must clearly label entries as “medical student”. Their entries should be subsequently checked by a doctor or other appropriately trained person.

5.3 Professionally Qualified Clinical staff (to include medical staff, Nursing, Midwives, Allied Health Professionals, Scientific and Technical Staff).

Each practitioner bears individual responsibility for:

- Their own clinical record keeping.
- Any pages added to a record have as a minimum the patient name and unique reference number
- Entries to a record are dated with the time added, and signed with the name of the individual also printed clearly.
- Ensuring that where students on non –professionally qualified staff under their supervision complete clinical documentation, the training requirements have been met and their documentation is appropriately checked and countersigned.

5.4 Local Health Economy Staff (LHE)

LHE staff have a responsibility to comply with this policy in relation to their specific role.

5.5 Medical Secretaries

Medical Secretaries are responsible for:

- Ensuring all clinical information not recorded electronically is filed securely in to the hard copy medical record
- Ensuring any records in their possession are tracked in to their location and tracked out when forwarding on to another location, or back to file, using the Electronic Casenote Tracking System

5.6 Ward Clerks

Ward Clerks are responsible for:

- Ensuring a new Inpatient folder volume is requested for a patient admission, or where a patient is transferring from another ward, the inpatient folder is obtained from the transferring ward.
- Ensuring all inpatient documentation is filed securely in to the inpatient folder before the folder leaves the ward.
- Ensure all folders are tracked in to their location on receipt, and tracked out when forwarding on to another location, or back to file, using the Electronic Casenote Tracking System.

5.7 Other Non-clinical Divisional Staff

Must have a justifiable reason for accessing the records and comply with the general principles

5.8 Health Records Department Staff

Health Records staff are responsible for:

- Filing and retrieval of records within the library to support clinical care
  - Records requested from the library will be processed in accordance with the following standards-
    - Urgent requests – processed within 2 hours
    - Non urgent requests received before 12 noon – processed same day
    - Non urgent requests received after 12-00 noon – processed before noon next working day
- Identification of records within the library that meet the requirements for archiving to the off-site secondary storage
- Identification of records that meet the minimum retention period as outlined in the NHS Records Management Code of Practice 2021 – Appendix E
- Disclosure of Medical Records in accordance with the requirements of the Data Protection Act and General Data Protection Regulations 2018 (Subject Access Requests)
- Scanning of information to the Trust's Electronic Document Management System that has been generated in clinic locations where such information is not directly added to the Electronic Record (iPortal)
- Ensuring all records received in to the Health Records Library are booked in using the Trust's Electronic Casenote Tracking System.
- Ensuring all records being sent out of the library are tracked out to the correct location using the Trust's Electronic Casenote Tracking System.

5.9 Divisional Auditors

Ensure that Audits are undertaken in relation to the standard of record keeping within their Division and recommendations made where improvements are required.

5.10 Divisional Governance and Quality Managers

- Ensure that incidents that arise within the Division relating to Health Records are investigated appropriately.
- That Clinical Audits are reviewed and actions developed where deficiencies are identified.

5.11 Clinical Directors & Matrons

Clinical Directors and Matrons are responsible for :

- Providing suitable means to enable recording of care planning, intervention and evaluation in line with the Trusts Multi-Disciplinary health records standards
- Ensuring that a programme of audit occurs and outcomes of such audits are reviewed and ensuring that appropriate action is taken to address any shortcomings in record keeping stands that arise from the audits.
- Ensuring the results of the audits of record keeping are reviewed by the Division

5.12 Associate Directors/Directorate Managers/Divisional Senior Nurses

Associate Directors/Directorate Managers/Divisional Senior Nurses are responsible for:

- The overall standard of record keeping within their Division, including the recording of information, the filing of documentation and maintenance of records in accordance with the Trust's Multi Disciplinary health records standards – appendix B
- Ensuring that all Divisional staff with a responsibility for Health Records functions file information appropriately within the medical record.
- Ensure all areas return records to file in a timely manner.
- Ensure that all Divisional staff with a responsibility for Health Records functions utilise the Electronic Casenote Tracking system to ensure a complete audit trail is maintained for the records whilst out of the Health Records library.
- Ensure Audits are undertaken using both paper and electronic records.
- Ensure that individual responsibility for Health Records and data security is clearly documented in the individual job descriptions as appropriate.

