RECORDS MANAGEMENT POLICY

POLICY AND GUIDELINES

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1.0 INTRODUCTION

Records management is a discipline which utilises an administrative system to direct and control the creation, version control, distribution, filing, retention, storage and disposal of records, in a way that is administratively and legally sound, whilst at the same time serving the operational needs of the Trust and preserving an appropriate historical record. The key components of records management are:

- Record creation
- Record keeping
- Record maintenance (including tracking of record movements)
- Access and disclosure
- Closure and transfer
- Appraisal
- Archiving and Storage
- Retention and Disposal

1.1 Scope of the Policy

This document sets out the policy for the management of records within Kingston PCT. The term Records Life Cycle 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 closed files which may still be referred to occasionally) and finally either confidential disposal or archival preservation.

1.2 Related Policies

- Confidentiality – Staff Code of Conduct
- Data Protection Policy
- Data Quality Policy
- Trust IMT Policies
- Freedom of Information Policy
- Clinic Record Keeping (including use of RiO community system)
- Root Cause Analysis Guidance
- Serious Untoward Incident policy
- Disciplinary Policy
2.0 DEFINITION

Records are defined as ‘recorded information, in any form, created or received and maintained by the Trust in the transaction of its business or conduct of affairs and kept as evidence’.

Information is a corporate asset. The Trust’s records are important sources of administrative, evidential and historical information. They are vital to the Trust to support its current and future operations (including meeting the requirements of Freedom of Information legislation), for the purpose of accountability, and for an awareness and understanding of its history and procedures.

In the context of this policy, a record is anything which contains information (in any format) which has been created or gathered as a result of any aspect of the work of NHS employees, including:

- All patient health records (including private patients; electronic or paper based; including those concerning all specialities, and Independent Contractor records e.g. GP / Dentists / Pharmacists / Optometrists.
- All administrative records (including e.g. minutes of corporate meetings, personnel and estates records, financial and accounting records; notes associated with complaints-handling)
- X-ray and Imaging reports, photographs, slides and other images
- Scanning or Microform (i.e. fiche/film)
- Audio and videotapes, cassettes, CD-ROM etc.
- Computer databases, output, and disks etc., and all other electronic records e.g. memory sticks (Floppy disks are NOT accepted by the PCT and must not be used)
- E mails/texts
- Digital records
- Computerised records
- Material intended for short term or transitory use, including notes and ‘spare copies’ of Documents, message books and team, ward or professional diaries

This list is not intended to be an exhaustive list but to give a broad indication of the range of items likely to constitute a record.

The policy extends to all records including those of staff and those records noted in Part 2 of the Records Management: NHS Code of Practice (2009) which gives comprehensive details of applicable documents and their minimum retention rates.

3.0 LEGISLATION and GUIDANCE

Recent legislation and guidance has had a significant effect on record keeping arrangements in public authorities. NHS bodies must ensure that records management policies and procedures are fully compliant with key legislative requirements. These include:

- The Data Protection Act (DPA) 1998
- Freedom of Information (FOI) Act 2000
- The Caldicott Report 1997 (best practice guidance)
- Records Management: NHS Code of Practice’ Part 1 “(NHS Connecting for Health, 17/06/05) Part 2 (January 2009)

Other bodies are also likely to comment on records management performance including the Information Commissioner when investigating alleged breaches of Data Protection or Freedom of Information legislation and the Health Service Commissioner when investigating a complaint (A description of this legislation and national policy is attached as Appendix 1).

All trust staff will be made aware of their responsibilities for record-keeping and record management through generic and specific training programmes and guidance. The training is monitored through the appraisal, PDP process and attendance at in-house training.

4.0 DUTIES AND RESPONSIBILITIES

4.1 Managerial Accountability and Responsibility

Executive Directors and Senior Managers are personally accountable for the quality of records management within the Trust, and all Line Managers must ensure that their staff, whether administrative or clinical, are adequately trained and apply the Trust’s records Management Policy, i.e. they must in particular have an up-to-date knowledge of the relevant legislation and guidelines concerning confidentiality, data protection and access to patient information.

The Caldicott Guardian (currently the Director of Professional Development) is responsible for approving and ensuring that national and local guidelines and protocols on the handling and management of confidential personal patient information are in place.

A contingency or business continuity plan should be in place to provide protection for records, which are vital to the continued functioning of the organisation. Key expertise in relation to environmental hazards, assessment of risk, business continuity and other considerations is likely to rest with information security staff and their advice should be sought.

Appraisal refers to the process of determining whether records are worthy of permanent archival preservation. This should be undertaken in consultation with the PCT’s own archivist (where such a post exists), or The National Archives, or with an approved Place of Deposit where there is an existing relationship.
4.2 Role of Records Management Group

The role of a Records Management Group has been subsumed into the responsibilities of the Provider Services Information Governance Committee. This is to oversee the successful management of records within the Trust and to ensure that best practice is adopted until new organisational forms and structures are in place. A systematic and planned approach to the management of records within an organisation, from the moment they are created to their ultimate disposal; ensures that the organisation can control both the quality and the quantity of the information that it generates; it can maintain that information in a manner that effectively services it needs, those of government and of the public; and it can dispose of the information efficiently when it is no longer required.

The Group has divided its work into three very distinct areas focussing on:

- Clinical records (separate PCT policy available);
- Organisational and administrative records;
- Technical and IMT support needed to maintain effective records management arrangements.

The Group has a clear remit to:

a) Ensure record collections are rationalised by:
   - Encouraging users to share records and the information they contain, by the use of shared or group drive (but subject to Data Protection and Data Sharing protocols and agreed confidentiality guidelines)
   - Advising local managers/Multi-disciplinary teams (MDT) with regards to ensuring effective cross-referencing or merging (e.g. of all records for the same patient)
   - In line with emerging guidance ensure a framework for sharing and merging records is established.

b) Disseminate and publicise and promote an understanding of the Records Management Policy.

c) Records Management System Audit - The Trust will regularly audit its record management practices for compliance with this framework. The audit process is delivered through the Provider Services Information Governance Committee and shared with the Corporate Information Governance committee

d) The audit will:
   - Identify areas of operation that are covered by the Trust’s policies and identify which procedures and/or guidance should comply to the policy
   - Follow a mechanism for adapting the policy to cover missing areas if these are critical to the creation and use of records, and use a subsidiary development plan if there are major changes to be made
   - Set and maintain standards by implementing new procedures, including obtaining feedback where the procedures do not match the desired levels of performance, and Highlight where non-conformance to the procedures is occurring and suggest a tightening of controls and adjustment to related procedures

The work of the Records Management Group (Provider Services Information Governance Committee) will be scrutinised by the Provider Services Governance Committee and reports
will be available on request to the Information Governance committee.

