Leeds and York Partnership NHS
NHS Foundation Trust

HEALTH RECORDS POLICY

Date effective from:	5th February 2016
Review date:	5th February 2019
Version number:	6.0

See Document Summary Sheet for full details

DOCUMENT SUMMARY SHEET

Document title*:	Health Records Policy
Document reference number*:	IG-0002
Member of the Executive Team Responsible*:	Medical Director
Document authors*:	Lynda Clapham Health Records Manager
Approved by:	IG Group
Date approved:	16 December 2015
Ratified by:	Finance & Business
Date ratified:	27 January 2016
Date effective from:	5 February 2016
Review date:	5 February 2019
Frequency of review:	Every three years or when significant changes affect the system
Responsible for the review:	Health Records Manager
Target audience: (People for whom this procedural document is essential)	Medical Records staff Clinical Administrative staff Clinical staff Medical and Allied Health Professionals
Responsible for dissemination:	Health Records Manager

* used as search information on Staffnet

DOCUMENT AMENDMENT SHEET

Please record what changes you have made to the procedural document since the last version.

This is a summary of changes to the document and is designed to show people exactly what has changed. The version number recorded below should correspond to the ratified version number shown on the Document Summary Sheet.

Version	Amendment	Reason
0.1	This policy has been formatted into the Trust's template	NHSLA template adopted in order to standardise policies and comply with Risk Management Standards
1.0	Ratified	Ratified and published
1.1	Amended	To meet NHSLA Risk Management Standards
1.2	Amended	To meet NHSLA Risk Management Standards and Care Quality Commission requirements
2.0	Ratified	Trust Board ratification 28/01/2010
2.1	Amended	To update the policy and incorporate the acquisition of services in York and North Yorkshire
2.2	Amended	Carl Starbuck – final draft review amendments.
3.0	Ratified	Ratified by Executive Team 18/12/2012
4.0	Addition of Appendix F	Inclusion of records lockdown protocol as requested by Linda Rose (Assistant Director of Nursing), in parallel with redevelopment of Unexpected Death Procedure. Approved for inclusion by IGG – July 2014
5.0	Amended & Ratified	• Inclusion of records "ownership". Removal of the services in York and North Yorkshire • Electronic Record Tracking • Psychology Notes Ratified and published
5.1	Review undertaken. Policy at review date	2 January 2016
6.0	Ratified	Ratified by Business & Finance Committee 27 Janaury 2016

PART A

1. EXECUTIVE SUMMARY

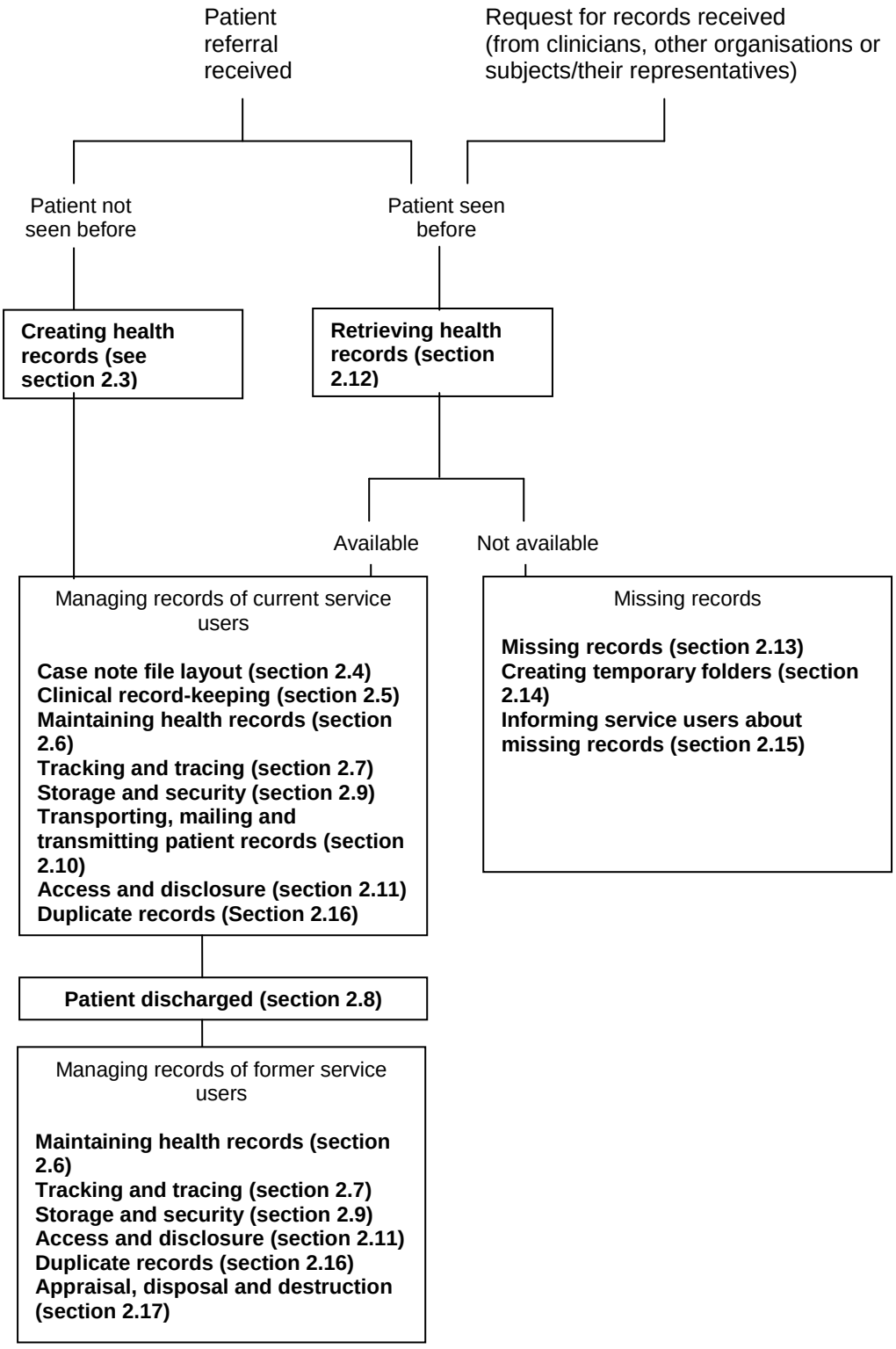
The Trust's Health Records are its clinical memory, providing evidence of actions and decisions and supporting consistency, continuity, efficiency and equity in the delivery of care. They also help in policy formation and in protecting the interests of the Trust as well as the rights of patients, staff and members of the public, including patients' right of access to data held about them.