5.13 Health Records Manager

The Health Records Manager Oversees the operational management of the Trust's paper health records ensuring that security is maintained in accordance with the legislation. The Health Records function also provides the subject access function for patients to access their clinical records.

5.14 Executive Digital and Data Security and Protection Group [EDDSPG]

The Executive Data Security and Protection Steering Group is responsible for providing assurance to the organisation that personal and corporate information is managed legally, securely, to support patient care in accordance with General Data protection Regulations 2018. It is required to ensure that the Trust has expert knowledge together with effective policies and management arrangements covering all aspects of Data Security and Protection, in line with the Trust's Data Security and Protection Policy.

5.15 Quality and Safety Oversight Group

The Quality and Safety Oversight Group is responsible for providing assurance to the organisation that the medical records are managed effectively against policies and procedures to enable the patient to receive the best clinical care.

5.16 Caldicott Guardian

The Trust's Caldicott Guardian champions patient confidentiality issues at board level and has a particular responsibility for reflecting patients' interests regarding the use of Personal Identifiable Data (PID). The Caldicott Guardian is responsible for ensuring PID is shared in an appropriate and secure manner.

A key role is to ensure that Trust and partner organisations satisfy the highest practical standards for handling patient information. Acting as the "conscience" of an organisation, the Guardian should also actively support work to facilitate and enable information sharing, advising on options for lawful and ethical processing of information as required.

5.17 Senior Information Risk Owner (SIRO)

The Trust SIRO is responsible to the Chief Executive for Data Security & Protection and acts as an advocate for information risk on the Trust Board

5.18 Chief Executive

The Chief Executive as the Accountable Officer for the Trust has overall accountability and responsibility for Records Management throughout the Trust and is required to provide assurance that all risks to the Trust are effectively managed and mitigated

6. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

6.1 Specific online training sessions are provided for staff via the Electronic Staff Record (ESR) where their job role involves processing medical records and includes:

- Medical Secretaries

- Ward Clerks
- Clinical Support Workers
- Reception Staff
- Health Records Staff
- Other Directorate staff who have a responsibility for processing records within their job role.

6.2 All staff contributing to electronic patient records and accessing electronic patient information undertake training specific to their needs and access requirements.

6.3 All Trust staff where identified as appropriate for their job role, undertake the Health Records training bi-annually in line with the Trust Training Needs Analysis, which advises on the legal implications surround Health Records. All staff training is recorded against their Electronic Staff Record. (ESR)

7. MONITORING AND REVIEW ARRANGEMENTS

7.1 Quality

7.1.1 The Standards of health records within the Trust will be audited against the minimum audit criteria for NHSLA as specified in A on an annual basis using the Audit Data Collection form Appendix I

7.1.2 The Ward spot check audits of health records will be subject to approval by the Quality and Safety Oversight Group. There may be a requirement for spot check audits to be performed more frequently if a serious concern arises and/or a serious major incident occurs and part of the investigation requires an audit for that speciality to be undertaken**.**

7.1.3 The results of the audits will be reported to the relevant Divisional and Directorate Management teams.

7.1.4 Clinical Directors/Matrons are to draw results of audits to the attention of the Divisional Governance Group and ensure that appropriate action is taken to address any shortcomings identified during the audits.

7.1.5 The Divisional Governance Group will identify high risk specialties requiring audits to be undertaken.

7.2 Casenote Availability

7.2.1 It is the individual's responsibility to follow the policy to ensure records are accurately tracked using the Casenote tracking system and where records are identified as missing an incident report should be completed on datix.

8. REVIEW

This Policy is subject to review when any of the following conditions are met:

- Where errors or omissions in the content are identified following implementation
- Where other policies/strategies/guidance issued by the Trust conflict with the information contained within this policy.
- Where the procedural or guidance framework of the NHS evolves/changes where a revision of the policy is required
- Where the review date has elapsed.

