HEALTHCARE RECORDS POLICY
(INCORPORATING RECORD KEEPING STANDARDS)

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[1] Where there is a full review, amendment details are not required in the version control sheet.

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1. INTRODUCTION

Accurate healthcare records are a tool of professional practice that should improve the care process for all patients. Records are a valuable resource because of the information they contain. High quality information underpins the delivery of high quality evidence based healthcare as well as many other key service deliverables. Information has most value when it is accurate, up to date and accessible when it is needed. Good record-keeping can determine accountability; facilitate clinical decision making; improve patient care through clear communication of the treatment rationale; provide a consistent approach to team working; and help defend complaints or legal proceedings.

Records Management is the process by which an organisation manages all the aspects of records whether internally or externally generated and in any format or media type, from their creation, all the way through their lifecycle to their eventual disposal.

The Records Management Code of Practice for Health and Social Care 2016 published by the Information Governance Alliance is a guide to the required standards of practice in the management of records for all those who work within or under contract to NHS organisations in England. It is based on current legal requirements and professional best practice.

The author consulted with members of the Healthcare Records Committee and the Information Governance lead in the production / review of this Policy.

2. PURPOSE AND OBJECTIVES

All NHS records are public records under the terms of the Public Records Act 1958, sections 3 (1) – (2). The Secretary of State for Health and all NHS organisations have a duty under the Public Records Act to make arrangements for the safe keeping and eventual disposal of all types of their records.

The Royal Surrey County Hospital NHS Foundation Trust (herein after referred to as 'The Trust' or 'RSCH') needs robust records management procedures to meet the requirements set out under the Data Protection Act 1998 as well as the Freedom of Information Act 2000. The Records Management Code of Practice for Health and Social Care 2016 sets out the required standards of practice in the management of records.

Records are a valuable resource because of the information they contain, but that information is only usable and useful if it is correctly recorded in the first place, is regularly updated, and is accessible when it is needed subject to appropriate controls to ensure confidentiality.

The purpose of the Healthcare Records Policy is:

- To provide a process framework for consistent, coherent and compatible management of healthcare records,
- To ensure that, from the moment a record is created until its final disposal, the Trust can:
    - Control both the quality and quantity of information it generates;
    - maintain that information in a manner that effectively and efficiently services its needs and those of its stakeholders;
    - Dispose of the information efficiently and confidentially when no longer required.

- To manage the risks associated with health records in all media: electronic, paper, digital images and scanned records.

The purpose of the Healthcare Record is:

- To support patient care and continuity of care.
- To inform any clinician who has a responsibility for the patient of all the key features which might influence the treatment proposed.
- To provide a contemporaneous and complete record of the patient's treatment and related features.
- To support day-to-day business which underpins the delivery of care.
- To support evidence-based clinical practice.
- To support sound administrative and managerial decision making as part of the knowledge base for NHS service.
- To meet legal requirements, including requests from patients under subject access provisions of the Data Protection Act.
- To assist clinical and other types of audit.
- To support patient choice and control over treatment and services designed around patients.
- To assist in the management of claims and complaints.

3. SCOPE OF POLICY

The Policy applies to all staff working for the Trust in respect of records management standards and to all staff involved in the handling of both paper and electronic records in respect of their effective management.

All records are covered by this Policy: whether they are manual records filed in the patient's official casenotes, or kept separately within individual departments or whether they are electronic within the main hospital patient administration system (PAS) or within departmental systems e.g. Pathology, Radiology, Audiology.

3.1 Definitions

3.1.1 Health Record

The Data Protection Act 1998 defines a health record which 'consists of information relating to the physical or mental health or condition of an individual, and has been made by or on behalf of a health professional in connection with the care of that individual.'

For the purposes of this Policy, a 'Healthcare Record' relates to any electronic or paper information recorded about a person for the purpose of managing their healthcare. This policy has tried to be consistent with regard to the terms used to describe a record. However the terms used in this policy, which describe medical records, healthcare records, casenotes, casenote folders, folders and healthcare records folders, are also used to describe the structured folder in which records can be found.

3.1.2 Being open

Being open is about ensuring the development of an open and transparent culture within the organisation.

3.1.3 Contemporaneous
Contemporaneous means completed at the time events or incidents occur.

3.1.4 Confidentiality
The Trust gives an assurance that all patient information is treated in confidence.

3.1.5 Audit
Audit refers to the processes used in verification and examination.

3.1.6 Patient Administration System
The Trust's electronic Patient Administration System (PAS) has a facility to record the movement of healthcare records (tracking).

3.1.7 Safe Haven
Safe Haven used to apply to the location of fax machines that would routinely receive confidential or person identifiable information. The definition has now been expanded to be a place where confidential information can be securely received or dispatched, i.e. this includes areas used for the opening of mail.

4. DUTIES AND RESPONSIBILITIES

4.1 Individual Responsibilities

- Trust Board
  The Trust Board have overall responsibility and accountability for healthcare records management in the Trust. They are also responsible for ensuring appropriate mechanisms are in place to support service delivery and continuity. Records management is key to this as it will ensure appropriate, accurate information is available as required.

- Caldicott Guardian
  The Caldicott Guardian acts as the 'conscience' of the Trust and actively supports work to enable information sharing where it is appropriate.

  Each NHS organisation is required to have a Caldicott Guardian: this was mandated for the NHS by Health Service Circular: HSC 1999/012. The Guardian plays a key role in ensuring that the Trust satisfies the highest practical standards for handling patient identifiable information, and advises on options for lawful and ethical processing of information.

- Senior Information Risk Owner (SIRO)
  The SIRO has overall ownership of the organisation's information risk and acts as champion for information risk within the trust

  The SIRO is responsible for ensuring organisational information risk is properly identified and managed and that appropriate assurance mechanisms exist.

- Healthcare Records Manager
  Responsible for the overall development and maintenance of healthcare records management practices throughout the Trust and for promoting compliance with this Policy. The Healthcare Records Manager is responsible for ensuring systems within the Medical Records Library are effective and efficient for making healthcare records available to clinical staff when and where they are needed for treatment as inpatients or outpatients. The Healthcare Records manager is also responsible for producing quarterly reports for the Healthcare Records Committee on issues related to the overall development and maintenance of Healthcare Records management practices throughout the Trust.

- Information Governance Manager
  Information Governance ensures that personal information is dealt with legally, securely, efficiently and effectively. The Information Governance Manager will work with the Healthcare Records Manager to ensure that storage, processing and use of personal information meets the requirements of the Data Protection Act.

- Clinical Quality Risk Management Group
  The Clinical Quality Risk Management Group is responsible for noting the risks identified by the Healthcare Records Committee and escalating, as per their terms of reference, for any risk management strategy action as appropriate.

- Healthcare Records Committee
  The Healthcare Records Committee is responsible for monitoring the effectiveness of this Policy, identifying risks and escalating as required to the Clinical Quality Risk Management Group. It is responsible for reviewing and developing practices in order to keep healthcare records management systems accurate, accessible and compliant with relevant legislation and advice. This includes ensuring the Trust's Retention and Disposal Schedules are maintained and kept up to date with record management and systems development changes; regulating, authorising and controlling the contents of the healthcare record; promoting good practice for clinical documentation throughout the Trust and thereby supporting staff in raising record-keeping standards.

  The Healthcare Records Committee is chaired by the Healthcare Records Manager and reports quarterly to the Clinical Quality Risk Management Group.

  Refer to Appendix 1 for the Healthcare Records Committee Terms of Reference.

- Senior Managers
  Deputy Directors of Operations, Deputy Medical Directors, Director of Nursing and Patient Experience, Medical Director, Clinical Directors, Clinical Leads, Matrons, Associate Directors of Operational Divisions or Clinical Support Services Management Teams, Ward Managers/Heads of Departments are responsible for:

  - ensuring that all staff under their management (including bank, agency, contracted, locum and volunteers) are aware of, and meet, their individual responsibilities as stated in this Policy, including monitoring compliance.
  - ensuring that this Policy and procedures are implemented across the Operational Division and department and that they operate efficiently and effectively.
  - developing local procedures to support implementation of this Policy.
  - providing a safe and secure space for the storage of healthcare records.
  - ensuring staff are aware of their responsibilities in relation to healthcare records and, where appropriate, identifying and creating specific responsibilities within their job descriptions.
  - ensuring staff track all medical records on PAS at all times.
  - ensuring that all tracking locations within their area are updated on PAS and that the 'casenotes at location' report is run regularly to ensure all medical records are tracked correctly.

- Information Management & Technology (IM&T) Department and Departmental Information Asset Owners

Those designated with these roles are to ensure that sufficient controls are in place to protect the confidentiality and integrity of all electronic information and to restrict its availability to appropriate users. There is also a requirement to ensure the on-going availability of reliable systems-based information.

- Ward/Departmental Nurse Managers
  Ward and Departmental Nurse Managers must ensure staff attend nursing documentation training relevant to their role, including induction and updates to maintain competency as required. They are professionally accountable to the Director of Nursing & Patient Experience for ensuring nursing record keeping is accurate, and completed in a timely manner. They are also responsible for ensuring healthcare records are stored securely within their ward / department.

- Registered Nursing Staff (RN), Allied Health Professionals (AHP) and Associate Practitioners (AP) (including ward / departmental managers)
  Those designated with these roles are professionally accountable to the Director of Nursing & Patient Experience. They must keep clear and accurate records of the discussions they have, the assessments they make, the treatment and medicines administered and how effective these have been.