4.3 PCT Health Information Team Leader (Health Records)

The PCT Health Information Team Leader (Health Records) is responsible for:

- Reviewing/adopting tracking and registration systems for appropriate records
- Ensuring that clinical records are bound and stored so that loss of documents is minimised
- Ensuring semi-current records are archived appropriately and in a secure area
- Ensuring that there is a mechanism for identifying records which must be kept for permanent preservation

4.4 Individual Responsibility

All NHS employees are responsible for any records, which they create or use. This responsibility is established by the Public Records Act 1958. Furthermore, as an employee of the NHS, any records created by an employee are public records.

Everyone working for or with the NHS who records, handles, stores, or otherwise comes across patient information is subject to a common law duty of confidence to patients and their employer.

The duty of confidence continues even after the death of the patient or after an employee or contractor has left the NHS. This responsibility is outlined in individual employee contracts and job descriptions.

Personal information (e.g. about a patient / member of staff) processed/kept for any purpose should not be kept for longer than is necessary for that purpose. Patient information may not be passed on to others without the individual’s consent except as permitted under Schedule 2 and 3 of the Data Protection Act 1998 or, where applicable, under the common law where there is an overriding public interest. Further guidance on disclosing patient information can be found within the Trust’s Confidentiality Policy.

5.0 RECORDS CREATION/REGISTRATION

The organisation is in the process of implementing RiO – the ‘electronic case record’ across all services. RiO has been designed to mimic the structure of a typical paper based medical record. By electronically storing and displaying patients’ electronic notes RiO presents clinicians with a holistic view of a patient/client record. The record comprises all elements of a case record, including assessments, care planning, progress Notes, risk history, current and historic medication details and a summary of significant events, displayed using a graphical timeline.

Due to the complexity of service delivery within Primary Care, the differing requirements of services, and the rolling programme of RiO implementation the format of patient records varies across services. Until such time that the electronic patient record has been implemented across the organisation all services creating records to support patient care should contain the criteria set out in section 5.1. This is not an exhaustive list but is seen as the minimum requirements to support safe and effective patient care.

5.1 Medical Records

The patient shall be identified and the record shall be set out in such a way that there is a record of:

- Patient Identifiable information including NHS Number, Next of Kin and GP
• A referral letter. Alternatively details of the referral shall be recorded.
• History
• Diagnostic requests, investigations and results
• Care Plan and recommendations
• Treatment
• Progress Notes
• Instructions given to the patient
• Details of referral to other sources, follow-up, or discharge.

5.2 Quality of the Written Record

The following standards of record keeping are expected in all health records.

• All documentation relating to patient care must be clearly written and legible
• All entries into a health record must be concise, objective and accurate and will relate only to the healthcare episode
• No entry must contain subjective or judgmental statements
• All entries must be clearly defined as to the date they were made and the time the entry was made using the 24 hour clock
• All entries must be signed with the signature printed alongside the first entry as well as designation.
• All entries must be made in black ink
• The use of terminology and jargon must be avoided wherever possible
• If abbreviations are used for the sake of speed, the full meaning must appear the first time the abbreviation is used.
• Any alternations or additions must be dated, timed and signed (not initialled) and must be made in a way which ensures that the original entry can still be read.
• All entries must be in chronological order and must be made at the time
• Every document in the record must contain the patient's name and NHS number
• Provide clear evidence of the care planned, the decision made, the care delivered and information shared.
• Records should be written wherever possible with the involvement of the patient/carer and in terms that the patient can understand.
• Parental responsibility must be identified where the records relate to a child
• Patient agreement/restrictions on information sharing must be documented.
• Records are bound and shared in such a way as to minimise any loss of documents
• Be readable if photocopied and/or scanned.

5.3 Nursing records shall comply with the Nursing and Midwifery Council: Standards of Record Keeping 2006.

The nursing records will include:

• Patient Profile Sheet,
5.4 Health Professional Council - Standards of Conduct, Performance and Ethics – 1st July 2008 (Standards for Record Keeping).

Making and keeping records is an essential part of care and you must keep records for everyone you treat or who asks for your advice or services. You must complete all records promptly. If you are using paper-based records, they must be clearly written and easy to read, and you should write, sign and date all entries.

You have a duty to make sure, as far as possible, that records completed by students under your supervision are clearly written, accurate and appropriate.

Whenever you review records, you should update them and include a record of any arrangements you have made for the continuing care of the service user.

You must protect information in records from being lost, damaged, accessed by someone without appropriate authority, or tampered with. If you update a record, you must not delete information that was previously there, or make that information difficult to read. Instead, you must mark it in some way (for example, by drawing a line through the old information).

5.5 Record Information

Records are created to ensure that information is available within the Trust: -

- To support patient care and continuity of that care;
- To support day to day business which underpins delivery of all services;
- To support evidence based clinical practice;
- To support sound administrative and managerial decision making;
- To meet legal requirements, including requests from patients under subject to access legislation;
- To assist clinical and other audits;
- To support improvements in clinical effectiveness through research and also to support archival functions by taking account of the historical importance of material and the needs of future research;
- Whenever and wherever there is a justified need for information, and in whatever media it is required.

5.6 Record Registration

To ensure records can be identified and retrieved when needed it is necessary, in most cases, to allocate a registration system to a set of records. Registration is a system which allocates a unique identifier (number and/or alphabetical prefix) to each item, and which records that sequentially in a ‘register’ or index, preferably NHS Number.

Determining which records require registration is a decision that should be made by staff with advice from the Team Leader (Health Records), and, in the case of clinical records,
between the Team Leader (Health Records) and the Caldicott Guardian. The kinds of
records, which are most likely to be placed on a registered file, include:

- Care/clinical records
- Personnel records
- Financial papers
- Estates papers
- Performance monitoring
- Policy papers (reports, correspondence, etc)
- Agenda, Minutes, and circulated papers of meetings
- Papers relating to the preparation of legislation
- Complaints papers and correspondence
- Research and development papers

Registration will depend on the Trust’s business need to maintain accountable records of
particular activities, its information needs, how many records there are on that particular
topic or in that series.