9. REFERENCES

Data Protection Act 1998
General Data Protection Regulations [GDPR 2018]

Department of Health Data Protection Guidance
Freedom of Information Act 2000
NHS Records Management Code of Practice 2021.
Royal College of Physicians Generic Keeping Standards (June 2015)
GMC Keeping Records Keeping records - GMC (gmc-uk.org)
Allied Health Professions Council Record Keeping - Record keeping | (hcpc-uk.org)
NMC Code (section 10) https://www.nmc.org.uk/standards/code
Care Quality Commission standards
Data Security and Protection Toolkit,
NHSLA Risk Management Standards
Policy IT01 Corporate Policy for Information Security
Policy IT02 Personal Information Security and Acceptable use
Policy DSP10 Trust Policy for Data Protection Security and Confidentiality
Policy DSP16 Information Lifecycle and Records Management
Policy DSP17 Access to Personal Information (Subject Access)
Policy C43 Consent Policy
Policy HR53 Statutory and Mandatory Training Policy
WHO Surgical Safety Checklist
UHNM SOP - Next of Kin

Appendix A

DIGITALISATION PROGRAMME

As part of the Digitalisation programme the use of the Trust's IPortal, and other electronic systems that are accessible via iPortal (Electronic Document Management System, Medisec, Radiology systems, Maternity, Pathology, Pharmacy etc) are now widely used across the Trust. Once clinical data has been recorded within iPortal or scanned to EDMS, it is viewable by healthcare professionals and other relevant staff groups.

Any information scanned to EDMS or recorded electronically on any of the electronic systems will not be recorded in paper format within the medical record. The Digitalisation Programme has removed the necessity for paper records from Outpatient Clinics. Any information that still needs to be generated in hardcopy form should be returned within the clinic pack to the Scanning Office at the end of the clinic session. All documents should clearly state the patient's name and unique unit number or NHS Number. Where barcoded clinic sheets are generated for individual patients, these should be used solely for the patient printed on the sheet. Under no circumstances should this information be crossed out and reused for another patient. The information is specific to the patient printed and will be scanned to the patient record printed on the sheet.

It is essential that all the standards that are applied throughout this policy for paper record keeping also apply to recording clinical data electronically.

Appendix B

STANDARDS FOR RECORD KEEPING

Many professional disciplines produce guidelines for record keeping. These guidelines are seen as an integral part of this policy and should be read in conjunction with this policy.

Accessibility of health records is a significant factor in the delivery of safe, efficient and effective health care. Where paper records are still in use for a patient and in order to ensure that health records are accessible when needed, all users of clinical records are required to maintain the record and its contents. Records should be tracked when received by a location and also when records leave a department using the Trust's Electronic Casenote Tracking system, ensuring that the correct volume for the patient is tracked.

National guidance requires that there is a unified health record that is used by all specialities. The creation of separate speciality /departmental records is therefore not acceptable except where they have been previously sanctioned by the Health Records Strategy Group.

All documents must be checked before they are filed within the case note folder to ensure that the patient's name and unit number are correct. All documents should be filed securely within the medical behind the relevant section divider.

Care should be taken to ensure that all relevant documentation which is located on the ward is collated and filed in the case notes before the notes leave the ward.

NB. **Any loose filing or where records are returned to the library containing loose documents will be returned to the relevant ward**.

Overarching principals for Health Records

These principals apply to any individual who handles the Health Record

- Where records are removed from a location, the record must be tracked appropriately using the Electronic Casenote tracking system to ensure a clear audit trail is maintained and records can be located.
- Records should be held securely to maintain confidentiality but accessible if required urgently
- Records should be secure and confidentially packaged during transportation
- Anyone making entries in the record is responsible for their own clinical record keeping in accordance with their own professional record keeping standards
- Entries to a records should be dated (with the time in 24 hour clock for inpatient entries) and signed with the name of the individual clearly printed
- Where pre-printed documents are used (eg booklets) items if not used should be marked "n/a" or crossed through. Where information is not available or not known this should be noted.
- All documentation created should be securely filed within the folder before being forwarded on to another location or returned to file
- In all cases, for entries made onto electronic systems, the person recording the information must be the user logged in to the system.
- Where records are transferred between locations this should be done using the Portering Service/ Transport Service , or hand delivered. Under no circumstances must records be sent via the postal system.

Appendix C

STORAGE AND SAFEGUARDING OF RECORDS WITHIN THE HEALTH RECORDS LIBRARY

After use Health Records should be returned to the Health Records Library. The Trust operates a closed library system with restricted access to authorised staff only.

- On occasions where non-library staff have a need to access the libraries (for filing, audit purposes etc), authorisation will be at the discretion of the Health Records management team.