- Health Care Assistants (HCA's)
  Health Care Assistants can complete nursing documentation, where appropriate, under the supervision of a Registered Nurse. All documentation must be countersigned by the supervising Registered Nurse.

  Maternity Support Workers (MSW's)

  Once deemed competent, as indicated by completion of the relevant competency in the fundamental skills clusters, the Maternity Support Worker should document all care given in the patient's medical records. Prior to achieving this competency, all records should be countersigned by the appropriate member of staff supervising.

- Students
  Students who are on placement within the Trust are permitted to complete documentation under the supervision of a Registered Professional. The author of every entry must be recognisable by the printing of their forename and surname, followed by a legible signature and job title. This will be followed by the counter entry of the Registered Professional by the printing of their forename and surname, followed by a legible signature and job title.

- All Staff
  All staff are responsible for tracking healthcare records into and out of their own locations. Users are responsible for locating all healthcare records still tracked to their location unless the records are in transit.

  All staff, whether clinical or administrative, who create, receive and use records have records management responsibilities. All staff will maintain patient records as a complete and contemporaneous record of care ensuring the safety and security of all patient records, whether held electronically or manually.

  All staff employed by the Trust should be aware of the legal and ethical implications of disclosure of clinical and personal information relating to patients.

This will be achieved upon induction training within the Information Governance presentation.

All staff must report any incidents relating to Healthcare Records in accordance with the Incidents and Serious Incidents Management Policy. An adverse incident form must be submitted via Datix within 24 hours of any incident or near miss being detected.

4.2 Legal Obligations and Guidance

The Trust will take actions as necessary to comply with the legal and professional obligations as set out in the Records Management Code of Practice for Health and Social Care 2016 and also any new legislation affecting the management of records as it arises. In particular all staff should be aware of the following;

4.2.1 Public Records Act 1958

All NHS records, and those of NHS predecessor bodies, are public records under the term of the Public Records Act 1958. The Act sets out broad responsibilities for everyone who works with such records, and provides for guidance and supervision by the Keeper of Public Records. It requires that those records that have been selected for archival preservation are transferred to The National Archives or a Place of Deposit appointed under the Act.

4.2.2 Access to Medical Reports Act 1988

The Act allows those who have had a medical report produced for the purpose of employment and / or insurance to obtain a copy of the content of the report prior to it being disclosed to any potential employer and / or prospective insurance company.

4.2.3 Access to Health Records Act 1990

The Act establishes the right of access to a deceased patient's healthcare records by the patient's personal representative and any other person who may have a claim arising out of the patient's death. There are no clear legal obligations of confidentiality that apply to the deceased. Nevertheless the Department of Health and the General Medical Council agree there is an ethical obligation to the relatives of the deceased in requiring that confidentiality obligations continue to apply.

4.2.4 Data Protection Act 1998

The Act covers the way in which information on individuals is managed and is the principal means of regulating healthcare records within manual and computerised systems. Appropriate security measures must be taken against unauthorised access, alteration, disclosure or destruction and accidental loss or destruction. All staff accessing information whether on computers, produced from computers, or hard copy healthcare notes, have an obligation to ensure that this is not disclosed in any way.

4.2.5 Freedom of Information Act 2000

The Act aims to promote a culture of openness and accountability by providing people with rights of access to the information held by the Trust. The Act does not change the right of patients to protection of their patient confidentiality in accordance with Article 8 of the Human Rights Convention, the Data Protection Act 1998 and Common Law. Any Freedom of Information requests must be referred to the Information Governance Manager.

4.2.6 Common Law Duty of Confidentiality

Common Law is not detailed in a single document like an Act of Parliament. It is a form of law based on previous court cases decided by judges; hence, it is also referred to as 'judge-made' or case law. The law is applied by reference to those previous cases, so common law is also said to be based on precedent.

The general position is that if information is given in circumstances where it is expected that a duty of confidence applies, that information cannot normally be disclosed without the information provider's consent.

Therefore, under the common law, a healthcare provider wishing to disclose a patient's personal information to anyone outside the team providing care should first seek the consent of that patient.

4.2.7 Confidentiality: NHS Code of Practice (November 2010)

The document extends the guidance on disclosure of confidential information in the public interest that is contained within Annex B of the Department of Health's *Confidentiality; NHS Code of Practice.* Its purpose is to assist NHS staff in making what are often difficult decisions on whether a breach of patient confidentiality can be justified in the public interest.

4.2.8 Caldicott Principles

The 7 Caldicott Principles must be observed when disclosing personal confidential data information to any other person.

- Justify the purpose (s)
- Do not use personal confidential data unless it is absolutely necessary
- Use the minimum necessary personal confidential data
- Access to personal confidential data must be on a strict "need to know" basis
- Everyone with access to personal confidential data should be aware of their responsibilities
- Everyone must understand and comply with the law
- The duty to share information can be as important as the duty to protect patient confidentiality

4.2.9 Paragraph Removed

4.2.10 Health and Social Care (Safety and Quality) Act 2015

The Act requires that the NHS number is used as the unique and consistent identifier. The Act also introduces a new legal duty requiring health and adult social care bodies to share information where this will facilitate care for an individual.

5. PROCESS FOR ENSURING HIGH QUALITY HEATHCARE RECORD-KEEPING

The Life Cycle of a Healthcare Record

The life cycle of a healthcare record describes the life of a record from its creation / receipt through the period of its 'active' use, then into a period of 'inactive' retention (such as a closed file which may still be referred to occasionally) and finally either confidential disposal or archival preservation.

5.1 The Unified Record

An integrated and unified approach to the structure of the healthcare record ensures that information contained within is correctly recorded, regularly updated, legible, factual and easily accessible.

5.1.1 Medical Records Department

The location for the 'active' retention of records is the Medical Records Department Library of the Royal Surrey County Hospital. The department comprises three distinct and connected areas;

- Front Office in which is located the reception as well as staff dealing with subject access requests [SAR] under the Data Protection Act 1998, insurance enquiries, Emergency Admission, Elective Waiting List and Scanning,
- Medical Records Library in which is housed current RSCH records and staff dealing with the Kelly's storage system (off-site storage)
- Back office which includes the Outpatients Clinic Preparation team, and staff dealing with patient referral letters and record merging requests.

Whilst the Trust aims to operate a unified medical record for patient care, with all speciality records held in a single Trust record, some departments within the Trust create and manage their own clinical record. These include:

5.1.2 Accident and Emergency

When a patient attends the Trust's Emergency Department a record will be created on the department's computer system detailing the care and treatment provided. On admission of a patient, via the Emergency Department, a copy of the Emergency Record (CAS Card) is filed in the clinical note section of the Healthcare Record for continuity of care, and accompanies the patient to the admitting ward.

Where a patient is not admitted, the record is filed separately by the Accident and Emergency Department who retain for a period before sending to the Trust's off-site storage facility.

5.1.3 Maternity

The Trust currently supports Patient Held Records used/held within the Maternity services and Gynaecology. The patient held record remains the property of the Trust and should be returned to the named professional in the Trust on request, or on completion of treatment or discharge.

During the patient's pregnancy, the Trust's healthcare record is held securely in the Obstetrics & Gynaecology Department and is available at all consultations. They are available, should they be required elsewhere in the Trust, via the Midwives. At the end of the patient's pregnancy their ante-natal records will be amalgamated into the main healthcare record in the obstetric record section by the Obstetrics and Gynaecology department and are returned and tracked to the medical records library.

Please refer to the Storage and Completion of Maternity Records Policy for information on the storage of maternity records.

5.1.4 St Luke's Cancer Centre

The St Luke's Cancer Centre currently holds records for patients who have been treated for cancer in the last two years. These records are kept in a dedicated alphabetically-ordered secure library.

These records are available for appointments at St Luke's, and elsewhere in the Trust if the patient is receiving treatment concurrently in another department. When notes leave St Luke's they are tracked via PAS as per the tracking process (5.10).

5.1.5 Therapies

In-patient therapy treatment records are documented within the patient's Healthcare Record.

All outpatient therapy records are kept within the Therapy department. These are not taken outside the department and are therefore not tracked. If notes are requested (e.g. in the event of a complaint or solicitor request) the notes are copied and taken to Medical Records Department/ Legal Services as appropriate.

5.1.6 Radiology

Radiology records are managed and stored by the Trust's Radiology Department both electronically and in paper form.

Imaging: All modalities at the Royal Surrey County Hospital and Haslemere Community Hospital acquire digital images; these are stored electronically on the Picture Archive and Communications System (PACS) and in the central data centre.

Milford Hospital acquires images on film; these are stored in the local film store.

Films taken during 2005 are stored off site at Kelly's and those from 2006 to the present day, on site in the Medical Records Department.

Request forms: Paper request forms are stored short-term in the Radiology Department initially in the modality areas, then in the secretary's office for reporting and then to the medical records department. Longer term storage is off site at Kelly's. CT and MRI request forms are also scanned onto the computerised radiology information system (CRIS).

Reports: Paper copies are sent to the referring clinician/ward/GP to be manually inserted into the patient's medical records. All reports are stored electronically on the CRIS.

CRIS: CRIS data is stored in a central data centre; this is readily viewable to authorised staff on Trust computers.

