Leeds and York Partnership
NHS Foundation Trust

HEALTH RECORDS POLICY

The key messages the reader should note about this document are:

1. Sets Trust policy for the management of paper health records.
2. Outlines the lifecycle of paper health records from creation to disposal.
3. Advises retention schedules aligned to the Records Management Code of Practice for Health & Social Care.
4. Informs Trust staff about health record keeping standards, derived from authoritative national sources.
5. Sets out the requirement to electronically track paper records via CareDirector.

This policy/procedure may refer to staff as qualified/registered/professional or other such term to describe their role. These terms have traditionally referred to individuals in a clinical role at band 5 or above. Please note that the use of these terms **may or may not** include nursing associates or associate practitioners (band 4). For clarification on whether a nursing associate or associate practitioner is an appropriate person to take on the identified roles or tasks in this policy/procedure please refer to the job description and job plan for the individual, or local risk assessment.

Leeds and York Partnership
NHS Foundation Trust

DOCUMENT SUMMARY SHEET
ALL sections of this form must be completed.

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Executive Team member responsible (title)	Medical Director
Document author (name and title)	Carl Starbuck Head of Information Goverance
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Amendment detail

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 C	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
	Review date extended from 05/02/2019 to 30/11/2019	Agreed at PPG 27 February 2019
7.0	Changes to reflect "Care Services" and "Head of Operations" structure and naming conventions	Review undertaken aligned to instructions received from Peter Johnstone (24/12/2019) Actions completed 07/01/2020
7.1	Reviewed to align to CareDirector go-live 03/2020	Re-authored in current procedural document template Update of terminology to reflect cut-over from PARIS to CareDirector Update of field references for paper case-note files, from PAS Number to Casenote Folder Number Removal / update of references to closed sites and retired staff Review of external references and supporting documentation. Review and update of terminology, legal references
8.0	Ratified	Ratified by Policy & Procedure Group

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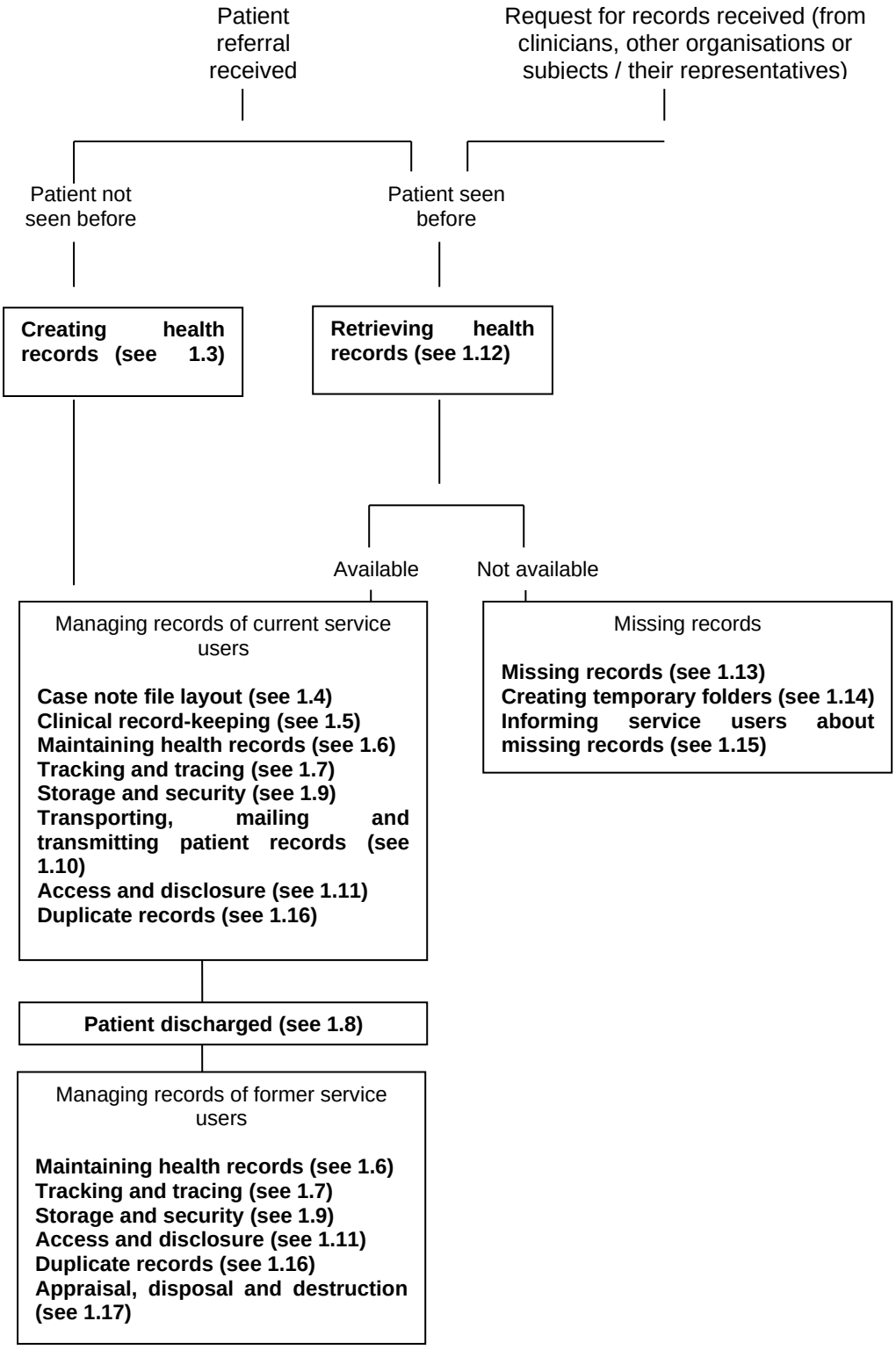
1. The Policy