The Department of Health's *Records Management: NHS Code of Practice* sets out required standards and professional best practice in the management of records for those who work within or under contract to the NHS. This policy is designed to ensure health records management at the Trust complies with the Code's requirements and integrates fully with the Trust's Information Governance framework.

All the requirements of this policy are achievable within the resources available.

2. THE PROCEDURE

2.1 Flowchart of Procedure



2.2 Creating Health Records

Before creating a new set of health records for any service user, staff must check on the Patient Administration System (PAS) that there is no previously created record. The check should be made by using the ultimate unique identifier which is the NHS no. in the first instance.

If there is no existing record, staff will need to register the service user on the electronic PAS with the following details: name, address and postcode, date of birth, GP and NHS number. Staff with appropriate SmartCard access must verify these details against those held by the Summary Care Records Service.

The next step is to allocate the service user the next sequential folder number and input this to the Trust's PAS (currently PARIS) and set up a manual case notes file.

Teams are issued in advance with proforma folders bearing the next sequential folder numbers, and staff in these teams will be able to complete the registration process themselves.

Psychology records are part of the Health Record and should be integrated with the main paper record post discharge from psychology services. Additionally aspects of the psychology record should be recorded on the Trust's PAS System.

2.3 Case Note File Layout

It is essential that case note files are kept in the agreed layouts. Clinicians need to be able to access information quickly and to be able to rely on case notes being in the proper order; the alternative can create delays and serious risks for service users.

- All documents should be filed in the main records folder, including nursing notes.
- Plastic wallets must not be used to store / file documents.
- Loose filing must be filed directly inside the records folder.

Any teams (including the Medical Records Department) presented with case notes that are not in good order should submit an incident report.

Any new documentation or structural changes to the folder layout will be decided by the Information Governance Group and notified to staff.

2.4 Clinical Record-Keeping

Good record-keeping is essential to patient safety and the continuity of care. The requirements of good record-keeping are set out in the NHSLA's *Risk Management Standards*, the Care Quality Commission's *Essential Standards for Safety and Quality*, the Health & Social Care Information Centre's

Information Governance Toolkit, and the Royal College of Physicians *Generic Record Keeping Standards.*

All health professionals have a duty to maintain high standards of clinical record-keeping and each of the main professional associations provides guidance (see Appendix B). Staff who are responsible for supervising students or other unqualified staff are professionally accountable for those persons' record-keeping and should review and clearly countersign each entry.

This policy does not attempt to repeat the detailed guidance issued by regulatory and professional bodies, and where staff are in any doubt they should consult those authoritative sources.

Basic record-keeping standards

Records should be:

- Legible
- Free from jargon
- Clear and unambiguous
- Written in language that can easily be understood by service users
- Factual, not subjective
- Accurate
- Contemporaneous, i.e. events should be documented as they occur or as soon as is safe and practical afterwards. Only in exceptional circumstances should this exceed 24 hours
- Chronological and consecutive

Each entry should:

- Record the name and designation of the author and the date and time of the entry. Manual entries must also be signed by the author. If the record is not contemporaneous – i.e. there has been a significant delay between events and their recording - the date and time of the event must also be recorded to make this clear. A delay of 24 hours or more is always significant
- Show the patient's name and a unique identifier, preferably the NHS number (for manual records this should be recorded on each page)

Additionally:

- Any amendments / corrections should be clearly crossed through and countersigned by the author
- The advice of the Information Governance Team and / or Caldicott Guardian should be sought before considering any outright deletion or removal of content from records
- Abbreviations should be kept to a minimum and must be set out in full at least once in the text. Exceptions can be made for abbreviations that

are unambiguous and commonly understood by the population at large, whether they are non-medical (Kg, cm, am, pm, UK, etc) or one of a small number of medical abbreviations (NHS, GP, AIDS, HIV, MRSA, A&E, etc.) that have passed into general use. Particular care should be taken with this latter group: remember a layperson should be able to understand the notes at first reading and without assistance

How much information should health records include?

Staff are expected to use their professional judgement to decide what is relevant and what should be recorded. Notes will normally include:

- All discussions or attempted contacts with doctors or health professionals
- Any education provided to the patient or carers, e.g. instructions on care, medication, diet, smoking cessation etc
- All assessments and reviews undertaken
- Any risks or problems and action taken to deal with them
- All patient contacts, including over the telephone, and any team meetings or discussions with other health professionals used to inform the assessment, planning or delivery of care

Recording medication in case notes

There is a particular need for detail and accuracy in case notes about patients' medication. The Trust's guidelines on how patients' medication should be recorded are reproduced at Appendix E. The intention to move to E-prescribing in February 2016 with the roll out complete by September 2016.