Medical Records: Medical Records are retrieved and held in Radiology for the duration of relevant procedures such as interventional procedures. These are then returned to either the Medical Records Department or the ward.

5.1.7 Radiotherapy

Radiotherapy records are managed and stored by the Radiotherapy Department both electronically and in paper form.

Imaging: All images generated in the radiotherapy department are digital.

Images for radiotherapy planning are stored within Varian Aria database.

Chemo trials images are stored within PACs.

Urology team treatment images are stored within PACs.

Medical Records are retrieved and can be held in radiotherapy for the duration of the treatment course. These are then stored in the Oncology Medical Records Library.

Radiotherapy referrals: these are electronic and held within a web based system (Casper).

A radiotherapy summary is filed within the Healthcare Records at the conclusion of a treatment course.

5.2 Creation and Amalgamation of a Healthcare Record

5.2.1 Creation of a New Record

Upon attendance, referral or admission the name, date of birth and address of the patient will be searched on PAS to establish if a record currently exists and to avoid duplication. If no previous records exist, a new record will be created electronically. Thereafter a new physical healthcare record folder will be created and tracked for a clinic, elective admission, emergency admission or other episode. At the point of creation of the new healthcare record a current year sticker is placed on the folder to assist in determining retention / disposal / destruction criteria.

The front cover of the healthcare record will display two labels containing the patient name, healthcare record number, and the barcode of the healthcare record number.

Labels for all other uses will contain the same information as previously, but with the addition of the NHS number and address.

5.2.2 Creation of Temporary Healthcare Records

There are occasions when an original healthcare record cannot be located upon request or is not readily available. A temporary record will only be created with approval from the Healthcare Records Manager or Assistant Manager.

Where a temporary healthcare record is generated, it must include as much information as possible to assist the clinician; including previous copy letters, any available results, including hypersensitive information, details of the patient's GP and a supply of labels. The clinician must be informed of the situation at the earliest opportunity and asked whether they are willing to see the patient using this temporary record.

If the clinician is unwilling to use the temporary records and the patient is not seen, the clinician should provide a full explanation to that patient and this explanation documented in the temporary healthcare record. The patient may prefer to defer their appointment until the original healthcare record is available.

When the original record becomes available, the Medical Records Department will ensure that all items from the temporary record folder are merged with the original, which will include the electronic date updated onto the database. When the missing healthcare record is found the Medical Records Department should inform the relevant clinician.

The temporary record is managed and tracked on PAS in the same way as the original, although care must be taken to track the correct record. The creation of temporary records, and their subsequent location, will form part of the audit

presented to the Clinical Quality Risk Management Group via the Healthcare Records Committee.

The Medical Records department will monitor the creation of all temporary healthcare records and initiate enquiries to search and locate the original.

If a temporary record is created due to the original record being unavailable, the completion of an adverse incident report may be appropriate.

5.2.3 Creation of Additional Healthcare Record Folders (or Volumes)

A patient's healthcare record folder is limited by their size and binding facility. When the folder reaches its maximum content (too thick or unwieldy for handling or for neatness, either completely or in a single section) a second volume for the patient will be created by the Medical Records Department or by Ward Receptionists. The latest volume will be used when the patient attends the hospital unless specifically requested otherwise by the treating clinician.

5.2.4 Amalgamation of Healthcare Records

Where there are two or more healthcare records for one patient, these must be identified, information validated and, where appropriate, merged. Identification of records requiring investigation with a view to possible merging can come from a generated PAS report as well as via telephone or e-mail from within the Trust.

Similarly, if as a result of an error, additional hospital numbers are given to a patient they must be immediately amalgamated on all systems by designated staff (those authorised by the Healthcare Record Manager), and any records merged in strict date order.

Besides ensuring that patients receive effective treatment, amalgamation is important in order to identify all activity within the Trust:

- every effort must be made to identify any existing patient identification each time activity commences. Checks should be made, particularly prior to registration, this could be as the result of a referral, a walk into clinic or by admission
- all identified double registrations must be dealt with immediately through an appropriately trained and competent healthcare records clerk.
- there must be complete certainty that the two records relate to the same patient before a merge is undertaken.
- under no circumstances may the PAS merge take place without the paper health record merge also being completed at the same time.
- all healthcare records must be retrieved before a decision is made by the Healthcare Records Manager, Assistant Healthcare Records Manager, supervisor, or team leader regarding which identification number is to be retained. The oldest number will usually be kept but this may vary (if for example the letters oldest appear at the end of the number) and the newer number kept.
- the ability to merge is subject to departmental training and password control.
- any amalgamations must be immediately recorded on the hospital PAS [patient administration system] PAS to prevent future use/confusion of any minor number(s). Contact the PAS Application Team through the IT Service Desk on ext: 4377.

5.2.5 Reconstitution of previously scanned healthcare records

In order to save library space, a large number of healthcare records have been electronically scanned and, following quality assurance guidelines, the original paper record destroyed. Subsequently when a patient whose records were included in the historic scanning programme presents, their healthcare record needs to be reconstituted from the electronic form.

Reconstitution of scanned records will be undertaken by dedicated and trained Medical Records Department staff. Records reconstituted from a scanned image will have a footer to each page to indicate that it is a scanned record plus a sticker on the front of the healthcare record folder. A current year sticker will be affixed to the folder as normal and the record returned to the current library following use. The tracking step will also confirm the return to current use.

The scanning system has the ability to record a critical note against each record raised to ensure duplication does not occur and has a link to PAS. It is able to highlight any potential un-scanned item and produce information sheets.

Healthcare Records that have been identified as previously scanned but have not been reconstituted can be viewed in the Medical Records Department by appointment.

5.3 Structure of a Healthcare Records Folder

The establishment of a uniform structure for all healthcare records is essential to ensure that medical information is readily identified and easily retrieved. All staff who use the patient record must comply with the filing standards.

5.3.1 Basics

All documents should have patient identification which must be matched against the folder in which they are filed. Misfiles should be reported as adverse incidents through the Trust Adverse Incident Reporting system.

The Healthcare Record folder is clearly identified with the following:

- patient registration unit number
- patient identifying details
- trust title imprint
- confidential – not to be removed from hospital imprint
- alert notices imprint

Complaints regarding the condition of the healthcare record, or where a new folder may be required, should be directed to the Healthcare Records Manager.

All new patient medical record registrations are provided with a healthcare record folder which currently has 11 sections (5.3.2).

There is a plastic pocket in the rear inside cover which is to be used only for patient labels. No other items will be placed in this pocket.

The recently introduced new healthcare record folder is laminated for infection control purposes and is made of heavier card for durability. There are two sets of anchorage points to ensure paperwork remains in situ. Printing on the inside rear cover confirms the need to use the plastic pocket for labels only and reminds staff, '*Healthcare Records – If you touch them, track them*'.

Some 'old' case note folders still in use within the Trust have a pocket within the rear cover. These pockets are to be used for patient labels and nothing else.

5.3.2 Filing order

There is a defined and agreed filing order for all documentation within the sections of the folder. The sections are all clearly labelled. It is essential that all documentation is filed in the correct section by all staff who handle or use healthcare records:

Section 1. Correspondence and summaries

- file in date order, most recent uppermost
- include in this section Advance Directives which must always be kept at the forefront of any correspondence and summaries

Section 2. Clinical case notes

- file in date order book wise i.e. earliest entry through to latest entry, using the specialty colour coded stationery
- If patient admitted through A&E a copy of the A&E record must be inserted

Section 3. Diabetic clinic sheet

- file in date order, most recent uppermost

Section 4. Investigations

- file in date order, most recent uppermost (with the mount sheets behind)
- including reports issued in letter format
- hypersensitive information
- colour coded mount sheets (e.g. pathology / radiology) to which the appropriate reports are to be adhered
- the results must always be signed and dated by clinical staff as soon as possible after receipt and then filed, irrespective of whether they've been viewed on Pathology Partnership System (PPS), the electronic system
- cardiotechographs [CTGs] and other machine produced recordings, dental x-rays and Compact Discs [CDs] must be securely stored in manila envelopes [not a plastic folder] which can be sealed and hole punched
- photos should be mounted onto punch holed card.

Section 5. Consent, operation and anaesthetic notes

- file in date order, most recent uppermost.
- this section must also include:
  - the consent form for hospital post mortems, endoscopy reports, pre-op assessment forms [this will also contain Infection Control information]

Section 6. Care Pathway Booklets

- file in date order – most recent uppermost.