- Staff must at all times provide ID evidence, and log in and out of Library Register. No person will be allowed into the library without the appropriate identification. Under no circumstances should medical records be removed from the Health Records Library until they have been tracked out on the Electronic Casenote Tracking System (Filefast)

- Secondary Storage - noncurrent case notes (No attendance within the previous 2 years) will be gradually weeded and stored with the offsite storage bureau. All case notes that meet this criteria will be tracked to the Offsite Storage Bureau on the Casenote tracking system for ease of retrieval if required should the patient re-attend. Any notes required must be requested via the Health Records Department. Although an urgent courier is available for urgent requests that are critical **to the clinical management**, requests will routinely be processed on the next available working day delivery

- Deceased patients – health records will be stored either off site or will have been scanned. The Case note Tracking system will indicate the location of the record. The records will be retained for the retention period of 8 years after death and then destroyed confidentially. A log of all records destroyed will be held centrally within the health records library . A Standard Operating Procedure for the identification of deceased patient records suitable for destruction will be used and a quality assurance check of all records made prior to destruction.

OUTSIDE THE LIBRARY

The health record whilst booked out from the library becomes the responsibility of the person(s) holding the file.

The record must:

- **Not be taken off Trust Premises – unless prior agreement has been arranged**
- Be tracked using the Trust's electronic casenote tracking system, to the location in which they are to be stored ensuring the correct volume is tracked – use free text comment field to provide more defined information.
- All records must be transferred between locations in line with the Trust's safer manual handling policy
- All records must be transferred between locations securely and using the Trust's Portering service allocated to this function. **Under no circumstances should medical records be put into the Trust's internal postal system.**
- Be accessible if required out of hours but stored securely
- If stored in locked clinic cupboards, cabinets or offices overnight or out of hours, access to the keys must be available to health records on call staff at all times at Royal Stoke and the County Site Manager.
- Wherever possible, stored to avoid fire or water damage
- Not be left lying around on view to the general public or left in areas deemed to be insecure, (e.g. open windows, or in vehicles)
- If awaiting action (e.g. clinic /discharge letters) the record should be adequately marked with appropriate identification, i.e. clinic and date or ward discharges etc.
- Be stored in a manner to comply with health and safety to readily assist staff in the location and retrieval.

Appendix D

RETENTION AND DESTRUCTION OF MEDICAL RECORDS

Records will be retained in accordance with the NHS Records Management Code of Practice 2021. The code of Practice is a guide to the required standards of practice in the management of Healthcare records but is based on current legal requirements and professional best practice.

Records will undergo an appraisal to identify if they meet the minimum retention period using the Standard Operating Process (Appendix F).

Where the minimum retention period is applicable, Destruction of medical records will be undertaken by the Health Records Department using the Trust's confidential methods of either incineration or shredding. A log of the patient details will be retained as a permanent record of destruction.

Records that have been marked "DO NOT DESTROY" by the Medico-Legal Department, these will not be destroyed and the hard copy will be maintained until advised by the Medico-legal Department that they are no longer required.

Appendix E

University Hospitals of North Midlands NHS
NHS Trust

Standard Operating Procedure

Identification of medical records that meet the minimum criteria for destruction

Purpose:	To enable Health Records Library staff to correctly identify Medical Records that meet the minimum retention period for destruction in accordance with the NHS Records Management Code of Practice 2020 (A guide to the management of health and care records)
Scope:	For the identification of records held by the Main Health Records Libraries and identification of electronic records held on EDMS/iPortal (County and RSUH) commencing with all records held on microfiche as a prompt.
For use by:	Health Records Library
Document Owner;	Health Records Manager
Policy Reference	NHS Records Management Code of Practice 2020 RE01 Multi-Disciplinary Health Records Policy DSP16 Information Lifecycle & Records Management Policy (Corporate and Clinical Records)
Definitions/Acronyms	• EDMS – Electronic Document Management system storing scanned medical records • HTA – Human Tissue Authority • CJD - Creutzfeldt-Jakob Disease • SaTH – Shrewsbury and Telford Hospitals • iFIT – Electronic Casenote Tracking System

Version Control

Date	Version	Detail
21.09.21	HREC.1.0	Health Records Team for review
20.10.21	HREC1.1	Data Security & Protection Manager
11.11.21	HREC1.2	Trust Management working Group