Different types of health record

It should also be remembered that health records can take many forms, not just clinical notes. Laboratory reports, X-rays, print-outs, incident reports, photographs, videos, sound recordings, correspondence, emails, notes of phone conversations and even text messages can all form part of a service user's health record and the principles of good record-keeping apply to all. Staff should remember that whatever they record about a patient may one day be viewed by that patient or their representatives or reviewed as part of an investigation by the Information Commissioner's Office, Care Quality Commission, the Health Service Ombudsman or the Courts. Staff must therefore be confident that the factual content, professional opinion, wording and tone of their records will withstand such scrutiny.

2.5 Maintaining Health Records

All staff have a responsibility to make sure the patient records they deal with remain accurate and up to date.

For healthcare information and details of care delivered, this will be achieved through staff following the guidance at 2.4 above. As is usual across the NHS,

the Trust holds paper and electronic health records, and most service users have a combination of both. The Trust aims to move to an entirely electronic system, but until that is achieved the two sets of records need to be maintained simultaneously and used in conjunction.

Each team to which a service user is referred is expected to obtain the service user's paper case notes. This is to make sure the team has all the required information available and can update the paper record as required; it also helps prevent parts of the service user's record becoming separate from the rest and supports the system of case note tracking and accountability across the organisation.

For demographic information (name, address, date of birth, GP practice, etc), the Trust regards the electronic record as the *prime* record, i.e. the definitive source. It is the responsibility of any member of staff who becomes aware of changes to or inaccuracies in a patient's demographic details to make sure that the patient's electronic record is updated accordingly. A full list of the data items for which the electronic system is the definitive source is provided at Appendix D.

2.6 Electronic Tracking and Tracing

An effective health records service requires knowledge of where the records are held and by whom. The movement of all hard-copy patient health records is therefore electronically tracked, and the last recorded person to have a health record will be responsible for its safekeeping and recovery.

Staff must make sure that when they transfer records the electronic tracking system is updated. If they do not, they may be held accountable for notes no longer in their possession. Though the prime responsibility for tracking records is with the person or team transferring them, any staff who become aware that tracking has not been recorded should update the system.

In addition to the main electronic record-tracking system, many teams and locations across the Trust use local manual tracking books to record short-term movements of notes away from team bases and similar locations. Where these exist, staff taking notes away must make sure they are updated.

Whoever transfers a record on a short-term basis, must update their local tracer card or book at that location with the following details:

- Patient name
- PAS number
- Date transferred
- Name and department of the person to whom the notes are being transferred
- Date returned

2.7 Discharge

When a patient is discharged from a team's care, that team is normally responsible for completing the discharge documentation (i.e. discharge letters plus, where applicable, risk assessment, care plan and crisis plan). To prevent delays, some teams have arrangements whereby they take immediate control of a patient's record without having to wait for the previous team to complete the discharge process and documentation. Where this occurs, the receiving team will be responsible for returning the patient's records to the correct department to ensure that the discharge process and documentation is complete.

2.8 Storage and Security

Current records stored onsite

Health records and the information they contain are confidential. All staff processing them must do so in accordance with the Trust's *Safe Haven Procedures* (IG-0009), the main principles of which are:

- Every team must have areas secure from unauthorised access and observation where confidential patient information can be processed and stored
- Every team must ensure the security of health records both in use and within the local designated storage areas
- Files should be stored in the following order:

Folder Number

- The Health Records team recommends the storage of records in Folder Number order. This mitigates the risk of patients with same / similar names being stored adjacent to each other in racks / filing cabinets, and the risks this raises. It is recognised however that this necessitates the look-up of the folder number on the PAS prior to selection, which may add an unwieldy overhead to busy clinical environments.

- Records may therefore be sorted into alphabetical order – by Surname & Forename(s), however this will always place same / similar names together, increasing the risk of selecting the wrong record.

- Regardless of ordering regime above, staff will be responsible for ensuring that they always use additional identifiers to ensure that the correct patient file is selected. Staff are reminded that the single unique identifier which should always be checked is the NHS number, except in the minority of cases where this is not available. NHS numbers, as well as other demographic data, can be looked up on the PAS system and corroborated using the Summary Care Record System on the National Spine Portal using your SmartCard.

Teams should hold only the records of current users of their services. When a patient is discharged from a team's care, their records should either be passed onto the team to which the responsibility for care has transferred, or returned to the local Medical Records Department (see Appendix A).

All service user records must be part of either their main paper or electronic health record or, where applicable, part of the record held by the Mental Health Legislation team or the Psychology Service. There should be no service user records held separately to these. For convenience, teams or individuals may wish to keep part of the record (CPN notes, etc) in a smaller folder of their own while they are dealing directly with that patient. It is the responsibility of those teams and individuals to make sure that (a) staff at the location to which the main record has been tracked are aware of the existence of this folder and its whereabouts and (b) to make sure all such records are amalgamated back into the main record once their responsibility for the service user's care transfers.

Storing non-current records off-site

The Trust recommends that health records are kept onsite for two years after the patient's last contact before transfer to offsite storage. Services may vary this period where there is justification (e.g. services which have short-term and largely non-recurrent service user engagement).

Offsite storage is by arrangement with Restore Limited. Teams transferring hardcopy records to Restore must make sure that:

- As a minimum, each patient's record is in a separate folder or envelope clearly marked with the patient's full name and a unique identifier (either the NHS or PAS number).
- Preferably, to minimise the risk of errors, these folders or envelopes show the patient's name, NHS and PAS number, the patient's date of birth and the disposal date (which is usually 8 years after death or 20 years from the last entry in the record).
- Records are placed into Restore's own storage boxes, to ensure safe handling, movement, stacking and long-term storage at the warehouse facility.

For assistance with this process, including obtaining storage boxes from Restore and arranging for the boxes to be collected, staff should contact their local Records Manager or Medical Records Department (see Appendix A).

Once records have been collected by Restore, teams must make sure that the electronic tracking system is updated to record the notes as in offsite storage.