With the development of electronic patient records, there will be a need to identify every
item which is patient/client related with the relevant NHS number to provide the necessary
links through all electronic records.

The best practice principles of registration are:

- The file title must be unique
- The reference identity assigned to each file must be unique
- Both must be relevant to and easily understood by all users
- The identifier should be restricted to no more than four elements
- Details should be recorded both on the file cover and in the register

Types of registered file systems include:

- Alphabetical
- Numerical
- Alpha-numeric
- Keyword

Registration systems should be monitored regularly and reviewed at least once every two
years to ensure that they continue to operate effectively and efficiently and meet the needs
of users.

5.7 Clinical Records

When clinical records are created it is essential that unique identifier references be used to
avoid duplicate records being created for the same patient. In line with best practice the
preferred unique identifier is the NHS number. The management of clinical records is
addressed in the PCT’s Clinical Record Keeping Policy (including the RiO Community
Health System policy)
6.0 RECORD KEEPING

Records are valuable because of the information they contain and that information is only usable if it is correctly and legibly recorded in the first place, is then kept up to date, and is easily accessible when needed. Section 11 of this Policy directs staff around the retention requirements.

To ensure quality and continuity of operational services all records should be accurate and up to date. Local procedures should be developed to ensure data quality for both manual and electronic records. These procedures should be passed on to all staff that is responsible for recording the information. This policy will be reviewed every two years (or sooner if new legislation, codes of practice or national standards are to be introduced).

Patient and client records should reflect all of the attributes in the record guide. NB: All records should be produced in line with the requirements of any relevant governing professional code of conduct that binds a particular individual.

7.0 TRACKING of RECORDS

Accurate recording and knowledge of the whereabouts of all records is essential if the information they contain is to be located quickly and efficiently. One of the main reasons why records get misplaced or lost is because their next destination is not recorded anywhere. As such the PCT had adopted the National Archiving Tracking System.

7.1 The core elements of the manual tracking system involve the following documents and information:

- The item reference number or other identifier
- A description of the item (e.g. the record title)
- The person, unit or department, or place to whom it is being sent
- The date of the transfer to them
- Who has requested or borrowed the record
- Their Location and/or contact phone number
- Date returned (if appropriate)

All Services must ensure that they adopt the manual records tracking process set out in appendix 2, 3, 4 5 & 6.

7.2 Electronically Operated Tracking Systems

All services are required to maintain a local data base to record the current status of records in terms of the following elements of the records management pathway:

- Transferring
- Archiving
- Retrieval
- Disposal

This will allow services to have an up-to-date and easily accessible movement history and audit trail for records within the service.
RiO has been implemented in a range of services across the PCT and the functionality of
this electronic records management solution facilitates immediate access to a range of
records including diary systems, patient records and registration details records. As such no
electronic tracking system is required.

Tracking systems should be reviewed / implemented in liaison with the Team Leader
(Health Records).

8.0 ARCHIVING AND STORAGE

The PCT currently adopts a range of options for archiving and storage of records, these
primarily fall in to two categories, onsite, and offsite storage solutions. See appendix 11 for
archiving and Imaging process

8.1 Onsite Archiving and Storage - Current/ Semi Current paper records

When a record is in constant or regular use (less than three years), or is likely to be needed
quickly, it makes sense to keep it within the area responsible for the related work. All
services must ensure that Records must always be kept securely and when a room
containing records is left unattended, it should be locked.

A sensible balance should be achieved between the needs for security and accessibility.

There is a wide range of suitable office filing equipment available. The following factors
should be taken into account:

- Compliance with Health & Safety regulations (must be the top priority)
- Security (especially for confidential material)
- The user’s needs
- Type(s) of records to be stored
- Their size and quantities
- Usage and frequency of retrievals
- Suitability, space efficiency and price.

8.2 Off Site Archiving and Storage - Physical Records

As the need for quick access to particular records is reduced, it may be more efficient to
move the less frequently used material out of the work area and into archive storage.

The PCT has commissioned an external contractor to archive and store physical records -
appendix 11 sets out the process for archiving and storage of physical records.

8.3 Off site - Archiving and Imaging of non-paper records

A large proportion of the organisations archived records are stored at Surbiton Hospital

The PCT currently commissions an external archiving and imaging company to scan
records and create CD ROMs - the process is set out in appendix 11

8.4 Actions for Managers when archiving and storing records

Service managers to liaise with Information Governance lead and the Health Information
Team Leader (Health Records) to undertake the following:
• Identify if the record is to be stored On or Off site – see appendix 11 for local process

• All services in discussion with the Team Leader (Health Records) must determine the appropriate option of storage regarding physical or electronic (scanned records other formats)

• Once the method and location of storage has been determined all services must ensure that they complete the relevant documentation in accordance with this policy.

• All services must ensure that they transport and store in line with the conditions set out in appendix 10 & 11

• To minimise storage costs of materials which would otherwise face destruction

• To make copies available for other uses (such as research) whilst safeguarding the original

• To reduce the storage space occupied by low activity paper records and the consequent storage costs

The Trust has collections of visual images – either as artistic images and still photographs (which may be prints, negatives, slides, transparencies, and electronic-readable images) or as moving images (film or video).

In the case of photographs, the quality of image available from negatives or original prints should be considered and new prints may be made in cases where the original is deteriorating. Photograph and film collections assembled by medical and other staff through their work within the Trust, should be regarded as Public Records and subject to these guidelines. Note that the provisions of the Data Protection Act 1998 on registration of records and restriction of disclosure, relate to photographs of identifiable individuals as well as to other personal records.

• Film should be stored in dust-free metal cans and placed horizontally on metal shelves. Microform, sound recordings and videotape should be stored in metal, cardboard or inert plastic containers, and placed vertically on metal shelving.

• A copy of all scanned documents is in the PCT safe at Headquarters as well as being accessed from the Health Care Records manager at PCT headquarters.