Section 7. Miscellaneous

- file in date order, most recent uppermost
- this section will include nursing reports, fluid balance charts, temperature charts, prescription charts, risk assessments, waterflow score sheets, drug charts, Intensive Care Unit [ICU] records and any other documentation where no clear guidance for filing has been identified

Section 8. Obstetrics

- file in date order book-wise [i.e. earliest entry through to latest entry]
- refer to Appendix B of the Policy for the Completion and Storage of Maternity Records for full standards for filing

Section 9. Chemotherapy

- file in date order, most recent uppermost
- this section will include referral forms, consent forms, pre-prescribing check lists, prescription charts and clerking/assessment sheets

Section 10. St. Luke's Cancer Centre Documentation (except Radiotherapy)

- file in date order, most recent uppermost
- this section will include medical history sheet / clerking sheets, nursing kardex, care plans, assessment tools, pre-assessment clinics, on-treatment review, consent for central venous lines

Section 11. Radiotherapy

- file in date order, most recent uppermost
- this section will include consent forms, request forms, physics sheets, isodose plans, planning sheets, treatment cards

5.4. Healthcare Records Filing Standards

It is the responsibility of every Trust employee, when handling healthcare records, to ensure all documents are filed appropriately **before** the record is returned to either Clinical Coding or the Medical Records Department. Any documents that are available electronically do not require filing provided the steps outlined below have been followed.

o X-ray and test results

When requests are made by medical staff for investigations, x-rays and/or tests, the resulting reports are returned to the requesting consultant to act as a prompt for review. All reports should be read and signed within 24 hours of their receipt to indicate that they have been seen and may now be safely destroyed by either the Clinician or the appropriate medical secretary or ward receptionist. Clinicians may make notes on the investigation results in which case the paper copy with annotations must be filed.

o Inpatient results

In-patient results that are not available electronically should be filed by Ward Receptionists as soon as possible after the clinician has signed. Thereafter, in the event of delay, the responsible for this action passes to the medical secretary. (However, this should be exceptional and most often will be due to the ward receptionist not having access to the patient's record).
Patients receiving CT/US/Screening procedures in emergency situations will also have a report written in their notes
Where the results are available electronically there is no requirement to file the paper copy unless the Clinician has made handwritten notes, in which case the paper copy must be filed.

- **Outpatient results**

In the normal course of events, outpatient results are dealt with by the medical secretaries. An exception may occur when the patient is on a ward, and under such circumstances if the results are not available electronically the signed results should be passed to the ward receptionist for filing. The following must be considered before filing:

- All signed investigations or results that are not available electronically must be filed in the appropriate section of the patient record as soon as possible, but always within 7 days of signing by the clinician
- If there is no signature on the reports, it must be assumed that the results have not been read or seen by a member of the medical staff
- Should an inpatient be discharged home before the investigation or test results is returned to the ward, it is the responsibility of the ward receptionist to ensure that the results are seen and signed by a member of the medical staff and filed in accordance with this policy in the healthcare record by the appropriate member of staff.
- Where the results are available electronically there is no requirement to file the paper copy unless the Clinician has made handwritten notes, in which case the paper copy must be filed.

- **Duplicate Documents**

Only one copy of any document is required to be filed unless multiple copies have been annotated by a Clinician.

- **Documents Not to be Filed in the Healthcare Record**

- No letters or other documentation relating to patient complaints, or incident forms relating to patients should be filed within the patient record, but in separate administration files used for this specific purpose.
- Litigation Papers
- Coroners Reports

5.5 Quality and Standards of Healthcare Records Documentation

Standards contribute to maximising patient safety and quality of care (through improved completeness of documentation by clinicians) and improved clinical performance, support professional best practice and assist compliance with Information Governance and NHS Litigation Authority (Clinical Negligence Scheme for Trusts) standards.

It is essential that complete healthcare records are available for each appointment and admission to provide the clinician with a detailed medical history of the patient. To achieve this:-

- The healthcare record should have a standardised structure and layout (refer to Section 5.3)
- All patient details must be checked for accuracy and completeness.
- Any pre-arranged procedures should have taken place and the ensuing documentation have been received.
- All clinical letters and investigations must be available.

- Every patient record must be in good order and complete for each attendance and contain an up to date and adequate supply of labels.
- The referral letter to another specialty must be dated and the referrer and the receiver must be identified.
- Where a patient is identified as having additional records this will be clearly recorded by use of the trust's coloured sticky label system and all treating staff must take note that other records do exist.

It is essential that **all** staff; clerical, medical, nursing and allied health professions ensure that in matters relating to the composition and legibility of healthcare records every effort is made to comply with basic record keeping standards.

5.5.1 Basic Record Keeping Standards

The following generic medical record keeping standards have been based on published advice provided by the Academy of Medical Royal Colleges

- The patient's complete healthcare record must be available at all times during their stay in hospital
- It is essential that there be a corporate standard and approach to the creation of any new documentation. (The process for creating, reviewing and approving nursing documentation is shown in Appendix 4)
- Identification of the patient must be without risk or error, this means always ensuring that the correct healthcare record is available for the patient who is being treated.
- Every page in the healthcare record must include the patient's name, NHS number and local hospital number.
- The patient's full name, address, postcode and date of birth on every page – use label or handwrite if no label available.
- Clear identification of the Consultant responsible for each episode of care and any change/transfer to another Consultant to be noted.
- All notes are written in chronological order and provide evidence of each doctor/clinician contact with the patient.
- There is a designated section on the inside front cover marked 'Alerts'. This section is used to record information and special warnings such as allergies/adverse reaction to drugs, advance directives, special precautions and do not attempt to resuscitate [DNAR's] instructions.
- Write in black indelible ink. (However Pharmacists write on Drugs Charts in Purple ink in order to identify information written by the Pharmacist to that written by the Clinician).
- Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature.
- Clear indication if a consultation or advice is provided by telephone.
- All entries must be written as legibly as possible so that others can clearly read and understand the text; clear communication between members of the care team is essential.
- Staff are expected to complete records as soon as possible (within 24 hours). A nurse document completion guide has been created to guide nurses on the frequency of documentation as a minimum. It is recognised

that there will be times when more frequent documentation is required and nurses should make an independent clinical decision to do so. The guide can be found at Appendix 3.

- Drug names must be printed in full on the medication charts.
- Never erase or use correcting fluid. If an error occurs in recording, the following procedure should be implemented:
- ~~**Strike through the entry with a single line**~~
- Initial, date and record the time the error was corrected and then sign the entry. Then make the correct entry.
- Do not leave spaces between each entry.
- Document facts - use objective rather than subjective comments whenever possible.
- Record accurately information given to patients in respect of treatment choices and risks.
- investigation results must always be signed and dated by clinical staff (if nursing staff it must be by a registered nurse) as soon as possible after receipt.
- Do not use unnecessary abbreviations.
- Retrospective entries are to be clearly documented as such, with the time of entry and the time the entry pertains to.
- If using multi-layer forms make sure that the final copy is as legible as the top copy.

5.6 Availability of Healthcare Records

The Medical Records Department will make every effort to ensure that records are available for patients attending for clinic or elective admissions in advance of the appointment or admission date. Checks will continue to be made up to the time of the admission/appointment, adding any outstanding records.

The clinic/elective admissions lists should be further checked again at 24 and 12 hours in advance for additions and cancellations.

Records should not be kept for longer than is necessary. As a guide the record should not be requested more than **3** working days prior to a clinic and should be returned to the Medical Records Department no later than **3** working days after the clinic or discharge.

Following patient clinic appointment or inpatient episode or any other patient activity the healthcare record must be made available to the Coding Department to enable the correct coding to be applied.

Please refer to Section 5.12.1 for information regarding emergency access to the Medical Records Department.

Records required for the purposes of audit and research:

A Clinical Audit Request Form must be completed and authorised by the Clinical Audit Department before the Healthcare Records Manager can authorise the pulling of notes.

To obtain healthcare records for audit and research the clinician may experience a waiting period. This is due to records for inpatient and outpatient services taking priority.

5.7 External Requests for Healthcare Records

It is the Policy of the RSCH that **original** healthcare records are **never** sent to requesting bodies outside of the Trust. Staff must always consider the Data Protection Act 1998 and the Caldicott Principles when responding to requests for copies of patient records.

The Healthcare Records Manager has overall responsibility for the implementation of Subject Access Requests (SAR's) under the Data Protection Act and Access to Health Records Act and should be contacted in the first instance to provide advice before releasing patient information.

Subject Access Requests - access to healthcare records by individuals
Individuals have a right to apply for access to health information held about them and, in some cases, information held about other people. The main legislative measures that give rights of access to health records include The Data Protection Act 1998, The Access to Health Records Act 1990 and The Medical Reports Act 1988.

The Data Protection Act (DPA) gives individuals, or their authorised representative, the right to apply to see and/or have copies of certain personal data held about them, including health records.

A request for access to health records in accordance with the DPA should be made in writing, which includes by email, and should be directed to the Healthcare Records Manager. If an inpatient is requesting further advice regarding a Subject Access Request, contact should be made with the Patient Advice and Liaison Service (PALS) who will be able to visit the patient while in hospital to advise further.

The requester should provide enough proof to be able to satisfy the Healthcare Records Manager of their identity and enable the information requested to be located. If this information is not contained in the original request proof should be sought as required.

Where requests are made on behalf of the individual patient, the Healthcare Records Manager, on behalf of the Data Controller (the Trust), should be satisfied that the individual has given consent to the release of their information.

It is good practice that an enquiry is made with the applicant to ascertain whether all or just some of the information contained in the health record is required before processing the request. This may decrease the cost for the applicant and eliminate unnecessary work by staff. However, there is no requirement under the Act for the applicant to define which parts of their health record they require.

Where an access request has previously been met, the Act permits that a subsequent identical or similar request does not have to be fulfilled unless a reasonable time interval has elapsed.

The Healthcare Records Manager will send out the information pack containing the application request form. Once the form and fee [if appropriate] are received, the required records are retrieved and then must be checked by the consultant in charge of the patient's care to ensure that nothing that could cause mental or physical harm or third party information nor information provided in confidence is disclosed.

Once an application/request form and fee [where relevant] has been received, the request is recorded on internal systems and complied within 40 calendar days.