Offsite records storage and movements to and from archive has costs associated. Moving records to archive should therefore be considered as a permanent / semi-permanent arrangement, with records sent to archive considered dormant as defined above.

2.9 Transporting, Mailing and Transmitting Patient Records

Patient records contain person-identifiable & sensitive information – as defined by the Data Protection Act (1998). Whenever records or parts of them are transported, mailed, e-mailed, faxed or delivered by hand, it must be in accordance with the requirements for sensitive person-identifiable information set out in the *Safe Haven Procedures* (IG-0009).

Accordingly, case notes can be transferred between Trust locations using the internal mail service and following the procedures set out in IG-0009. Notes that are needed urgently can also be transferred by taxi. Taxis must be booked through the Transport Department, and the precautions described in IG-0009 followed, i.e. the records must be in a securely sealed envelope or container marked 'private and confidential' and, wherever practicable, sent to a named recipient who is expecting and will confirm the delivery.

2.10 Access and Disclosure

Trust staff and associated personnel must access health records only as necessary to carry out their duties, on a strict 'need to know' basis.

Access to patient information by persons and agencies external to the Trust should be provided only in accordance with the Trust's *Confidentiality Code of Conduct* (IG-0003) and *Subject Access Request Procedure* (IG-0008).

If staff are in any doubt they should not release any information from the patient record without first checking with their line manager, Medical Records Department or Medical Records Manager (see contact details at Appendix A).

Decisions on disclosure for non-healthcare purposes ultimately rest with the Trust Caldicott Guardian, who will be the final arbiter on all disclosure decisions, when required. The Caldicott Guardian may cede this duty to the Information Governance team, whose guidance should be sought prior to disclosure.

2.11 Retrieval

Staff requiring case notes should use the electronic tracking system and contact the location to which they were last tracked.

Additionally, Restore's electronic tracking system (iTrack) is available on a read-only basis upon request to the Medical Records Department.

If that location is one of the Medical Records Departments (see Appendix A) notes can be obtained by providing the service user's full name, date of birth and PAS or NHS number, along with their own name and contact details. For health records required outside normal office hours, 24/7 access is available via the receptionist or site co-ordinator at each location. Staff in Medical Records will arrange for the case notes to be delivered directly to the

requestor. Alternatively, they may be collected from the Medical Records Department in person upon proof of identity.

Obtaining notes from other teams or members of staff may be a less formal process, but wherever notes are obtained from, staff must make sure the tracking record is updated (see 2.6 above). If notes are not available at the location to which they were tracked, staff should follow the missing records procedure at 2.12 below.

If the records have been transferred to offsite storage (see 2.8 above), staff should ask their local Medical Records Department, to organise their retrieval and delivery. The offsite storage company makes routine deliveries to the Trust three times a week, and Medical Records staff will be able to advise how quickly records can be expected to arrive. It is also possible 24/7 to make emergency requests to the offsite storage company for delivery within two hours, though this involves additional cost and should be used only in genuine emergencies. If such a request needs to be made out of office hours staff should contact their site co-ordinator.

2.12 Missing Records

Staff requiring records should contact the location to which they were last tracked. It is the responsibility of staff at that location to make the records available. If the records cannot be found, it is the responsibility of staff at the location to which the records were last tracked to search for them. The first step in any search will usually be to check the electronic tracking system and secondly to review the service user's activity on the patient information system to identify any other possible locations.

Missing records must always be reported using the DATIX incident reporting system. It is the responsibility of the staff or team needing the records and who have been inconvenienced by their unavailability to do this. They should do it either (a) as soon as the staff at the location to which the records were tracked confirm that the records cannot be found or (b) if the records are not provided within a reasonable period of time.

The team needing the records will also have to contact their local Medical Records Department to arrange for a temporary set of notes to be issued (see 2.13 below). Where notes are needed for clinical purposes, the team should also review with an appropriate clinician the risks to the service user. Where notes are needed in response to a subject access or other non-clinical request, it is the responsibility of the Records Manager to consider what further action should be taken. The Records Manager will also consider whether the service user should be informed, taking advice from the clinical team and Information Governance team as necessary.

Loss of health records may also necessitate informing the Information Commissioner's Office and other external bodies. The Information & Knowledge Manager, as Trust Data Protection Officer, will make that decision.

The Information Governance Group will monitor all incidents involving the loss of health records.

2.13 Creating Temporary Folders

Temporary folders should be created only when the search procedures set out in 2.12 above have been exhaustively carried out. They can be created only when Medical Records staff are satisfied that every effort has been made to locate the original record.

The new health records folder must be clearly marked as 'Temporary Notes' and the date of and reason for their creation recorded on the inside of the folder.

As soon as the original health records are located, the temporary and original notes must be merged in the original folder.

2.14 Informing Service Users about Missing Records

The Trust considers breaches of patient confidentiality a serious matter and any outright loss of patient records may be regarded as a Serious Incident Requiring Investigation (SIRI). The Trust wishes to operate an open and transparent culture under our Duty of Candour obligations, and consideration must be given to informing service users about breaches of confidentiality.

Where person-identifiable or sensitive patient information is lost in circumstances that mean it is likely to be viewed by non-Trust employees, we will notify the service user. Our notification will include an apology, an indication of how the incident occurred, how recurrence will be prevented, and the opportunity and method of making a formal complaint.

In cases where we can be reasonably sure that the loss is internal and data is unlikely to be viewed by non-Trust employees, the service user will not routinely be informed.

The Trust will look to the current 'team with care' to inform service users of breaches or potential breaches of their confidentiality. This allows the team to choose a method and time at their discretion, with a view both to appraising the risks arising from the breach while at the same time minimising the impact on the service user and the therapeutic relationships in the current phase of care. The Records Managers and Information Governance Team will assist staff in assessing whether to notify the service user and confirm any additional reporting requirements. In all cases a DATIX incident report must be completed.