• For Disaster Recovery purposes a copy is also housed in a safe at (WHERE) Estate Office

9.0 RECORDS IN TRANSIT

9.1 Labelling and Packing

Records that have been identified as requiring transfer, archiving, storage or disposal must be transported in the appropriate manner. Guidance for the process for safe transportation and labelling is set out below. Specific requirements are set out in appendix 10.

Service managers must ensure the following

• Each box or envelope should be addressed clearly and marked confidential with the senders name and address on the reverse of the envelope.

• The option chosen is safe and appropriate for the material being transported

When choosing options staff should consider the following:
- Will the records be protected from damage, unauthorised access or theft?
- Is the level of security offered appropriate to the degree of importance, sensitivity or confidentiality of the records?
- Does the mail provider offer ‘track and trace’ options and is a signature required on delivery?
- Cost implications, i.e. postage/couriers/materials

9.2 Handling and Transporting Records

Transporting of records from site to site or from home to home is not considered to be normal practice. It is expected that patient records will not be taken to the staff member’s home. If staff are required to take records home or if records have to be transported around the PCT, the member of staff will be expected to take responsibility for their physical security. If transporting records the staff member is to keep them on his / her person.

The following factors should be taken into account when handling and transporting records:

- No one should eat, drink or smoke near the records and hand hygiene is crucial at all times to avoid cross-infection
- Clinical records being carried on-site e.g. from the archive storage to the department, should be enclosed in an envelope, secured and clearly labelled.
- Records should be handled carefully when being loaded, transported or unloaded. Records should never be thrown around.
- Records should be packed carefully into vehicles to ensure that the movement of the vehicle will not damage them.
- Vehicles must be fully covered so that records are protected from exposure to weather, excessive light and other risks such as theft.
- No other materials that could cause risks to records (such as chemicals) should be transported with the records.
- Vehicles containing records should be locked when stationary and any records out of site.

9.3 Taking Records Off Site e.g. Storage of Records in a Client’s Home

Records should only ever be taken off site with the approval of the Line Manager. Security of these records should be paramount, especially in the case of confidential records. Records should never be left unattended e.g. in a car. If the record is to be taken home, the records must be stored securely in accordance with the staff members Professional Code of Conduct.

It is essential that any such records be tracked out of the department so that staff and managers are aware of the location of the record. To assist with this the information of the records should be recorded on the Record Tracking Location Card (appendix 5) and the record Movement Sheet (appendix 3).

9.4 Transferring Children’s Records

- The transfer of information from Health Visitors to School Nurses for all children should be done within 2 months or 10 days for Children in Need or on the Child Protection Register.
- The transfer of clinical records for children on the Child Protection Register or where there are child protection concerns must occur promptly in order to facilitate effective
information sharing and minimise risk to the child.

- A verbal handover must take place with the receiving Health Visitor / School Nurse.
- The transfer of records out from Health Visitors should be done within 48 hours of providing verbal handover to a receiving health visitor.
- The transfer of records out from School Nurses is within 5 days of providing a verbal handover to a receiving School Nurse.
- All transfers will be noted on a ‘Transfer Out’ form. A copy of the ‘Transfer Out’ form is sent to the Community Nurse Leader and Child Protection Named Nurse.
- Records must be sent out by recorded delivery and marked ‘Private & Confidential’ with the sender’s name and address on the back of the envelope.
- All children’s records received in a practice should be scanned by the General Practitioner or Practice Nurse for any urgent action or follow-up before filing.

9.5 Transferring Medical Records

The transfer of medical records is covered by HSG (93) 27, The Patient’s Charter and Primary Health Care protocol within the service and this Records Management Policy. Any record sent out of the PCT MUST be through a registered process or a reliable courier service.

10.0 ELECTRONIC RECORDS

10.1 What is an electronic record?

An electronic record is any file that you create that affects the way that you or any other person does their work. It may be a policy document (such as this one), the minutes of a meeting, a letter or memo, working notes, e-mail, a spreadsheet or any other sort of file. ‘NHS net’ is the only ‘safe’ method of transferring records electronically.

All such files must be treated as formal records and are subject to the same rules of accessibility, security, privacy, Freedom of Information and disposal as are paper records.

10.2 Accessibility of Electronic Records

Records are not accessible when they are on the local disk of your PC; no one other than the originator can find them. They must be stored on a central file server in a location defined by the IMT Manager and the Team Leader (Health Records).

10.3 Security of Electronic Records

Records must be preserved securely; the file store in which they are kept must be backed up regularly according to good IT practice. If you use a memory stick/laptop it must be purchased and encrypted by the IMT Department and the user must transfer all data daily to the main system for back up and delete from the laptop/memory stick. Loss of records due to negligence or non adherence to the Records Management Policy is a disciplinary and very serious matter.

10.4 Privacy of Electronic Records

Confidential records must be stored in a directory tree to which access is controlled on a user-by-user basis and be password protected. Never share your password.

10.5 Registration of Electronic Records
With hard-copy records there is a problem of relating a document title to a physical folder to a location on a shelf. This problem does not arise for electronic records; the file’s path name is a complete description of how to find it. You must however ensure that the document’s title, as represented in its file name, is a good description of what it contains. The very act of creating a file in the correct place with a sensible name registers it; no other action is necessary.

Letters should have a title containing the recipient, the topic and the date. Minutes should have a title containing the committee name, the topic, the date and an attendees list.

An example of how to do it is by version of the document or date and author.

11.0 RETENTION of RECORDS

The length of the retention period depends upon the type of record and its importance to the business of the Trust. The destruction of records is an irreversible act, whilst the cost of keeping them can be high and continuing.

The Department of Health guidance Records Management: NHS Code of Practice Parts 1 (30.03.2006) and 2, (08/01/2009) upon which this Records Management Policy has been based, takes account of legal requirements and sets out the minimum retention periods for both clinical and administrative records. The Trust has local discretion to keep material for longer, subject to local needs, affordability and, where records contain personal information, the requirements of the Data Protection Act 1998.


If a particular category of record is not listed within the hand book, advice must be sought from the Strategic Programme Manager who will establish the retention period in consultation with the Health Information Team Leader (Health Records) and the department/directorate concerned.