As well as the patient, someone with their written consent, a personal representative, a parent or guardian, by Court Order or someone with a claim arising from the death of the patient may also apply for access to the records.

Staff can also access information held about them under the Data Protection Act. Such requests must be referred to the Human Resources Department.

Under certain circumstances access may be refused. These may include where, in the opinion of the holder of the record, giving access would disclose information likely to cause serious harm to the physical or mental health of the patient or any other individual, where giving access would, in the opinion of the holder of the record, disclose information relating to or provided by an individual other than the patient who could be identified from that information or where the relevant part of the clinical record was made before the 1st November 1991.

Requests for access to patient records can also come from various other sources including solicitors, the police, the Department of Work and Pensions, the Criminal Injuries Compensation Board, the War Pensions Department, Insurance Companies and Consultants working outside the Trust to name but a few. The Medical Records Department has a mechanism to deal with requests for access to patient information from the various parties as mentioned above.

The police do not have an automatic right of access to a patient's healthcare record. However they may, upon presentation of a court order, or with the written consent of the patient or under Section 29 DPA (crime, terrorism etc) be given photocopies. Please refer to the Legal Services Manager, Information Governance Manager or the Healthcare Records Manager if you have any doubt about releasing information. Refer to the flow chart at Appendix 5 regarding Police Requests for Information.

Solicitors acting on behalf of a patient must provide their client's signed authorisation before any copying and disclosure can be undertaken.

Anyone seeking information from a patient's healthcare record by the presentation of a Lasting Power of Attorney for Health and Welfare must provide a registered certificate which must be placed on file.

Access to the medical records relating to a deceased patient may be granted to a patient's Personal Representative (an executor appointed under the deceased's will or where there is no will a person appointed as an administrator) or to a dependent who may have a claim arising out of the death. Proof of the appointment as a Personal Representative or that the applicant is a dependent who may have a claim must be obtained. Only those records that are relevant to a potential claim should be disclosed. Before giving access to health information relating to a deceased patient, the records should be reviewed to ensure that the deceased made no request that the records being considered for disclosure should not be disclosed.

The coroner may require access to a patient's healthcare record and the trust should assist with such a request wherever possible. If in doubt advice should be sought from legal services.

All requests for validation of insurance documentation made by an individual or a company will be dealt with by the Medical Records Department.

Requests for patient information from NHS Trusts
The Medical Records Department procedure in response to requests from other NHS Trusts or from outside agencies (with responsibility for the care of the patient) for a copy of a patient record is as follows:

- All requests must be in writing (or fax/secure e-mail) to the Healthcare Records Manager. This request must be filed in the case notes.
- The request must state the reason(s) the record is required.
- Urgent requests for patient records must be given priority and copies may be sent by secure email or fax subject to 'Safe Haven' criteria.
- Copies of records related to non-urgent requests will be forwarded in a securely sealed correctly addressed package to a named individual and sent by recorded delivery.
- In the event of an emergency transfer it is recommended that a covering letter should always accompany the patient together with a copy of the appropriate records. A copy of the letter should be placed in the healthcare records. However at night or during weekends copying of the records may not be possible and records should be sent by secure email or fax as early as possible the next working day.

Requests for Patient Information from Private Healthcare Providers
The original record is, and always remains, NHS property. Requests from the private sector for patient information will be dealt with as follows.

- The original record will **never** be sent unless the private provider is undertaking authorised Trust activity. It is therefore important to distinguish the reason for the request at the earliest opportunity.
- If the request does relate to Trust activity the original record may be sent provided that PAS is fully updated with the destination and contact details of the requestor.
- If the request does not relate to Trust activity the requestor must provide an audit trail of written/faxed request and include the written consent of the patient to whom the record relates. Upon receipt of the audit trail copies of the record may be disclosed. Both request and patient consent must be filed in the patient's record.

5.8 Amendments to Healthcare Records

Credible records are an important aid in providing safe healthcare to patients. Records should reflect the observations, judgements and factual information collected by the contributing health professional. The DPA fourth principle requires that information should be accurate and kept up-to-date. This provides the legal basis for enforcing correction of factual inaccuracies. An opinion or judgement recorded by a health professional, whether accurate or not, should not be deleted. Retaining relevant information is essential for understanding the clinical decisions that were made and to audit the quality of care.

If a patient feels that information recorded on their record is incorrect, they should first make an informal approach to the health professional concerned to discuss

the situation in an attempt to have the records amended. Where both parties agree that information is factually inaccurate it should be amended to clearly display the correction whilst ensuring that the original information is still legible. An explanation for the correction should also be added.

Where the health professional and patient disagree about the accuracy of the entry, the Department of Health recommends that the data controller should allow the patient to include a statement within their record to the effect that they disagree with the content.

5.9 Transfer of Healthcare Record for Patient Transfers or Discharge

5.9.1 Patient Transfer

When a patient is transferred to a hospital outside the Trust, relevant copied sections should be transferred with a covering letter, a copy of which must be retained in the patient's healthcare record. Transfers between consultants should be recorded in the patient record and also on PAS.

On discharge, an in-patient's record must contain a copy of the Discharge Advice Letter which should be completed on the day of discharge, or as soon as possible and forwarded to the GP within 48 hours. The discharge letter should be a complete and accurate record of the diagnosis and treatment and the medication requirements and follow up arrangements for the patient.

If an inpatient dies the healthcare record is passed to the Relatives Officer's office for the completion of a death certificate. If a death certificate cannot be completed the death will be referred to the Coroner's Officer. Coroner's post-mortem reports are held by the Coroner.

Please refer to the Clinical Coding Standard Operating Procedures 'Medical Notes required for Coroner use' and 'Patients transferred to Milford and Haslemere Hospital' for further guidance.

5.9.2 Method of Transfer of Copied Records

Before the transfer of a healthcare record takes place, check the best and most secure method of transfer and follow 'Safe Haven' procedures as set out in the *RSCH Code of practice for employees in respect of confidentiality*. This applies to all methods of transfer e.g. fax, e mail and internal / external post.

5.10 Electronic Healthcare Record/Case Note Tracking

5.10.1 PAS

All healthcare records are tracked using the Patient Administration System: **this is mandatory.**

The location of all healthcare records must be traceable at all times. Staff members who transfer healthcare records are responsible for ensuring that the new location is accurately entered on PAS as close as possible to the actual time of the movement of the healthcare record.

Tracking will apply to the main healthcare record, the temporary healthcare record and also to any multiple volumes. Identification of the type of record to be tracked is available via 'List Patient ID' under the Functions screen on PAS.

Healthcare records must be returned, and tracked, to the Medical Records Department as soon as possible after use.

Failure to track a healthcare record may create a clinical risk and therefore may trigger completion of an incident form which could lead to an incident investigation.

PAS System unavailability – "down time"
Healthcare Records moved whilst the system is unavailable must have a healthcare record tracking form on the front of the healthcare record which is completed for each tracking step undertaken whilst the system is not available.

When the system becomes available again the person in possession of the record, at the time it becomes available, must record the relevant details on PAS from the tracking form. The form should then be removed and destroyed**.**

5.11 Security and Safeguarding of Healthcare Records

The healthcare record is a vitally important legal document containing confidential information used in the treatment of patients and its safe custody is therefore essential.

5.11.1 Security

To comply with the DPA Principle 7 healthcare records must be stored securely at ALL times. Healthcare records must be stored securely in lockable locations throughout the Trust and must be stored in a lockable notes trolley when located in ward or outpatient areas.

All staff should be informed of the importance of patient records and their security as part of their Local Induction.

All staff, when signing contracts of employment undertake to maintain the confidentiality of patient information.

The Trust will ensure that all feasible steps are taken to preserve the confidentiality of healthcare records and that their contents are not disclosed to unauthorised persons.

All Trust employees must act in a responsible manner to safeguard the interests of patients by honouring the obligation the Trust places upon them to maintain the privacy and confidentiality of patient information. Access to information held within healthcare records is restricted to authorised personnel only.

Staff must take caution when dealing with an enquiry for information and if in doubt refer to their Manager. Discretion should be used by all staff when relatives or friends enquire about a patient's condition, type of treatment or patient information. For further guidance, refer to the *RSCH Code of practice for employees in respect of confidentiality.*

Only staff required to handle healthcare records as part of their duties should do so.

Access to the Healthcare Records Library and affiliated storage areas is restricted to staff working in the Medical Records Department and only those staff authorised to do so by the Healthcare Records Manager.

Staff must not conduct unauthorised searches on PAS for other members of staff who do not have their own access.

5.11.2 Removal of Healthcare Records from Trust Premises (clinical care or storage)

Where original healthcare records need to be transferred to another location to support the Trust services (e.g. for outpatient appointments at off-site clinics – Haslemere, Cranleigh, Farnham etc.), the transportation of healthcare records must be undertaken by Trust transport in sealed envelopes or, in the case of bulk, in the security pouches provided.

Only where staff need to treat a patient outside of the Trust premises (e.g. at the patient's home, nursing home, provision of community services etc.) are they permitted to take the patient's healthcare record.

When staff are transporting a healthcare record they must ensure all records are kept secure during transit (e.g. in the boot of a car and not on a seat) and are not left in an unattended car overnight.