	Introduction
	The Records Management Code of Practice for Health and Social Care 2021 provides a framework the effective management of records based on established standards which the Trust is required to conform to. The Code of practice is based on published guidance from the National Archives and best practice in the public and private sectors and includes recommendations from the Mid Staffordshire NHS Foundation Trust Public Inquiry relating to records management and transparency.
	Appraisal of Records
	In order to determine if records have reached the minimum retention period records should be appraised.
	The outcome of an appraisal will be one of the following • Destroy (and/or delete) • Continued retention if on-going care or there is justification for retaining longer than the minimum retention period • Defer for review at a later date if they do not yet meet the criteria. • Permanent preservation
	When undertaking an appraisal the following process must be followed and the criteria must be applied to each record to establish if the minimum retention period has been reached and what action is required.

Procedure		
1.	**Obtain all records for a patient**	
1.1	Take the microfiche jackets still held in the department for the patient (these are likely to be the oldest records held for the patient and use this as a prompt to check other records for the patient)	
1.2	Obtain all records registered against the patient displayed on the Casenote tracking system , including any stored at the off-site storage bureau	
1.3	Check Careflow Patient Administration system to validate any activity for the patient	

1.4	Check EDMS and iPortal for any electronic records for the patient	NB. A decision to be made as to whether these can be hidden from view if they meet the destruction criteria
1.5	Any records that do not meet the criteria should be returned to file	If there is an imminent date (ie within 12 months) where the record may meet the criteria for disposal, these should be returned to the archive filing area allocated in the Thornburrow building , in readiness for a review of them at a later date.
	If any microfiche is held for records that do not yet meet the criteria, place the microfiche in a sealed punch holed envelope and secure in the mediclip of the record	Add a label on to the front of the folder to indicate microfiche jackets enclosed.
2.	**The following criteria <u>must</u> be applied to each patient and <u>all</u> elements of the patient record checked <u>before</u> it can be determined if the records meet the criteria for destruction.** **(use the check list in appendix 1 for each patient)** It must be remembered that in some cases there may be gaps between episodes of care. If a patient begins a new episode of care whilst their previous records are still within agreed retention periods, then these episodes of care will link and the retention period will begin again at the end of the current episode This may mean that some or all of the information from the previous episode will go over a 20 year retention mark. This is acceptable as it links to a more recent episode of care	
2.1	Children and Young People	Retain until 25th birthday or 26th if the patient was 17 years of age when treatment ended
2.2	Obstetric Records (Maternity, Ante-natal, Post-Natal)	Retain for 26 years after delivery if no other entries made after this date that would extend this further
2.3	Clinical trials	15 years
2.4	Mental health records	20 years after last entry or 10 years after death
2.5	Cancer/ Oncology Records	Retain for 30 years or 8 years after death – if held within the main medical record retain the entire record.
2.6	Creutzfeldt-Jakob Disease (CJD)	Retain for 30 years or 10 years after death
2.7	Dental Records (any setting)	Retain for 15 years
2.8	Long term illness or life-long condition, or illness that may reoccur	Retain for 20 years from last entry or **10 years after death**
2.9	Transplantation records Human Application (Tissues and Cells, bone grafts for patient treatment), Organ Donation and Transplantation	Retain for 30 years If there is a HTA "**Do not Destroy**" label or stamp on the notes Retain until the end date on the label