2.15 Duplicate Records

When potential duplicate records are discovered, staff should first ensure the patient details are a complete match.

If they are, and there are duplicate electronic records, raise a call with the IT Service desk, assigning it to the Data Quality Team. They can carry out any merging of electronic records required.

If there are duplicate paper records, the different sets of case notes must be merged in chronological order. A member of the Medical Records staff must carry this out. The earliest PAS number must be used except when the majority of information is attached to the newer number.

When the records are merged, the incorrect number must be crossed through with a single line on all the documentation in the records.

2.16 Appraisal and Disposal

The Trust will retain health records for the minimum periods set out in the Department of Health's *Records Management: NHS Code of Practice*. For mental health, learning disability or psychology, these periods are usually:

- 8 years after death if the patient died in the care of the Trust, or
- 20 years after the last entry in the record.

Records will therefore usually be in the possession of the offsite storage company when they come to the end of their minimum retention period. Disposal dates will be assigned to records when they are placed with the storage company, who will notify the Trust when these dates are reached.

The Records Manager will then arrange for the records to be appraised by an appropriate clinician or clinicians to determine whether records are worthy of permanent preservation, whether they are still in use and should be retained for a longer period, or whether they can be destroyed.

The Records Manager will then arrange for the offsite storage company (Restore Limited) to dispose of records no longer needed and to provide a confirmatory list. A copy of Restore Services' Operating Procedures under which disposal will be carried out is available in the Information Governance section of Policy and Procedures on the Trust intranet. The local Records staff will also maintain a log of disposed records, including the date, parties involved, the disposal action and date.

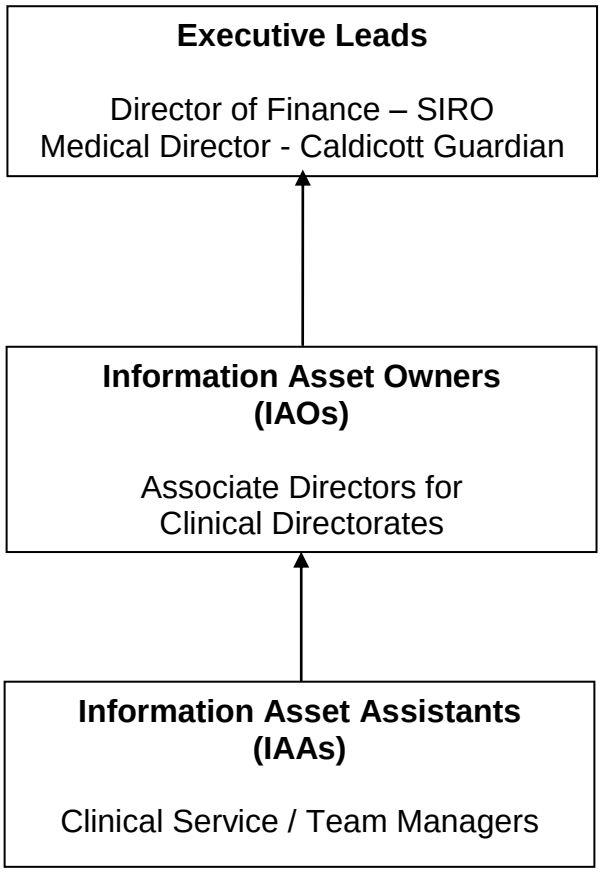
The Records Manager will arrange for those records selected for permanent preservation to be transferred to a recognised place of deposit.

All teams should regularly review the health records in their possession. Whenever staff come across records still held on Trust premises that have passed their minimum retention periods they should contact either the Medical Records Department or the Records Manager who will arrange for the appraisal and disposal process where appropriate.

2.17 Ownership of Health Records

In law, the owner of the content of records is the "data subject" – in the case of health records this is the service user. The Trust, as "data controller", is therefore the custodian of the records, responsible for their safe keeping and appropriate use. Health records are a vital information asset, and their ownership within the Trust must be clearly defined.

The Information Commissioner's Office recommends that appropriately senior personnel are responsible and accountable for records management issues, so that in the event of any incident there is a clear line of authority for escalation.



3. DUTIES AND RESPONSIBILITIES

The duties within the organisation are as follows:

Staff group	Duties
Chief Executive	The Chief Executive has overall responsibility for records management at the Trust. As Accountable Officer he/she is responsible for the management of the organisation, for ensuring appropriate mechanisms are in place to support service delivery

	and continuity, and to ensure the Trust complies with legal and governance requirements.
Caldicott Guardian	The Caldicott Guardian is a board-level member of the executive team and the Trust's ultimate authority on patient confidentiality. He/she is responsible for ensuring patient-identifiable information is used in an appropriate and secure manner and for providing advice where this affects records management.
Records Managers	The Trust's Records Managers are responsible for the overall development and maintenance of good Health Records management practices across the Trust and for producing, maintaining and promoting compliance with this policy.
Associate Directors and Clinical Service / Team Managers	Responsibility for local records management is devolved from the relevant Associate Director (as Information Asset Owners) to the Clinical Service / Team Managers (as Information Asset Assistants). Clinical service / team managers have responsibility for the day-to-day management of records generated by their team's activities, i.e. for ensuring that their staff and services process health records in accordance with this policy. Clinical Service / Team Managers are also responsible for ensuring that audit recommendations about record-keeping are implemented in their area.
All staff	All Trust staff are required to manage any records they create, use or otherwise come across in accordance with this policy and any guidance subsequently produced.
Contractors and support organisations	Service level agreements and contracts must include responsibilities for information governance and records management as appropriate. The Trust expects all 'associated personnel', i.e. contractors, support organisations, volunteers, locum staff, etc to observe this policy.
Information Governance Group	Supports the Records Managers in developing and enacting this policy and provides a forum for discussing and agreeing action on issues, developments and new guidance in this area. The Group is also the appropriate reporting and investigatory body for information governance and records management incidents.