Where records are being transferred to the Trust's off-site storage facility it is the responsibility of the off-site storage company to ensure all records are securely transferred in compliance with the Data Protection Act 1998 and the RSCH Code of Confidentiality.

5.11.3 Removal of Healthcare Records from RSCH Premises (other than above)
The Trust's healthcare record must not be removed from the Trust premises by individual members of staff unless for approved business use.

Where staff have a need to take a healthcare record off-site for a reason other than those detailed above, they must obtain approval of the Trust's Healthcare Records Manager or Assistant Manager.

A log will be made of the date and time of the request, the hospital number and full contact details of the requestor and reasons for the record being removed from Trust premises.

On return to the Trust the Healthcare Records Manager or Assistant Managers will be informed and the log updated accordingly. A weekly check will be made and entries in the log cross reference with PAS.

5.12 Storage, Retention and Retrieval of Healthcare Records

The healthcare record is essential in the treatment of patients and should be available for every patient as and when required. The retrieval and availability of patient records depends upon accurate and timely filing and tracking. Records must be available 24 hours a day, 7 days a week.

5.12.1 Medical Records Library

A patient's healthcare record contains the majority of the clinical records created by the Trust. These records are stored in the Trusts Medical Records Library.

Whilst the Trust operates a closed library system operated only by designated staff, who are authorised to file and retrieve records, in recent times access has been made available to Secretaries, Ward Receptionists and staff from departments to allow them to file into the record.

Visitors to the Medical Records Library sign into the library and conduct their filing under the supervision of Medical Records staff who are available to assist with locating records if so requested.

Any member of staff requesting a healthcare record must be an authorised Trust employee. Records requested on a routine basis will be prioritised and made available within three days. Urgent requests will be acted upon immediately.

The Medical Records Department Reception is open Monday to Friday 8.30 am to 5 pm in order to deal with enquiries and requests in respect of Healthcare Records within these hours. When the Reception is closed contact may be made with the Medical Records Department and requests or enquiries dealt via phone, fax or email. The full contact details can be found on the Healthcare Records section on TrustNet.

Where Healthcare Records have been requested they will be made available for collection from the Reception area during opening times. Outside of these hours Medical Records staff are available to deal with emergency admissions and urgent requests from wards.

In emergencies, and where no Medical Records staff are available, Site Nurse Practitioners are able to access the library and retrieve records if they are there filed.

Staff who are able to use the tracking system to locate the last known holder of the record may request assistance from security/porters to gain access to other locations and retrieve them.

Records held in secretaries' offices should be accessible out of hours. Therefore filing cabinets and drawers that are used should not be locked.

The filing system operated in the Trust is terminal digit. It is essential that all staff with an input to patient records are fully aware of the system and are trained in the correct filing method operated in the department. Healthcare records being returned to the Library via 'subsort' should be tracked, immediately sorted into strict terminal digit order, and inserted in the appropriate 'subsort' pigeon hole. Medical records staff will sort from 'subsort' into terminal digit order and file the records into the current library or other location as appropriate or as indicated on PAS (coding sticker box for example). Batches of files should be stacked in trolleys and accurately and neatly returned to the appropriate position. A continual review of the records returning to the library via this means is essential to monitor quality and assess for retention and disposal. The subsort opening hours can be found on the Healthcare Records section on TrustNet.

5.12.2 Transfers to and from offsite storage

In order to maintain an efficient and manageable Medical Records Library, within the constraints of available space, it is necessary to continually monitor and control the volume of healthcare records within the Trust. This is achieved by means of a continual review and weeding programme. The Medical Records Department retain in its Current Library only the records of patients who have been attending the Trust within the last 18 months. Pre dated records are identified via the year sticker and, providing that the last entry agrees with the year of activity, transferred to archive storage off-site, (Kelly's Storage).

The system to be adopted for monitoring and controlling the volume of healthcare records in the current library is summarised as follows. Commencing at '00' and rolling through the number sequence healthcare records will be withdrawn using the last year of attendance sticker on the outer cover of the record. Following the

removal of the records selected for weeding the shelving may be adjusted so that the remaining records are stacked evenly and neatly.

The healthcare records will be placed in a trolley in strict terminal digit order and then, upon confirming no upcoming Trust activity, placed into a pre numbered Kelly's storage box. They are then tracked to offsite storage with the box number placed in the short note field of the tracking step. A random check of one box per terminal digit should be scrutinised for accuracy by a supervisor.

Records returned from archive /offsite storage for re-use will be given a current year of attendance sticker and will be returned to the Current Library.

Deceased records will be filed in alphabetical order in month of death and stored in the current library for a period of 5 months before being transferred to off-site storage.

At present multiple volumes, no longer current, will be packed and tracked to off-site storage.

The transferral of these records is securely and confidentially undertaken by Kelly's Storage who deliver to and collect from the Current Library. Further advice is available from the Healthcare Records Manager.

5.12.3 Retrieval of Records from offsite storage

All requests for case notes from offsite storage are undertaken by staff based in the library at the RSCH, for the Trust, Cranleigh Village, Milford and Haslemere District Hospitals. The information required to process the request will consist of Patient Name, Hospital Registration Number and storage box number (the number is located in the PAS short note and has a K prefix).

Designated members of library staff will generate clinic and elective admissions lists with a tracking step of **offsite storage** at 10 days in advance of an appointment and again at 5 days prior to an appointment to check records will be available.

Those not identified via the above method (reflecting late additions, changes and ad hoc requirements) are to be requested via a centrally held request folder within the library which is updated as requests are identified. Any requests for records held in offsite storage should be done in a timely manner to allow sufficient time for delivery and staff must ensure that all requests have the designated box number prior to commencement of the order. This information is located on the PAS 'short note' page and is prefixed with a 'K'. Place the order using Patient Hospital Number, patient name and Kelly's box number and select whether you require an individual record or complete box for next day delivery.

Each record/box requested will have a tracking step of 'Requested from offsite storage' with the date and time of the activity and a short note confirming the date, location or requesters details. Urgent requests are dealt with in the same way as requests for same day delivery.

Delivery will be to a pre agreed location in medical records between 9 am and 10 am Monday to Friday with the exception of Bank Holidays. Each individual record and box will be electronically tracked in by Kelly's. The Trust will confirm delivery via an electronic signature.

In the normal course of events an order placed before 4pm may reasonably be expected to be delivered the following morning.

Departmental Process for received records and boxes
Generate a list of records tracked to requested from offsite storage cross check each request in against the list as an individual record or extracted from a box and re track via PAS to 'returned from storage'. Records required at off-site locations will be tracked and sent on accordingly. Records requested ad hoc will be tracked to Medical Records Reception with a short note identifying the requestor. Records required by others within the library will be tracked accordingly. Where appropriate all returned casenotes should have Barcode labels placed on the outer cover together with a current year code label.

Validation/Audit
The request list and delivery should match. Where this is not the case a check will be made that the correct records or box were requested. Where the record cannot be located a check will be made of any withdrawal activity logged against that box via Kelly's data base. A further physical search will be made within the box and the original request checked. If an incorrect record or box delivery is identified arrangements will be made for return of the item and a credit issued to the Medical Records account which will be reflected on the appropriate invoice.

Return of Records to Storage
Individual records are to be placed in the returns box and re tracked to offsite storage ensuring that the correct box number from which the file originated has been identified and logged. Boxes will be left in a pre-determined location within the Medical Records Library to await collection. All boxes recalled from Kelly's should be subject to assessment regarding disposal/destruction processes as previously described.

5.13 Retention, Disposal and Destruction of Healthcare Records

5.13.1 Retention

Where individual records have been selected for permanent preservation or are to be retained for research or litigation purposes the Healthcare Records Manager must be informed and a 'do not destroy' stamp will be placed on the file cover and dated.

The RSCH has adopted the Records Management Code of Practice for Health and Social Care 2016 as a guide to the recommended minimum retention period for each record type. The schedule is available on the Healthcare Records intranet site.

5.13.2 Disposal and Destruction

The destruction process will be carried out in consultation with necessary health professionals, Information Governance Steering Group Committee and the Healthcare Records Committee. Agreement will be reached locally as to which records are to be preserved indefinitely for the purposes of research or for historical purposes.

The practical steps to be adopted for the destruction process are as follows. A search will be made via PAS and also the Kelly's Storage system to identify those boxes containing records matching the minimum retention criteria. Each box will be checked for appropriate healthcare records for destruction. Each batch of

returning boxes should, where possible, be amalgamated as space becomes available to ensure full box capacity at all times. Both the Trust's and Kelly's data bases will be updated with the new box location.

Staff will observe the guidance given in the Records Management Code of Practice for Health and Social Care 2016 and also this Policy when considering records for destruction and disposal. All details of the destruction will be entered onto the hospital information system PAS against the individual record as well as updating a spread sheet which will be held permanently within the department. A search will be made on PAS to ensure that those records due for destruction do not have another registration. If another registration is identified a merger will take place.

Reports on the destruction process will be made to the Healthcare Records Committee.

For further guidance on disposal of confidential waste, refer to the *RSCH Waste Disposal Policy and RSCH Code of practice for employees in respect of confidentiality*.

5.13.3 Archives

It is a legal requirement that NHS records which have been selected as archives should be held in a repository that has been approved for the purpose by The National Archives. Where an organisation is already in regular contact with Place of Deposit, they should consult over decisions regarding selection and transfer of records. Where this is not the case, the National Archives should be contacted in the first instance.