2.10	Electronic Patient Record Systems	Where the system has the capacity to destroy records in line with the retention schedule, and where a metadata stub can remain, demonstrating the destruction, then the Code of Practice should be followed in the same way for electronic as well as paper records, with a log kept of destructions. If the EPR does not have this capacity, then once records reach the end of their retention period, they should be made inaccessible to system users upon decommissioning. The system (along with the audit trails) should be retained for the retention period of the last entry related to the schedule.
2.11	Public Inquiry	Inquiries take into account a huge range of records and what is required can vary by Inquiry. When an Inquiry is conducted, the Inquiry Team will issue detailed guidance setting out what types of records they are interested in. If the Trust holds any records that an inquiry requests, they must be produced or explain why they cannot be produced. Before any records relating to inquiries are destroyed, a check must be made with Inquiry Team that they are no longer required. If there is any doubt, they must be retained until there is clear instruction from the Inquiry Team. At the time of writing this Standard Operating Procedure , there are two independent Inquiries which have requested that large parts of the health and social care sector do not destroy any records that are, or may fall into the remit of the Inquiry: • **The Independent Inquiry into Child Sexual Abuse (IICSA)** - Records that should not be destroyed include children's records and any instances of allegations or investigations or any records of an institution where abuse has or may have occurred • **The Infected Blood Inquiry** Retain any relevant records until given instruction by the Inquiry that they are no longer required. • **Shrewsbury and Telford Maternity services** Where patients have transferred between UHNM and SaTH as part of their maternity care • **Potential future inquiry-** ○ **Covid 19**
2.12	Adult records not previously mentioned where no treatment for the past 8 years or longer	8 years from last date of treatment Nb : Check Medway and hard copy records to establish
3	**Destruction Processs**	
3.1	When all records have been identified as meeting the criteria for destruction they should be tracked to the location “Destruction” on iFIT and marked as destroyed . See next step (**3.2)** for how to destroy the record.	
3.2	Remove all plastic mediclips /plastic wallets. Place the casenote folder into the confidential waste bin . Add the reference number from the bin to the individual check list Record the patient details on to the to the permanent record of destruction ensuring all fields are populated (including the referebnce numbr of the bin and date disposed of. **Retain the check list in date order of destruction**	
3.3	Any microfiche jackets should be held separately in white confidential waste bag ready for collection from the waste management team.	

Individual Check list for the identification and retention or disposal of medical records

This should be completed for all records appraised

Unit number		**Patient Name**	
Date of birth		**Date of Death**	

Microfiche jackets available ?	YES		NO		
Hard copy records available?	YES		NO		

Number of hard copy volumes **On site**		**Number of hard copy volumes** **Off site**	
*		*	
*		*	
*		*	
*		*	
*		*	
*		*	
*		*	
*		*	
*		*	
*		*	

Electronic Records							
Careflow PAS Is the patient registered on Careflow (If no, there is no need to check iPortal/EDMS)				**Careflow PAS** Are there any episodes of care displaying on Careflow PAS			
Yes		No		Yes		No	
Iportal Timeline				**Scanned to EDMS**			
Yes		No		Yes		No	

(Appendix 1)

Criteria	Retention period	Microfiche checked		Hardcopy records checked		Electronic records checked	
		Yes	No	Yes	No	Yes	No
Children and Young People	26 years or younger						
Obstetric Records (Maternity, Ante-natal, Post-Natal)	Retain for 25 years (or 26 years of age if the child's treatment ended at age 17)						
Clinical trials	15 years after conclusion of treatment						
Cancer/ Oncology Records	Retain for 30 years or 8 years after death						
Creutzfeldt-Jakob Disease	Retain for 30 years or 10 years after death						
Dental Records	Retain for 15 years						
Mental Health Records	20 years from last entry or 10 years after death						
Transplantation records	Retain for 30 years						
Human Application (Tissues and Cells, bone grafts for patient treatment), Organ Donation and Transplantation	If there is a HTA (Human Tissue Authority) Do not Destroy label or stamp on the notes - Retain until the end date on the label						
Long term illness or life-long condition, or illness that may reoccur	Retain for 20 years or 10 years after death						
Links with a public enquiry (if so specify which one)	Retain until public enquiry is closed						
Is the patient deceased?	Yes /No						
Other comments /notes:	It is likely that where there is a long term illness the patient would be an on-going patient and therefore the minimum retention period would not apply						

Date returned to file if it does not meet destruction criteria?	
Destruction Date	
Confidential Bin reference	

Simple flow chart for process

ACTION REQUIRED				
Do the records meet the criteria for destruction			IF YES Track to destruction on Casenote tracking and mark all volumes as destroyed	Make a note of the confidential waste bin the records are to be placed in **Bin number**:	Add the details of the patient to the permanent record of destruction **Added to register** :
YES		→			
NO		↓			
Do the Records have an imminent date for review within 12 months?			IF YES Transfer the records to the archive section of the library in the Thornburrow building ensuring that all microfiche jackets are filed securely inside the folder	Retain this check list in a pending file for future review	
YES		→			
NO		↓			
If NO to any of the above		→	Return to the library ensuring any microfiche jackets are filed securely in the folder and the folder marked as having microfiche enclosed. Place a label on the records to indicate the next review date	The checklist can be filed into the records for reference but a new checklist will need to be completed when the records are checked again	

Appendix F

FORWARDING OF HEALTH RECORDS TO OTHER HOSPITALS

The procedures detailed below have been developed with the assumption that patients who are to be referred to another Trust have given their consent for disclosure of the records to other Health Professionals as part of their continuing treatment.