4. TRAINING

Records management is part of the annual information governance training that all Trust staff are required to complete annually. Staff are referred to the training needs analysis in policy HR-0015 *Compulsory Training Procedure*.

Staff working within clinical services with record keeping duties may electively undertake specialist records management training modules on the HSCIC IG Training Tool website, to gain practical and enhanced knowledge of records management best practice in a healthcare context.

5 GLOSSARY OF DEFINITIONS

The following definitions are of relevance to this document

Definition	Meaning
Access and disclosure	Health Records should be accessible at all times to appropriate and authorised personnel. In certain circumstances, their contents may, or should, be disclosed to the patient (or their representatives) or third parties such as the police. Disclosure must always be in accordance with the Trust's *Confidentiality Code of Conduct* (IG-0003).
Archive	A secondary storage facility used for records of service users who are not accessing services at the current time and are deemed dormant.
Contemporaneous record of care	Entries to the medical record must be made as soon as possible after the event to be documented. Where delays cannot be avoided the time of the event and the delay should be recorded.
Disposal	Actions undertaken at a records end-of-life. This may be transfer to a place of permanent preservation or outright destruction.
Health record	From the Data Protection Act (1998): 'a record consisting of information about the physical or mental health, or condition, of an identifiable individual, made by, or on behalf of, a health professional, in connection with the care of that individual'. All NHS records are public records under the Public Records Act.
Record creation	The beginning of a health record's lifecycle; the point at which a unique PAS number is allocated to the patient and the paper folder and/or electronic file set up.
Record-keeping	The maintenance of health records to appropriate standards, as dictated by relevant healthcare professional bodies and the Department of Health.
Record maintenance	Means ensuring records remain usable and accessible. For paper records this means storing them in order and safe from damage and unauthorised access. For electronic records, maintenance must include backup and controlled

	migration to new platforms to ensure continued access to readable information.

6. APPENDICES

APPENDIX A

MAIN CONTACTS

Medical Records Departments:

Newsam Centre
Seacroft Hospital
York Road, Leeds LS14 6WB
0113 855 6308

Becklin Centre
Alma Street, Leeds LS9 7BE
0113 855 6602

The Mount
44 Hyde Terrace, Leeds LS2 9LN
0113 855 5503

For Medical Records
Email: medicalrecords.lypft@nhs.net

For Archive Requests:
Email: archiverequests.lypft@nhs.net

For York Forensic Services Managed by Leeds
Clifton House
Clifton House
Bluebeck Drive
York
YO30 5RA
01904 611903

For York CAMHS Services Managed by Leeds
Mill Lodge
CAMHS Inpatient Unit
520 Huntington Road
Huntington
YORK
YO32 9QA
01904 294050

Health Records Manager:

Lynda Clapham
Becklin Centre
Alma Street, Leeds LS9 7BE
0113 855 6725
Lynda.Clapham2@nhs.net

APPENDIX B

PROFESSIONAL ASSOCIATIONS' GUIDANCE ON HEALTH RECORD KEEPING

British Association of Arts Therapists
See *Guidelines for Members*: http://www.baat.org

British Dietetic Association
See *Code of Conduct*: http://www.bda.uk.com/publications
Also *Professional Practice Guidance: Records and Record-keeping* (membership required)

General Medical Council
See Ethical Guidance: http://www.gmc-uk.org/guidance/ethical_guidance.asp particularly: *0-18 years: Guidance for all Doctors; Protecting Children and Young People: The Responsibilities of all Doctors; Confidentiality; Consent: Patients and Doctors Making Decisions Together; Good Medical Practice.*

Nursing and Midwifery Council
See *Record-Keeping Guidance* at http://www.nmc-uk.org

College of Occupational Therapists
See record-keeping section of http://www.cot.co.uk/standards-ethics/professional-standards-occupational-therapy-practice

Chartered Society of Physiotherapy
See record-keeping guidance at http://www.csp.org.uk/publications (membership required)

British Psychological Society
See *Generic Professional Practice Guidelines* and *Guidelines on the use of Electronic Health Records* at http://www.bpsshop.org.uk

Royal College of Psychiatrists
See *Good Psychiatric Practice* at http://www.rcpsych.ac.uk

APPENDIX C

LEGAL OBLIGATIONS

All NHS records are Public Records under the Public Records Act. The Trust will take actions as necessary to comply with the legal obligations set out in the Records Management: NHS Code of Practice, in particular:

The Public Records Acts 1958 and 1967

Data Protection Act 1998

Human Rights Act 1998

Freedom of Information Act 2000

The common law duty of confidentiality

European Convention on Human Rights, Article 8

Essential Standards of Quality and Safety (Care Quality Commission)

Information Governance Toolkit (HSCIC, revised annually)

NHSLA Risk Management Standards

NHS Care Records Guarantee (National Information Governance Board for Health and Social Care, 2011)

Any new legislation affecting health records management

APPENDIX D

DATA ITEMS FOR WHICH THE ELECTRONIC RECORD IS THE DEFINITIVE SOURCE

NHS number

Forename

Surname

Date of birth

Gender

Address

Postcode

GP practice

Ethnicity

Civil status

Employment status

Accommodation status

Settled accommodation status

Religion

Living status

Language

APPENDIX E

STANDARDS FOR THE DOCUMENTATION OF MEDICATION IN CASE NOTES

It is important to note that there is the intention to move to E-prescribing in February 2016 with the roll out complete by September 2016