6. TRAINING

Trust staff are required to undertake training as defined in the Trust's Statutory & Mandatory (SaM) training matrix.

All staff who process requests for copies of medical records must complete the NHS Digital Information Governance e-learning module Records Management – Access to Health Records.

7. IMPLEMENTATION

No action plan required as implementation already in place.

8. MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS POLICY

Minimum requirement that is to be monitored	Monitoring Process e.g. review of incidents/ audit/ performance management	Job title(s) of individual(s) responsible for the monitoring and for developing action plan	Minimum frequency of the monitoring	Name of committee that is responsible for review of the results and of the action plan	Job title of individual(s)/ committee responsible for monitoring implementation of the action plan
1. Duties (Section 4.1)	Audit	Healthcare Records Manager	Annual	Healthcare Records Committee	Healthcare Records Manager

Minimum requirement that is to be monitored	Monitoring Process e.g. review of incidents/ audit/ performance management	Job title(s) of individual(s) responsible for the monitoring and for developing action plan	Minimum frequency of the monitoring	Name of committee that is responsible for review of the results and of the action plan	Job title of individual(s)/ committee responsible for monitoring implementation of the action plan
					Healthcare Records Committee
2. Legal obligations that apply to records (Section 4.2)	Audit	Healthcare Records Manager	Annual	Healthcare Records Committee	Healthcare Records Manager Healthcare Records Committee
3. How a new record is created (Section 5.2)	Audit	Healthcare Records Manager	Annual	Healthcare Records Committee	Healthcare Records Manager Healthcare Records Committee
4. How health records are tracked when in current use (Section 5.10)	Audit	Healthcare Records Manager	Annual	Healthcare Records Committee	Healthcare Records Manager Healthcare Records Committee
5. How health records are retrieved from storage (Section 5.12)	Audit	Healthcare Records Manager	Annual	Healthcare Records Committee	Healthcare Records Manager Healthcare Records Committee
6. Process for retention, disposal and destruction of records (Section 5.13)	Audit	Healthcare Records Manager	Annual	Healthcare Records Committee	Healthcare Records Manager Healthcare Records Committee
7. Basic record-	Audit	Healthcare	Annual	Healthcare	Healthcare

Minimum requirement that is to be monitored	Monitoring Process e.g. review of incidents/ audit/ performance management	Job title(s) of individual(s) responsible for the monitoring and for developing action plan	Minimum frequency of the monitoring	Name of committee that is responsible for review of the results and of the action plan	Job title of individual(s)/ committee responsible for monitoring implementation of the action plan
keeping standards, which must be used by all staff (Section 5.5.1)		Records Manager		Records Committee	Records Manager Healthcare Records Committee
8. Process for making sure a contemporaneous record of care is completed (Section 5.5.1)	Audit	Healthcare Records Manager	Annual	Healthcare Records Committee	Healthcare Records Manager Healthcare Records Committee

9. REVIEW, APPROVAL / RATIFICATION AND ARCHIVING

This Policy will be reviewed every 3 years or earlier if national policy or guidance changes are required to be considered. The review will then be subject to approval and re–ratification.

The Local Policy Officer or Central Policy Officer is responsible for ensuring that archive copies of superseded working documents are retained in accordance with the Records Management Code of Practice for Health and Social Care 2016; refer to Policy Development and Management: including policies, procedures, protocols, guidelines, pathways and other procedural documents.

Retrieval of archived versions persons requiring access to an archived Policy must contact the Central Policy Officer or the Company Secretary and provide them with the document title, name of author, ratification date and the version required.

10. DISSEMINATION AND PUBLICATION

Dissemination of the final policy is the responsibility of the author. They must ensure the Policy is uploaded to the Trust's Central Library (TrustNet) either via their Local Policy Officer or submitted directly to the Central Policy Officer.

The Head of Marketing and Communications is responsible for the trust-wide notification of existence of the Policy.

Clinical Directors, DDO's, Operational Division, or supporting services management teams, Ward Managers and Heads of Department are responsible for distributing this Policy and ensuring that all staff under their management (including bank, agency, contracted, locum and volunteers) are aware of the Policy.

11. EQUALITY IMPACT ASSESSMENT

The author of this policy has undertaken an Equality Analysis Initial Screening. No adverse impacts were identified. The Equality Analysis Initial Screening has been archived and is available via the Central Policy Officer.

12. ASSOCIATED DOCUMENTS

The following policies in relation to RSCH Healthcare Records Management and RSCH Information Governance Policies:

- Data Protection Policy
- Subject Access Request Pack
- Code of practice for employees in respect of confidentiality
- Freedom of Information Policy
- Information Security Policy for electronic and physical records
- Storage and Completion of Maternity Records Policy
- Incident and Serious Incident Policy

Other related Trust polices:

- Waste Disposal
- Clinical Audit Policy
- Nursing Documentation
- Dignity at Work Policy and Procedure
- Risk Management Strategy
- Policy Development and Management: including Policies, Procedures, Protocols, Guidelines, Pathways and other Procedural Documents
- Induction Policy
- Patient Information Policy
- Disciplinary & Grievance Policy
- Post Mortem
- External Agency Visits Policy
- Claims Management Policy (Clinical Negligence, Liabilities to Third Parties and Property Expenses Scheme Claims)
- Transfer and Repatriation Policy
- Discharge Policy
- Statutory & Mandatory Training Policy
- Being Open Policy
- Data Quality Guidelines
- Medicines Management Policy

NHSLA Evidence File

This Policy is a requirement of the NHSLA ref Standard 1 – Criterion 1.7 and 1.8.

13. REFERENCES

Public Records Act (1958) Sections 3 (1) – (2)

Data Protection Act (1998)
Access to Health Records Act (1990)
Access to Medical Reports Act (1988)
Freedom of Information Act (2000)
Health and Social Care (Safety and Quality) Act (2015)
Records Management Code of Practice for Health and Social Care (2016)
NHS Information Governance: Guidance on Legal and Professional Obligations (2007)
Information Security Management: NHS Code of Practice (2007)
Department of Health: Guidance for Access to Health Records Requests
Department of Health: Confidentiality: NHS Code of Practice
Supplementary Guidance: Public Interest Disclosures
World Health Organisation International Classification of Disease Code Book Version 10 [ICD/10] available at: www.who.int/entity/classifications
Royal College of Physicians: Generic medical record keeping standards https://www.rcplondon.ac.uk/projects/outputs/generic-medical-record-keeping-standards
Royal College of Physicians: Standards for the clinical structure and content of patient records https://www.rcplondon.ac.uk/projects/outputs/standards-clinical-structure-and-content-patient-records

APPENDIX 1: HEALTHCARE RECORDS COMMITTEE TERMS OF REFERENCE

1. Statement, Constitution and Purpose

(a) Statement

The Healthcare Record is one of the most important documents that circulate the Trust. Its condition, content and availability should be seen as vital to the effective and efficient working of the Trust.

(b) Constitution

The Healthcare Records Committee will operate within the framework set out in the terms of reference for the Committee in line with powers delegated to it by the Board as required to discharge the Trust's responsibilities.

(c) Purpose

The Committee is responsible for overseeing and supervising the maintenance of the Healthcare Records system throughout the Trust as well as creating a vision for the future as we move to a full electronic patient record.

2. Membership, Chairperson and Quorum

(a) Membership

Consultant representing all Divisions
Healthcare Records Manager (Chairperson)
Director of Informatics
Head of Patient Safety and Quality
Legal Services Manager
Information Governance Manager
Division Representative from Access and Medicine, Surgery, Women and Children, Oncology and Diagnostic and Clinical Support Services
Representative from Practice Development Nurses
Representative from Nursing
Representative from Outpatients
Representative from Pathology
Representative from X-ray
Representative from Midwifery
Representative from Clinical Coding
Representative from Data Quality
Representative from Secretariat
Representative from Allied Health Professionals

Deputies may attend in the absence of a Member but that deputy must hold appropriate authority to act.

(**b) Chairperson**

The Consultant shall be the Chairperson of the Committee.

(c) Quorum

A meeting shall be considered quorate if the Chair (or Deputy Chair) and six members are present.

3. Frequency of meetings

Meetings shall be held quarterly and members must attend at least 75 % of all meetings but should aim to attend all scheduled meetings. The planned duration will be one hour.

4. Conduct

Items for the agenda should be submitted to the Healthcare Records Manager a minimum of one week prior to the meeting. Membership and terms of reference will only be changed with approval and will be reviewed and agreed annually.

5. Objectives

The Committee shall:

- develop a healthcare records management Policy for the trust which sets out the management and standards for record keeping, as well as the disposal of records, as defined in the Department of Health: Records Management: NHS Code of Practice 2009.
- ensure the Policy is implemented within the Trust
- monitor the effectiveness of the Healthcare Records Policy
- promote good practice for clinical documentation throughout the Trust
- approve, monitor and control the contents of the healthcare record
- recommend Trust wide policies for the storage and retention of paper based clinical records in line with national recommendations and statutory requirements
- support the development of the electronic patient record
- advise IM&T and the Trust on developments which impact or involve medical records in particular the development of the electronic patient record
- ensure the compliance of medical records library functions and paper based case notes in line with the Data Protection Act.
- comply with CQC regulations and monitor and take steps to improve the quality of the healthcare record throughout the Trust.
- collect evidence for the standards set out in the NHSLA
- monitor the principles of confidentiality as set out in the legislation: Freedom of Information Act 2000, Data Protection Act 1998, Access to Health Records Act 1990 and Caldicott Guardians in accordance with Information Governance
- provide advice and support to staff within the Trust working with healthcare records in respect of the good practice guidelines set out in the healthcare records Policy
- monitor and assist with the training of staff to raise awareness of the need for good governance in respect of the healthcare record
- support the work of risk management by assessment of healthcare record risks and the recommendation of relevant controls.