For the purpose of this policy, 'Other Hospitals' would be defined as any other Hospital not managed by the University Hospitals of North Midlands County Records are able to be transferred to Royal Stoke, and Royal Stoke records transferred to County Hospital.

Original notes should not routinely leave Trust Premises unless transferring between the agreed locations. The exception to this would be where records are transferred to Combined Health Care or Haywood Hospital.

Where it is necessary for information to transfer to external Trusts outside of the area, copies of the relevant section should be made. **Originals must not be sent**.

Records are able to be transferred to local health centres for appointments where the activity is for UHNM. However, the records must be transferred securely using hospital transport service and are not held on the premises overnight.

Doctors who transport health records to such locations in their own vehicles are personally responsible for the security of the records and for making them available if they are required at any time whilst in their possession. Under no circumstances should records be held be held off Trust premises overnight and should never be left in cars, either visible or concealed.

All original notes must be clearly tracked out using the Electronic Casenote Tracking System stating the date and intended destination.

Patients Transferred to the Care of Other Hospital

Relevant sections of the health record, including clinical notes relating to the current condition, should be copied and forwarded e.g. original referral letter, any subsequent correspondence. A self-duplicating nurse to nurse transfer sheet should be completed.

Further information can be copied and sent if requested by the receiving hospital, providing this does not contradict any instructions provided by the patient for the disclosure of records to other Health Professionals within other organisation.

Appendix G

STORAGE OF DOCUMENTATION FROM EMERGENCY ADMISSIONS PORTALS AND SHORT STAY WARD

If the patient is only seen within the **Emergency Admissions portals** (A/E, AMU AEC) and their length of stay is less than 24 hours, these will be scanned within the emergency portal on to EDMS.

If the patient is seen within the Surgical Assessment Unit (SAU) and discharged home from this portal , these documents will be returned to the Scanning Bureau, Medical Records unit, Thornburrow Building. On receipt of the documentation the Document Scanning staff will scan the records to ensure they are accessible via the networked Document Management System if required.

If the patient is transferred to another ward from the SAU, the documentation will transfer with the patient to the new ward and filed within the medical records

The Electronic Document Management System is accessible to authorised users only via Trust's iPortal.

Appendix H

STANDARD FOR PAPER RECORDS

NB. Audits completed prior to the implementation of this policy measured practice against a combination of previous CNST and multidisciplinary health records policy standards. From the date of issue of this policy, all audits of record keeping will be undertaken as per the minimum audit criteria specified

** This discharge data relates to electronic data recorded on EPR. Where discharge information has not been recorded electronically, previous standards for discharge documentation will be utilised

Data Item	Monitoring
Entries in the record are dated	Clinical Audit
Entries in the record are timed	Clinical Audit
All entries are signed by the person making the entry	Clinical Audit
Entries in the record are signed in such a way that the identity of the signatory is clear	Clinical Audit
All entries in the record, including alterations, are legible	Clinical Audit
All entries are made in black ink with the exception of operation notes that may be made in red ink	Clinical Audit

Data Item	Monitoring
The record contains the patient's full name and unit number on every page	Clinical Audit
The record contains a chronological account of the patient / users care	Clinical Audit

The record includes the following clinical information where relevant: • A written diagnosis and reason for admission / referral • An initial patient / user history including a history of present condition, details of current medication, allergies, past medical and social history • A report of the initial physical examination performed by a clinician • Plans of care • Treatment / interventions given • Progress notes, observations and consultation reports • Results of investigations	Clinical Audit
The record includes the following clinical information where relevant: • Assessments	Clinical Audit
The record includes the following clinical information where relevant: • Drug therapy records	Clinical Audit
The 'alert' notation on the front inside cover of the notes is completed to show whether the patient/ user is known to have any allergies or sensitivities	Clinical Audit
The sensitivities section on the prescription chart is completed to show whether the patient /user is known to have any sensitivities	Clinical Audit

Data Item	Monitoring
For each in-patient episode, there is a discharge summary with the following information completed: · Discharge method · Destination · Outcome	Clinical Audit