1 Date

2 Type of consultation e.g. ward round, duty doctor visit, outpatient clinic

3 ALL current medication:

- drug name(s), strength, form, dose, route, indication.
- assessment of response
- assessment of tolerance
- patient's opinion
- source of this information i.e. GP, patient, prescription chart

NB Include medication purchased i.e. over-the-counter or pharmacy-only preparations, alternative remedies

4 Allergies / hypersensitivities: include what the reaction was and when it occurred.

5 New or changed medication:

- reason for new/changed medication i.e. indication
- intended duration (total or review date)
- any monitoring to be performed
- discussion with patient – to include risks, benefits and alternatives; this is essential if products are used outside the terms of their licence e.g. high dose, indication-wise or in unusual combinations
- whether script issued
- communication with GP or other care providers regarding medication changes and/or any relevant monitoring required or already done; an example form is shown below

6 Supply of medication

- source i.e. Trust pharmacy, community pharmacy, via community nursing team
- dispensing i.e. whether compliance aid used, weekly supplies etc
- risk of suicide or self-harm – no more than two weeks' medication should be supplied for service users who have a recent history of self-harm

7 Signature, name, position and contact details.

Leeds and York Partnership NHS
NHS Foundation Trust

Address

Tel:
Fax:

Consultant Psychiatrist – Dr

Dear Dr

Re: Notification of medication change

I write to inform you of a medication change. Please amend your records accordingly. A full letter will follow in due course.

Name of patient:
Date of birth:
Address:
Pas No:
NHS Number:
Medication change:
Details of prescription issued:
Comments:
Name of doctor advising the change:
Signature:
Date:

APPENDIX F

Post-Incident Records Lockdown Protocol

In the immediate aftermath of any serious untoward incident – in particular those involving sudden unexpected deaths (homicide / suicide), it is vital that the forensic integrity of paper and electronic records is maintained for any subsequent investigation. The following actions will therefore be required to be carried out when an appropriate serious untoward incident investigation is declared, necessitating records lockdown.

Staff local to the incident and other relevant parties – e.g. the Trust Health Records team(s) will have a duty to support the lock-down protocol as a matter of urgency.

Paper Records

- A copy of the paper record(s) of involved parties will be made as soon as is practicably possible. The copy will be marked as a copy, signed and dated so it is clear when this copy was made and by whom.
- The copy will be given to the investigating manager who will retain it securely and be ready to provide it to any external investigating authority.
- The investigating manager will request a copy (marked as above) of any relevant record currently held by our internal records team(s) and add this to the other records held.
- The investigating manager will request the return from external archive a copy (marked as above) of any relevant record and add this to the other records held.
- Our internal Health Records Team will process the return from archive of any relevant record and are authorised by the Information & Knowledge Manager (as budget holder) to use the fastest possible delivery method.
- When external investigating authorities demand original records, we will retain a copy and ensure that we receive an undertaking to have the original records returned to us on conclusion of any investigation.

Electronic Records

- Hard copy of the paper record(s) of the PARIS or other electronic system record(s) of involved parties will be made as soon as is practicably possible. The copy will be marked as a copy, signed and dated so it is clear when this copy was made and by whom.
- The copy will be given to the SI Administrator who will retain it securely and be ready to provide it to any external investigating authority.
- An audit trail of records access to core patient systems (PARIS) is available on request. Contact Carl Starbuck – Information & Knowledge Manager – to arrange this.
- PARIS keeps a robust audit trail of when entries were made and by whom.

Alteration / Interference with Records

Any attempt to inappropriately alter, append, amend or delete from historic and / or current records may be viewed as tampering with forensic evidence and may result in disciplinary action and / or prosecution.

PART B

7. PURPOSE OF DOCUMENT

7.1 Policy Statement

This policy applies to the processing of all clinical information by the Trust, whether in electronic or paper format, and is designed to ensure such processing is always carried out in accordance with the relevant legal and ethical framework and the Trust's *Information Governance Policy* (IG-0001) and associated procedural documents.

7.2 Purpose of Document

The purpose of this document is to provide instruction and guidance to staff on the management of service users' health records throughout the record's lifecycle of creation, usage, maintenance, storage and disposal. The aim is to support patient care and safety through records that are accurate, clear and available when needed, and also to manage access to those records in accordance with the NHS Care Record Guarantee.

8. IDENTIFICATION OF STAKEHOLDERS

Stakeholder	Level of involvement
Health professionals, administrative and medical records staff	Consultation
Information Governance Group	Development
Information Governance Group	Approving
Executive Team	Ratifying

9. REFERENCES, EVIDENCE BASE

A Clinician's Guide to Record Standards (Academy of Medical Royal Colleges/NHS Connecting for Health, 2008)

Caldicott Guardian Manual (DH, 2010)

Confidentiality: NHS code of practice (DH, 2003)

Data Protection Act 1998

European Convention on Human Rights, Article 8

Essential Standards for Quality and Safety (Care Quality Commission)

Freedom of Information Act 2000

Hospital Patient Care Records: A guide to their Retention and Disposal Health Archives Group, 2006)

Information Governance Toolkit (NHS Connecting for Health, revised annually)

*Information Security Management: NHS code of prac*tice (DH, 2007)

NHS Care Records Guarantee (National Information Governance Board for Health and Social Care, 2011)

NHSLA Risk Management Standards

Record-keeping: Guidance for Nurses and Midwives (NMC, 2009)

Records Management: NHS Code of Practice (DH, 2006)

Requesting Amendments to Health and Social Care Records (NIGB, 2010)

The NHS Constitution for England (DH, 2012)

The Right Information in the Right Place at the Right Time: A Study of How Healthcare Organisations Manage Personal Data (CQC, 2009)

Generic Medical Record Keeping Standards (RCP, 2015)