12.0 RETRIEVAL of RECORDS

The retrieval process set out in appendix 7 is determined by the following two pathways

- Electronic
- Physical

All services must undertake the following actions when retrieving or returning record(s):

- Complete Record Retrieval Request form
- Identify location of record – review local and PCT data base (Headquarters)
- Retrieval of physical records from internal and external storage supplier must be accessed through the Health Information Team Leader (Health Records).
- Ensure that the local data base is updated to reflect request and receipt details of record(s)
- Once the record(s) have been received a completed copy of the retrieval request form should be attached to the record(s) before handing record(s) over to the Healthcare Professional.
- The original retrieval request form should then be returned to file.
• The lead-time for record retrieval is (48 hours); the storage company will deliver the requested record/s to KPCT Headquarters.

• Off site record(s) are delivered to KPCT Headquarters in a box containing other records; the Health Information Team Leader (Health Records) will retrieve the correct record from the box and arrange for a safe handover of the file (i.e. by hand) to the requestor.

• The person who made the initial request for the retrieval of the record/s is responsible for safely returning the retrieved record/s back to the Health Information Team Leader (Health Records) who will arrange for the record to be returned to Storage Company.

• When returning a record back to storage the record request form (attached to file) must be updated by the requestor (complete name and the date of return) and given to the Health Information Team Leader (Health Records).

• The Health Information Team Leader (Health Records) will then confirm return of record on the retrieval request form, updating the original copy, and arrange collection of the record/s from the storage company.

13.0 DISPOSING OF UNWANTED RECORDS

Most NHS records, even administrative ones, contain sensitive or confidential information. It is therefore vital that confidentiality is safeguarded at every stage and that the method used to destroy such records is fully effective and secures their complete destruction. Normally this will involve shredding, pulping, or incineration and if carried out by an external agent KPCT will receive a destruction certificate. This certificate will be sent to the Strategic Programme Manager.

The process of disposal is determined by the type and nature of the record and is mapped out in appendix 12.

Electronic records, like hard copy records, must be disposed of properly when the time comes. Disposal may mean archiving or destruction. To simplify this process, records of different types should be stored in separate directories. It will then be possible to remove or archive a complete directory without the need to examine individual files within it.

Floppy disk/CD ROM/backup tapes/audio tapes identifiable information must be reformatted with a random pattern to ensure data cannot be recovered or they must be physically destroyed in line with guidance and advice from the Trust’s IMT Department. Removable media and hard drives must also be destroyed following advice from the Trust’s IMT Department. This can be done on site, or via an approved contractor.

13.1 All Services must ensure that they:

• Refer to the retention schedule

• Complete the relevant documentation as set out in appendix 12 together

• Must ensure that a certificate of disposal is obtained from external contractors

• Update the Local Records Management Data base recording:
  o Type of Record
  o Location
  o Service /Department
  o Years covered
  o DOB where appropriate
  o Date of Discharge
  o Index A-Z
Date of destruction

- The destruction of records can only be authorised by the Strategic Programme Manager, or with the agreement of the Information Governance Committee as documented in the records management policy.
- Confidentiality must be maintained at every stage in the destruction cycle.
- Shredding and / or incineration may be carried out for the destruction of paper-based records.
- A log should be kept by the Health Information Team Leader (Health Records) of everything that has been destroyed with details of dates and the contractor who undertook the work and a copy sent to the Strategic Programme Manager.
- Contractors who are disposing of the PCT's documents must sign confidentiality agreements and provide written proof of destruction.
- Destruction of electronic records must include all storage media (e.g., original files plus any backup media).
- The destruction of electronic records must be done in line with the requirements of the IT security policy.
- The audit trail relating to the electronic file will be retained for future reference.

14.0 PROCESS FOR MONITORING AND REVIEWING THE EFFECTIVENESS OF THE RECORDS MANAGEMENT POLICY

The Provider Services Management committee and the Trust Board are responsible for monitoring records management and ensuring that there are clear lines of accountability. The Records Management Policy will be overseen by the Strategic Programme Manager. As the designated Senior Managers they will be responsible for records management and will ensure that the policy is regularly monitored and reviewed through regular board reports including:

- Information Governance reports
- Governance reports
- Incident reports
- Quarterly Risk Management reports

The policy will be updated if and when new guidance or legislation is published or issued. It will be the responsibility of the Strategic Programme Manager to monitor the provisions of this policy and produce quarterly reports to the Governance Committee. These reports will outline the effectiveness of the processes described including responsibilities and duties, legal obligations which apply to records, tracking of records, creating records, retrieving records and retaining and disposal of records. The monitoring and effectiveness of the audit of healthcare records will also be reported to Provider Governance Committee who will in turn provide reports for the PCT Information Governance Committee.

15.0 APPLICABILITY OF POLICY TO INDEPENDENT CONTRACTORS

This policy sets out best practice, which it is recommended that Independent Contractors follow and apply as best they can to records within their individual practices. They are welcome to adopt the PCT policy to their own practices.

16.0 DISSEMINATION AND IMPLEMENTATION OF THE RECORDS MANAGEMENT POLICY

The PCT and all staff and managers have a responsibility to cascade and share the policy with their teams by:
• Implementing a formal training programme to launch and support the policy
• Including records management in induction training and staff handbooks
• Arranging speakers for staff meetings
• Attending set session organised by the PCT or Directorates
• Any other method necessary e.g. e-based training modules
• Through the Team Talk and KPCT News systems.

17.0 REFERENCES
• Nursing and Midwifery Council Guidelines for Records and Record Keeping, January 2005
• CNST Standard for Mental Health, Standard 4, NHS Litigation Authority
• British Psychological Society Guidelines on Confidentiality and Record Keeping. Division of Counselling Psychology (2002). Online: http://www.bps.org.uk
• British Association for Counselling and Psychotherapy Ethical framework (2005)
• Association of Counsellors and Psychotherapists in Primary Care Code of Ethical Principles (2006)
• Information Governance Toolkit (2007)
APPENDIX 1  LEGISLATION AND NATIONAL POLICY

1. **Records Management: NHS Code of Practice (Parts 1 & 2)**

   The Department of Health has published Records Management: NHS Code of Practice covering all types of NHS records regardless of the media on which they are held. The intended purpose of the Code of Practice is to help the NHS to meet its legal obligations in the management of its records - including data relating to clinical research.