· Contact nurse · Date of medical discharge · Time of medical discharge · Discharge date · Discharge time · Expected date · Clinician · Specialty · Ward	
The record contains a copy of the discharge letter which includes as a minimum, the following information: • History on Admission • Presenting Complaint: • Allergies / Alerts: • Co-morbidities: • Lives Alone: • Diagnosis on Discharge: • Investigations & Procedures • Investigations & Results: • Results Awaited: • Operations & Procedures: • Medications • Medications on Discharge: • Follow up arrangements and advice/action to GP • Changes to Admission Medications: • Hospital follow up: • Recommendations to GP: • Information given to patient: • Other Services Follow Up: • Clinician's Additional Comments:	Clinical Audit

Data Item	Monitoring
The folder is in good condition.	Clinical Audit
The folder is marked confidential.	Clinical Audit
The folder has no personal details on outside cover other than the patient's name and hospital number.	Clinical Audit
Correspondence is filed in a manner appropriate to the type of casenotes	Clinical Audit
The clinical record is filed in chronological order (appropriate to the type of case notes) within each individual speciality divider.	Clinical Audit
Results are fixed to the appropriate mount sheets.	Clinical Audit
Traces are mounted on paper or placed in envelopes and secured with mediclips	Clinical Audit
All documents are secured in the case notes.	Clinical Audit
If a patient is admitted to hospital following an attendance to the Emergency Department, a copy of the casualty record should be made and filed in the clinical section of the case notes.	Clinical Audit

Data Item	Monitoring
Specific record keeping requirements for surgical procedures will be audited by the WHO Surgical Safety Checklist	Clinical Audit

Appendix I

DATA COLLECTION FORM

University Hospital of North Staffordshire NHS
NHS Trust

Office Use ☐☐☐

NHSLA Standard 1.8 - Health Record Keeping Standards

Medical Entries

Total number of pages used for this admission:	☐☐	Total number of pages with patient last name:	☐☐
Total number of pages with patient first name:	☐☐	Total number of pages with patient NHS number / unit number:	☐☐
Total number of pages with ward location:	☐☐	Total number of medical entries:	☐☐
Total number of medical timed:	☐☐	Total number of medical entries dated:	☐☐
Total number of medical entries with name printed: (for the first entry only)	☐☐	Total number of medical entries signed:	☐☐
Total number of medical entries legible:	☐☐	Total number of medical entries with designation printed:	☐☐
Total number of alterations:	☐☐	Total number of medical entries completed in black ink:	☐☐
Total number of alterations signed:	☐☐	Total number of alterations dated:	☐☐
Total number of alterations legible:	☐☐		

Medical Admission Record

Responsible Consultant:	☐ Yes	☐ No	Name of Clerking Doctor:	☐ Yes	☐ No
Source of Referral:	☐ Yes	☐ No	History of Presenting Complaint:	☐ Yes	☐ No
Reason for Admission:	☐ Yes	☐ No	Past Medical History:	☐ Yes	☐ No
Current Medication:	☐ Yes	☐ No	Allergies / Sensitivities:	☐ Yes	☐ No
Social History:	☐ Yes	☐ No	Assessments:	☐ Yes	☐ No
Plan of Care:	☐ Yes	☐ No	Investigations and Inital Procedures:	☐ Yes	☐ No
Relevant Risk Factors:	☐ Yes	☐ No	Relevant Previous Drug History:	☐ Yes	☐ No
Patients Concerns:	☐ Yes	☐ No	Physical Examination:	☐ Yes	☐ No

Nursing Documentation

Total number of pages used for this admission:	☐☐		
Total number of pages with patient first name:	☐☐	Total number of pages with patient last name:	☐☐
Total number of pages with ward location:	☐☐	Total number of pages with patient NHS number / unit number:	☐☐
Total number of shift evaluation columns dated:	☐☐	Total number of shift evaluation columns used:	☐☐
Total number of shift evaluation columns signed:	☐☐	Total number of shift evaluation columns timed:	☐☐
Total number of shift evaluation columns with designation printed:	☐☐	Total number of shift evaluation columns with name printed: (for the first entry only)	☐☐
Total number of shift evaluation columns completed in black ink:	☐☐	Total number of shift evaluation columns legible:	☐☐
Total number of alterations signed:	☐☐	Total number of alterations:	☐☐
Total number of alterations legible:	☐☐	Total number of alterations dated:	☐☐

Private & Confidential