10. ASSOCIATED DOCUMENTATION

This policy document should be read in conjunction with its appendices, which set out how individual policy requirements will be delivered. Other LYPFT documents dealing with similar or overlapping areas are:

Information Governance Policy (IG-0001)

Confidentiality Code of Conduct (IG-0003)

Data Quality Policy (IG-0006)

Subject Access Request Procedures (IG-0008)

Safe Haven Procedures (IG-0009)

Procedure for Ensuring Valid Consent to Examination or Treatment (CM-0034)

Procedure for Advance Decisions and Advanced Statements (CM-0037)

Procedure for Mandatory Training (HR-0015)

Encryption Policy (IT-0001)

Internet Use Policy (IT-0002)

Email Use Policy (IT-0003)

Network Security Policy (IT-0004)

11. EQUALITY IMPACT ASSESSMENT

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Title: *Health Records Policy*

What are the intended outcomes of this work? *To set out and support systematic arrangements that ensure clinical records are managed safely and effectively.*
Who will be affected? *Staff and service users.*

Evidence
What evidence have you considered? *Leeds and York Partnership NHS Foundation Trust is committed to policies and procedures that meet the diverse needs of our population and workforce, and this policy has been framed such that none of its content will adversely affect any equality group. Health records are required to record certain protected characteristics, and this information is used to help ensure no groups are placed at a disadvantage in their dealings with the organisation. Protected characteristics will frequently be reflected in individuals' health records where this is relevant to the delivery of services. This policy is an integral part of the Trust's information governance framework, the fundamental objective of which is to protect the privacy of personal data and ensure it is processed only in accordance with the law.*
Disability *See above*
Sex *See above*.
Race *See above*
Age *See above*
Gender reassignment (including transgender) *See above*
Sexual orientation *See above*
Religion or belief *See above*
Pregnancy and maternity *See above*
Carers *See above*

Other identified groups *See above*

Engagement and involvement
Stakeholder engagement plan *N/A*
How have you engaged stakeholders in testing the policy or programme proposals? *N/A*
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs: *N/A*

Summary of Analysis *There is no evidence that this policy shows potential for differential impact on any group or groups.*
Eliminate discrimination, harassment and victimisation *N/A*
Advance equality of opportunity *N/A*
Promote good relations between groups *N/A*

What is the overall impact? *N/A*

Addressing the impact on equalities *N/A*

Action planning for improvement *N/A*

For the record **Name of person who carried out this assessment:** *Lynda Clapham, Health Records Manager.*
Date assessment completed: *November 2015*
Name of responsible Director/Director General: *Medical Director*
Date assessment was signed: *December 2015*

12. PLAN FOR DISSEMINATION AND IMPLEMENTATION

DETAILS OF DOCUMENT TO BE DISSEMINATED

Title of Document	Health Records Policy		
Date Ratified	27 January 2016		
Dissemination lead names	Lynda Clapham	**Contact details**	Lynda.clapham2@nhs.net 0113 855 6725

DETAILS OF DISSEMINATION

Date put on Staffnet	5 February 2016			
Who is the document to be disseminated to	Trust wide Medical Records Departments			
Disseminated to (either directly or via meetings, etc)	**Format (electronic/ paper)**	**Date disseminated**	**No of copies sent**	**Contact details/comments**
Trust wide	Electronic	5 February 2016	1	Staffnet
Medical Records Departments	Paper	5 February 2016	1	Medical Records Departments.

13. KEY PERFORMANCE INDICATORS

The following requirements of the HSCIC IG Toolkit map to performance under this Policy:-

- Requirement 205: There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data

- Requirement 404: A multi-professional audit of clinical records across all specialties has been undertaken.

- Requirement 406: Procedures are in place for monitoring the availability of paper health/care records and tracing missing records.

The following additional indicators will also be monitored:-

- HSCIC IG Training Record: The training status of medical records staff will be monitored to ensure that they have completed appropriate modules of the HSCIC IG Training Tool, in addition to the general requirement to complete an annual refresher of the "Introduction to Information Governance" as compulsory training. Additional modules include (subject to role):-
    - Access to Health Records
    - Records Management and the NHS Code of Practice
    - Records Management in the NHS

- Records-related Information Governance Breaches: Breaches with a root cause in health records management will be monitored as part of the standard IG incident reporting to the IG Group meetings.

14. MONITORING COMPLIANCE AND EFFECTIVENESS

The duties set out in this policy will be monitored as set out in the table below:

Topic	Monitoring/ Audit	Lead Manager	Data Source	Sample	Data Collection Method	Frequency Of Activity	Review Body
DPA / AHR performance (IGT #205)	Monitoring	Records Manager	SAR spreadsheet	All access requests	SAR spreadsheet summary tab	Monthly	Information Governance Group
Audit of clinical record keeping (IGT #404)	Audit	Head of Clinical Audit	Health records (paper)	Sample populations will be: Community: All service users with an open episode of care of at least six months' duration In-patients: All service users receiving in-patient care at the time of data collection. Records relating to all clinicians and clinical teams are eligible for audit; the number of records audited will be proportionate to caseload size.	Clinical Audit's data collection form designed specifically to cover defensible documentation and basic care provision.	Annually, aligned to IG Toolkit	Information Governance Group / IG team as part of IG Toolkit performance tracking.
Availability of paper healthcare records (IGT #406)	Monitoring	Records Manager	Health records team, DATIX	All records requests to health records	Regular reporting to IG Group	Monthly	Information Governance Group / IG team as part of IG Toolkit performance tracking.

Health records staff training	Monitoring	Records Manager	HSCIC IG Training Tool	All health records staff	Reporting from training records system	Annually, aligned to staff PDP	Line Manager
Records-related IG breaches	Monitoring	Information & Knowledge Manager	DATIX	All incidents reported.	Incident reporting system.	Monthly	Information Governance Group