2. **The Data Protection Act 1998**

   Since March 2000 the key legislation governing the protection and use of identifiable person based information has been the Data Protection Act. The Act does not apply to information relating to the deceased.

   The Act gives seven rights to individuals in respect of their own personal data held by others, they are:

   ♦ Right of subject access
   ♦ Right to prevent processing likely to cause damage or distress
   ♦ Right to prevent processing for the purpose of direct marketing
   ♦ Rights in relation to automated decision taking
   ♦ Right to take action for compensation if the individual suffers damage
   ♦ Right to take action to rectify, block, erase or destroy inaccurate data
   ♦ Right to make a request to the Commissioner for an assessment to be made as to whether any provision of the Act has been contravened.

   The Data Protection Act applies to 'personal data', that is, data about identifiable living individuals. Those who decide how and why personal data are processed (data controllers), must comply with the rules of good information handling, known as the data protection principles, and the other requirements of the Data Protection Act.

3. **Access to Health Records**

   Data subjects now have access rights to all records irrespective of when they were created, although under section 30 access to some health, education and social work data may be constrained or denied.

   The Data Protection Act 1998 supersedes the Access to Health Records Act 1990 apart from the sections dealing with access to information about the deceased. The Access to Health Records Act 1990 provides rights of access to the health records of deceased individuals for their personal representatives and others having a claim on the deceased’s estate. In other circumstances, disclosure of health records relating to the deceased should satisfy common law duty of confidence requirements.

4. **The Caldicott Review**

   In March 1996, guidance on *The Protection and Use of Patient Information* was published by the Department of Health. This guidance required that when the use of patient information was justified, only the minimum necessary information should be used and it should be anonymised wherever possible. In the light of that requirement the Chief Medical Officer established the Caldicott Committee to review the transfer of all patient-identifiable information from NHS organisations to other NHS or non-NHS bodies for purposes other
than direct care, medical research or where there is a statutory requirement, to ensure that
current practice complies with the Departmental guidance.

On completion of the work, the committee concluded that, whilst there was no significant
evidence of unjustified use of patient-identifiable information, there was a general lack of
awareness throughout the NHS of existing guidance on confidentiality and security,
increasing the risk of error or misuse

The Caldicott committee’s report, published in December 1997, included 16
recommendations, which related to ensuring best practice in the use of information flows
between organisations.

5. Audit Commission Report

The 1995 Audit Commission report, ‘Setting the Record Straight – A Study of Hospital
Medical Records’, criticised the poor standard of NHS record keeping and strongly
recommended that corrective action should be taken. The key issues to be addressed are the:

♦ Legacy of low priority given to records management and related facilities
♦ Lack of awareness of the importance of good record keeping
♦ Lack of information sharing between professions and work units
♦ Tendency to treat records as personal rather than corporate assets
♦ Lack of co-ordination between paper and electronic information strategies
♦ Need to maintain confidentiality whilst legitimately freeing information

The Audit Commission regularly monitors performance and has issued reports which
strongly criticised record keeping in the NHS. Also, the Health Service Commissioner has
a statutory right to obtain relevant records when investigating a complaint. If records are
missing or inadequately maintained, the Commissioner will criticise that in their report.

6. National Health Service Litigation Authority (NHSLA)

The National Health Service Litigation Authority (NHSLA) was established in 1994, to
provide a means for NHS trusts to fund the cost of clinical negligence litigation and to
encourage and support effective management of claims and risk. The scheme covers
claims arising from incidents on or after 1 April 1995. The PCT is bound by the PCT Risk
Management Standards.

If trusts comply with the standards, they should benefit from the investment in risk
management by having fewer claims and paying lower scheme contributions.

Standard 5: Health records, requires Trusts to have a comprehensive system for the
completion, use, storage and retrieval of health records.

7. Information for Health

Information for Health, an information strategy for the Modern NHS 1998-2005 (HSC
1998/168) sets out an information strategy for the introduction of Electronic Patient
Records (EPR) to eventually replace paper records, which means that the NHS will require
effective Records Management policies to cover electronic as well as paper records.
APPENDIX 2 RECORDS MOVEMENT FLOW CHART

WHEN?
- When a record is taken out of the filing system or sent out of the Service or Service location
- When a record is transferred to a new location or Service
- When a record is taken out of the filing system or sent out of the Service or Service location
- When a record is archived
- Once a year

WHO?
- Individual member of staff
- Individual member of staff transferring the record
- Individual member of staff
- Person requiring the record
- Nominated Person

WHERE?
- Replaces the record in the service location
- Travels with the record
- Travels with the record, and remains with the record
- Sent to the Line Manager to be authorised
- Sent to users who have records booked out to them

HOW?
- Shows the current location of the record and must be updated when the record is returned or transferred out of the Service or site
- Used to ensure the originator Service location is aware of records being transferred out of the Service or Service location
- A record movement sheet is kept with the record at all times to monitor who has used the record in the past
- Used to ensure the original Service location is aware of the record being retrieved
- Reminds staff to return records and updates the record system kept at Service locations

LOCATION OF RECORDS
DOCUMENTATION WHICH TRAVELS WITH THE RECORD
RETRIEVAL OF RECORDS
PERIODIC LOCATION CHECK ON RECORDS
Page left blank on purpose
Member of staff needs to locate Record

Record in use

Record not in use

Record on site or Record has been transferred

Archived on/off site. Please refer to Archiving and Storage Process

Option 1: Identify where the record is located and clarify movement via Record Tracking Location Form (Yellow card found in file location)

Option 2: Clarify the record location via Local Records Management Database and Record Transfer Form

Option 3: Locate and consult Record Transfer Form
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## Record Tracking Location Card

**Family Name or Record No:**

**Title of Record:**

**Location:**

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<th>Date</th>
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APPENDIX 5  RECORD TRANSFER AND MOVEMENT PROCESS

RECORD TRANSFER AND MOVEMENT

Record is taken out of file for use

Record Tracking Location Form (Yellow card found in file location) to be completed by member of staff and to remain in file location

Record is transferred internally/externally

INTERNAL
Member of staff to complete Record Movement Sheet that forms the top page of the Record at all times

EXTERNAL
Member of staff to complete Record Transfer Form which travels with the Record to the new location

Receiving Service/Department to complete and return Record Transfer Form to originating Service/Department

Transferring Service/Department to update Local Records Management Database
Page left blank on purpose
## Record Movement Sheet

Keep this sheet as the top page of the record at all times.