6. Accountability

The minutes of the Healthcare Records Committee meeting shall be formally recorded and submitted to the Clinical Quality Risk Management Group. The Chair of the Healthcare Records Committee shall draw to their attention any issues requiring disclosure or requiring action; the speed of communication should be proportionate to the seriousness and likely impact of the issue.

7. Review of effectiveness

On a quarterly basis the Group shall monitor its effectiveness against the annual Healthcare Records Strategy and Action Plan.

Agreed by Clinical Quality Risk Management Group

Signed:

APPENDIX 2: INTERNAL HEALTHCARE RECORDS LIBRARY AUDITS

Each year Supervisors/Team Leaders take a random selection of prepared clinics and elective admissions and audit against standards set in Record Library duties that each Healthcare Record (HCR) should have:

- Good quality outer covers
- Supply of up-to-date labels (no less than 20)
- History sheet with clinician's name
- Date of clinic or admission
- Creation of multiple volumes if appropriate
- Referral letter/ relevant documentation for current episode
- Year code and
- No loose paper work.

The required standard is 98% compliance for each item.
Healthcare record availability - Clinics and elective admissions on the day: This is linked via data base to give us percentage of healthcare records available by consultant and speciality.

The required standard is 98% availability of healthcare records

Tracking step audit
Generate a system based list of all healthcare records tracked to a selected tracking location. Using the list go to that location and cross reference healthcare record against the list. Where a healthcare record is found that is not tracked update tracking immediately. Where a healthcare record is not located further investigate by location enquiry and enquiry of PAS. When located track to the current location. Where a healthcare record has been tracked in error delete the incorrect tracking - this ability is restricted to trained and authorised staff.

Data Protection Requests
Take a random sample to see if the process has complied with the relevant timelines.
Split into:-
Subject access and/or Solicitor requests.
Date of request.
Date the request has been completed.
Number achieved within 40 days.
Number not achieved within 40 days.
Number achieved within 20 days.
Number not achieved within 20 days.
Highlight any issues for further action.

Retrieval of healthcare records
Linked to non-episodic requests verbal/telephoned /faxed/e-mailed
Each area to record the timeliness of the service
Verbal at reception - while they wait /or other
Telephoned request within 1hr 2hs etc. (or within time stipulated)
Faxes e-mails hand delivered lists of arrival /viewing within 2hrs 4hrs 6hrs same day/24hrs

Retrieval and availability of episodic healthcare records

The timely and accurate tracking of located healthcare records where the healthcare records are not located, the creation of a temporary healthcare record folder and the generation of an electronic recording of the temporary record and its subsequent location forms part of a data base providing us with the percentage of healthcare records not available. This is supported by ad hoc manual audits linked to the beginning and end of a clinic and date of admission against time of admission.

These audits form the basis of quarterly reports to the Healthcare Records Committee.

APPENDIX 3: NURSE DOCUMENTATION COMPLETION GUIDE

The following documentation guide has been produced to guide all registered and non-registered nurses on the frequency of documentation as a minimum.

However, it is recognised that there will be times when more frequent documentation is required and professionals should make an independent clinical decision to do so.

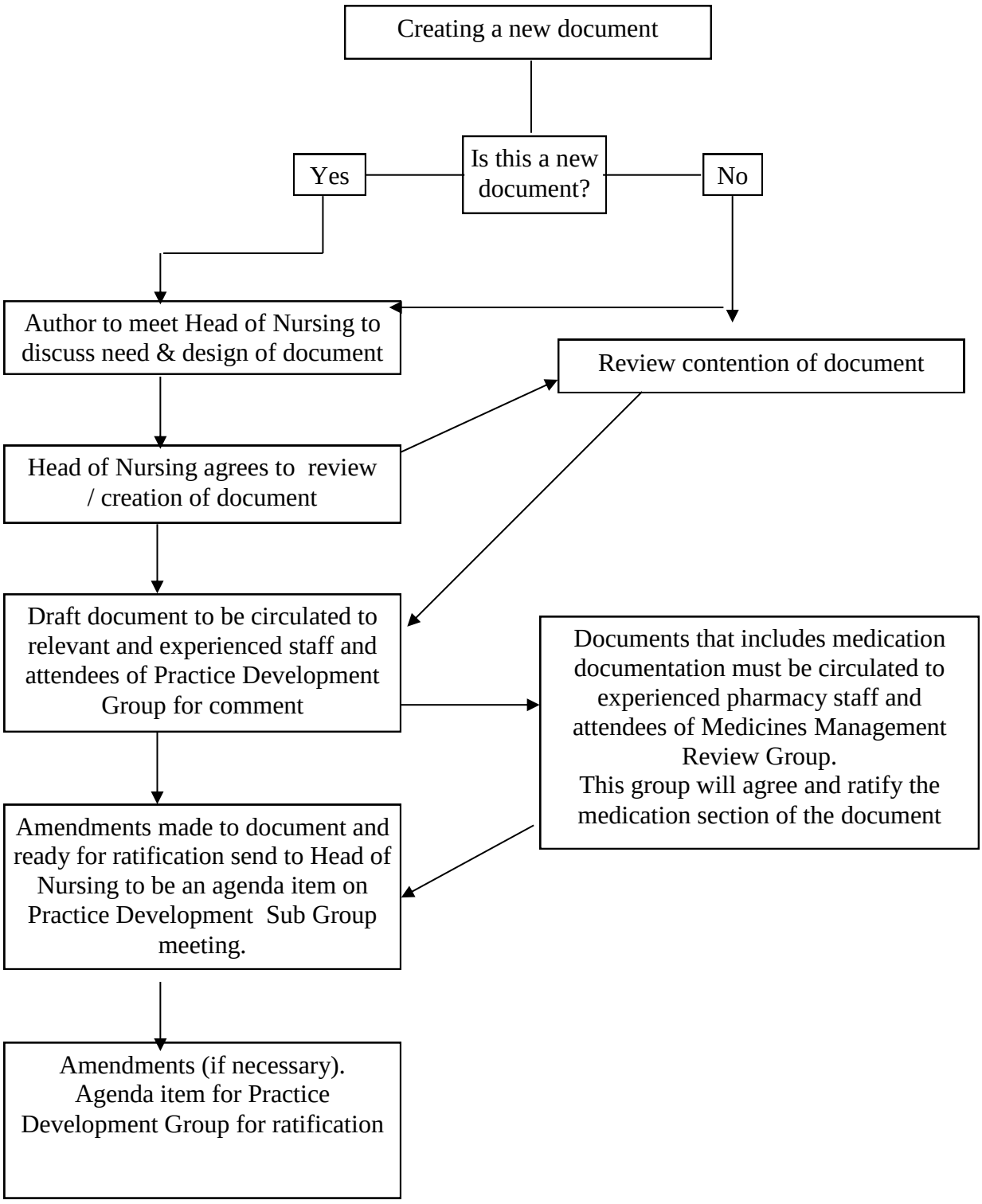
All nursing students are permitted to complete documentation under the supervision of a Registered Nurse.

Nursing Documentation	***When it should be completed***	***Completed by***
Pre-assessment document	Pre-operatively	RN, AP* Clinical Nurse Specialists
Care pathway documents	Commenced in pre-assessment and re-commenced within 6 hours of admission *****. If patient is admitted on day of surgery admission document must be completed prior to surgery.	RN /MDT /AP
Admission & Discharge Document	Commence admission within 6 hours of admission ***** Discharge checklist MUST be completed on day of discharge	RN, AP
Care plans	Within 6 hours of admission***** and further additional changes in condition during the patients stay	RN, AP
Nursing care plan & evaluation booklet	Every shift	RN, AP
Risk Assessments • Falls • MUST • Manual Handling • Waterlow • Side Rail • Continence • Side room	**All within 6 hours of admission* and if the patient condition changes;** • Weekly and every time someone falls • Weekly • Weekly and post procedure • Weekly and post procedure • Every 72 hours & only if needed and in use • If condition changes • If moved into a side room	RN, AP, HCA **if competency documents completed
Observation charts	As per care plan or medically indicated	RN, AP & HCA's
Fluid balance charts	Every meal time /end of every shift	RN, AP & HCA
Food and Hydration charts	Every meal time /end of every shift	RNs, AP & HCA's
Diabetic chart	As per care plan or medically indicated	RN AP & HCA

Stool Chart	After every stool / diarrhoea episode	RN, AP & HCA
Discharge /Referral letters	On discharge planning & preparation	RN, AP
Healthcare Records	On every consultation	Clinical Nurse Specialist

***Which includes Emergency Assessment Unit & Elective Surgical Unit**

APPENDIX 4: PROCESS FOR CREATING, REVIEWING & APPROVING NURSING DOCUMENTATION



APPENDIX 5: QUICK GUIDE FOR REQUESTS FOR INFORMATION BY POLICE