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<th>Requested by: Borrowed by:</th>
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**Family Name or Record No:** ____________________________  **Location:** ____________________________

PTO
Record Movement Sheet

Keep this sheet as the top page of the record at all times.

Family Name or Record No: __________________________

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APPENDIX 7  
RECORD RETRIEVAL PROCESS

PHYSICAL COPY STORED

Option 1:
Currently stored on site

Complete Records Retrieval Form

Submit to Service/Department Administrator

Administrator to locate the file, insert tracker card, complete record movement sheet then forward to requestor

Option 2:
Stored off site

Contact Health Information Team Leader (Health Records)

Complete Customer Delivery Form

The Record will arrive from the external storage provider within 48 hours. The Health Information Team Leader (Health Records) to retrieve file from box, hand to requester and complete record movement sheet

ELECTRONIC COPY STORED

On site

Option 1:
Complete Records Retrieval Form
– Scanned Records retrieved from within the service/department

Off site

Option 2:
Complete a Records Retrieval Form – Contact Health Information Team Leader to retrieve record from electronic storage

An electronic copy of the record will be sent electronically to requester via NHS Secure Mail
All services are required to undertake a yearly periodic Record check on the status of records transferred.

Service administrator/s to refer to Local Records Management Database to clarify details around Records transfer.

Periodic Record Check Form to be completed by the Service Administrator/s and sent to the service where the Record was transferred.

Periodic Record Check Form is returned to the Service Administrator from where the record originated.

Option 1:
Records returned with form

Option 2:
Records retained by current Service/department. Form only returned to the Service Administrator stating the above.

Option 3:
Records transferred elsewhere. Form only returned to Service Administrator providing records location and details.

Service administrator to update Local Records Management Database on receipt of Periodic Record Check Form.
Page left blank on purpose
PERIODIC RECORD CHECK

MOVEMENT of RECORDS

To: ___________________________ Service: ___________________________

Location: ___________________________

Family Name or Record No: ___________________________ of (Year): __________

Title/Subject: __________________________________________________________________________

Was sent to you on: _______________________________________________________________________

Please:

- Return it to the Service with this memorandum: or [ ]
- Confirm that you still hold and wish to retain it: or [ ]
- If not with you, say when and to whom you passed it* [ ]

*Record passed onto: ___________________________ Date: __________

Date: _________________ Signed: ___________________________

Service: ___________________________ Location: ___________________________
## APPENDIX 10: TRANSPORTATION AND LABELING REQUIREMENTS

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Location</th>
<th>Record Type</th>
<th>Transport Mechanism</th>
<th>Labelling</th>
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</thead>
</table>
| Transfer        | On Site  | Physical /CD Rom       | Envelopes or opaque wallets and sealed for transfer. Any records that may be damaged in transit should be enclosed in suitable padding or containers. | - Originating site Receiving site and Service  
- Type of Record  
- Location  
- Service /Department  
- Years covered  
- DOB where appropriate  
- Date of Discharge  
- Index A -Z  
- Date of destruction |
|                | Off Site | Physical /CD Rom       | Hand Delivery/ recorded delivery, registered mail Envelopes or opaque wallets and sealed for transfer. Any records that may be damaged in transit should be enclosed in suitable padding or containers. | Originating site Receiving site and Service  
Alphabetical Identifier for record  
Date of Birth where applicable  
Date of Transfer  
Index A - Z |
| Archiving and Storage | On Site  | Physical               | Storage Cartons                                               | - Type of Record  
- Location  
- Service /Department  
- Years covered  
- DOB where appropriate  
- Date of Discharge  
- Index A -Z  
- Date of destruction |
| Archiving and Storage | Off site | Physical               | Red Crates – to co-ordinated by external company Storage Cartons | - Type of Record  
- Location  
- Service /Department  
- Years covered  
- DOB where appropriate  
- Date of Discharge  
- Index A -Z  
- Date of destruction |
| Disposal        | On Site  | Physical               |                                                               | - Type of Record  
- Location  
- Service /Department  
- Years covered  
- DOB where appropriate  
- Date of Discharge  
- Index A -Z  
- Date of destruction |
| Disposal        | Off Site | Physical               | Red Crates – to co-ordinated by external company Storage Cartons | - Type of Record  
- Location  
- Service /Department  
- Years covered  
- DOB where appropriate  
- Date of Discharge  
- Index A -Z  
- Date of destruction |
APPENDIX 11: RECORDS ARCHIVE AND STORAGE PROCESS

Is the record in frequent use? i.e. will it be used within 2 years

YES

ON SITE (semi current records) Liaise with the Health Information Team Leader (Health Records)

PHYSICAL

Pack records in approved storage cartons.
Type of record, Location, Service, Alphabetical Identifier, Date of birth, Date of Discharge/Death, Destruction date

ELECTRONIC

Health Information Team Leader (Health Records) to contact Data Imaging and Archiving Company (DIAC)

DIAC to raise unique reference number and coordinate delivery of required number of cartons/crates to the site.

Services to pack records into supplied carton/crate with the Type of record, Location, Service, Alphabetical Identifier, Date of birth, Date of Discharge/Death, Destruction date

DIAC to collect crated records from the site. Identified lead to ensure that a Requisition form is signed on Record collection

DIAC produces 3 CD ROM copies of the records

One CD ROM for secure storage on site
One CD ROM to be stored with the Health Information Department
One CD ROM to be stored in the fireproof safe (Disaster Recovery Retrieval only)

DISPOSAL CONFIRMATION (see retention and Disposal Flow Chart). After one month DIAC to send Record Authorisation Form to the service manager.

Service confirms that they have the CD ROM and the files have been checked and there are no faults.
Service receives the Destruction Certificate from DIAC

ALL PHYSICAL AND CD ROM RECORDS TO BE STORED IN DESIGNATED STORAGE LOCATIONS ENSURING THAT THE STORAGE IS DRY, SECURE, ACCESSIBLE, IN CLOSE PROXIMITY TO THE WORKING AREA WHERE POSSIBLE

NO

OFF SITE

PHYSICAL

Lead contacts Health Information Team Leader (Health Records) stating their site and to contact and order from the storage company flat pack cartons and labels

Service Lead
To ensure that the following takes place:
Pack records into supplied cartons ensuring that the Type of record, Location, Service, Alphabetical Identifier, Date of birth, Date of Discharge/Death, Destruction date are recorded
Health Information Team Leader (Records) to add bar coded label to the indicated area on the outside of the carton.
Ensure that the Site and Service information is complete

Customer Collection Form is filled in with a copy to be kept at HQ as an inventory of Records that have been archived. The form is faxed to the archiving company and the Health Information Team Leader (Health Records) sends a customer collection confirmation email stating the date the cartons will be collected

Health Information Team Leader (Health Records) to ensure that the Customer Carton Registration Form is also completed and sent to the archiving company
APPENDIX 12: PROCESS FOR THE RETENTION AND DISPOSAL OF RECORDS

Retention and Disposal Process

Service Manager identifies the need to dispose of records and refers to the Department of Health Retention Schedule prior to disposal of the record/s. Then contacts Health Information Team Leader (Health Records).

PHYSICAL COPY

ARCHIVED RECORDS

ON SITE STORAGE

ELECTRONIC COPY

SCANNED RECORDS ON CD ROM

RETAIN
Archiving company advised of retention schedule on Customer Carton Registration Form

DISPOSE
DIAC notifies Health Information Team Leader (Health Records) of records identified for destruction on Destroy Work Order Form

RETAIN
Strategic Programme Manager notified and completes Duty of Care Form

DISPOSE
Service Manager to retain records on site for 1-3 years only (Service dependent). Records should then be archived or scanned

DISPOSE
Service Manager identifies the need to dispose of records prior to archiving or scanning. Must complete the Disposal Authorisation form

RETAIN
DIAC retain physical copies of the records for 1 month. Copies of scanned records are sent to the PCT (See Records Archiving and Storage Process Chart)

DISPOSE
DIAC requests authorisation from a Director to dispose of records on Disposal Authorisation Form

Strategic Programme Manager and Service Manager receive Destruction Certificate from the DIAC

Strategic Programme Manager to receive Destroy Work Order or Disposal Authorisation Form

Copy of Destroy Work Order or Disposal Authorisation form sent to Health Information Team Leader (Health Records)

HEALTH INFORMATION TEAM LEADER (HEALTH RECORDS) TO UPDATE AND MAINTAIN THE CENTRAL LOG FOR HEALTHCARE RECORDS DESTRUCTION
APPENDIX 13  MISS CASE NOTES

1. A "missing case-note" is one that cannot be found or is not available when required for a patient encounter.

2. When this occurs the following steps must be taken:
   
   i. The Clerical Officer should report this to his/her supervisor as soon as possible before the patient is due to attend
   
   ii. The supervisor should undertake a thorough search
   
   iii. If the supervisor is unable to locate the case-notes this should be escalated to the Health Information Team Leader (Health Records) who will complete the "Search Log for Missing Case-notes"

3. A log must be kept of all case-notes which are missing when required for a patient encounter (see 2iii above)

4. When the Health Information Team Leader (Health Records) or a designated deputy, has confirmed that the case-notes are missing a temporary set of case-notes can be created, the "Log of Temporary Case notes" should be completed, RiO should be updated to show that a temporary folder is in circulation and the temporary folder should be tracked/traced indicating clearly that it is a temporary folder.

5. If 24-hour health records cover is not available only A&E, ICU/ITU may create a temporary set of case-notes. This must be notified to the Strategic Programme Manager (using the "Temporary Case-notes Notification Form") as soon as possible.

6. A search must be made for all missing case-notes in the missing case-notes log on a regular basis (suggested weekly). The dates that searches are conducted should be entered in the log together with the person who undertook the search.

7. When a set of case-notes has been missing for six months it is reasonable to assume that the original set of case-notes has been lost. Accordingly the temporary set of case-notes should be converted into a duplicate set of case-notes. The log of missing case-notes and RiO should be updated to reflect this change.

8. When the original case-notes are located the following procedure should be followed: -
   
   i. Complete the missing case-note log to indicate that the original case-notes have been located
   
   ii. Merge the temporary or duplicate folder with the original set of case-notes
   
   iii. Remove the indicator on RiO showing that a temporary or duplicate folder is in circulation
   
   iv. Update the tracking/tracing system with the location of the merged case-notes

9. The Health Information Team Leader (Health Records) should complete the "Monthly Summary of Missing Case notes"

10. The numbers of missing case-notes should be reported to the Information Governance committee and Trust Board on a quarterly basis
1. Keeping clinical records

Counsellors working for KPCCS are required to keep data and clinical records for each client. Clinical records should include the following only:

- Initial referral letter
- Any professional communication or correspondence entered into as part of client care, e.g. further referral letter(s); letter to private, voluntary or NHS Organisations on behalf of the client; letters to/from client.
- Counsellor discharge summary letter to referrer, dated and signed
- Routine client data (collected for each client); to include all dates of client attendance.

This information will constitute the formal clinical record for each client; KPCCS will collect clinical records from counsellors in the service every 6 months. These records will be logged at PCT Headquarters and kept in a locked cabinet being archived on CD-Rom. Following archiving, all paper records will be shredded.

- Records on CD-Rom will be maintained for a maximum of 7 years, after which time they will be safely destroyed.
- Clinical records should not include the following:
  - Counsellors’ own process notes
  - Counsellors’ notes from clinical supervision for the client.

This information constitutes counsellors’ personal reference material for their ongoing work with each client. At the end of the client’s counselling contract, it is the responsibility of each counsellor that all informal, process and clinical supervision notes are shredded.

2. Storing clinical records

Normally, counsellors store their ongoing clinical records in a secure cabinet or cupboard in their place of work. However, it is recognised that counsellors may need to take records from their place of work on a regular basis in order to discuss client work in clinical supervision. This may also mean keeping client records at the counsellor’s home for short periods.

Where clinical records need to be removed from PCT premises, counsellors are expected to:

- Enclose client records in a suitable envelope/wallet
- Ensure records are protected from damage, public access or theft
- Ensure records are never left unattended e.g. in a car
- Take personal responsibility for the safety and security of client records and return them to their place of work as quickly as possible.