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 & Social Care's *Records Management Code of Practice for Health & Social Care* 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.

1.1 Flowchart of Policy



1.2 Creating Health Records

Before creating a new set of health records for any service user, staff must check on CareDirector that there is no previously created record. The check should be made by using the primary 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 CareDirector with the following details:

- Name
- Address and postcode
- Date of birth
- GP
- NHS number

Staff with appropriate SmartCard access must verify these details against those held by the national Patient Demographic Service.

The next step is to allocate the service user the next sequential folder number and input this to CareDirector and set up a manual case notes file.The folder number is input into the Casenote Folder Number field.

Teams are issued in advance with proforma folders, issued by Medical Records at the Newsam Centre, bearing the next sequential folder numbers, and staff in service 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 in CareDirector.

1.3 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 securely and correctly 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.

1.4 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*, 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.

Those responsible for supervising learners and non-registered staff should ensure they are clear of the standards expected to enable them to delegate record keeping and understand the circumstances where countersigning is required **(See Appendix D)**.

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)
- Clearly identify the expression of clinical opinion

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 / patient-related contacts, including over the telephone / e-mail, and any team meetings or discussions with other health professionals used to inform the assessment, planning or delivery of care

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.

1.5 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 1.4 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 B.

1.6 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
- Casenote Folder Number
- Date transferred
- Name and department of the person to whom the notes are being transferred
- Date returned

1.7 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.

1.8 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 Guidance – 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 Order

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 CareDirector 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 CareDirector and corroborated using the national Patient Demographic Service 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 Medical Records (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, securely filed in the appropriate section of the folder, and in chronological order.

Storing Non-Current Records Off-Site

The Trust recommends that health records are kept onsite for one year 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, via Medical Records. 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 (the NHS or Casenote Folder Number).
- Preferably, to minimise the risk of errors, these folders or envelopes show the patient's name, NHS and Casenote Folder 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 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 are 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.

1.9 Transporting, Mailing and Transmitting Patient Records

Patient records contain Personal & Special Category information – as defined by the Data Protection Act (2018) and the General Data Protection Regulation. Whenever records or parts of them are transported, mailed, e-mailed, faxed or delivered by hand, it must be in accordance with the **Safe Haven Guidance - 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.

1.10 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 **Medical Records 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 Data Protection Officer (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 / Data Protection Officer, whose guidance should be sought prior to disclosure.

1.11 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 the Medical Records Department (see Appendix A) notes can be obtained by providing the service user's full name, date of birth and Casnate Folder Number 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. 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 1.6 above). If notes are not available at the location to which they were tracked, staff should follow the missing records procedure at 1.12 below.

If the records have been transferred to offsite storage (see 1.8 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 four 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.

1.12 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 the Medical Records Department to arrange for a temporary set of notes to be issued (see 1.13 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 Head of Information Governance, as Trust Data Protection Officer, will make that decision.

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

1.13 Creating Temporary Folders

Temporary folders should be created only when the search procedures set out in 1.12 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.

If the original health records are located, the temporary and original notes must be merged in the original folder immediately.

1.14 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 aims to operate an open and transparent culture under our Duty of Candour and Data Protection Act (2018) / General Data Protection Regulation obligations, and consideration must be given to informing service users about breaches of confidentiality. There is also a consideration of whether the loss of records, if lost "in public", poses any risks to vulnerable service users.

Where personal or special category 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 Manager 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.

In all cases, the "First Do No Harm" principle will be paramount, and ultimately the decision to inform the service user, or not, about a breach of their confidence, will be based on the view of which approach does no harm or addresses potential harm, or which approach does the least harm.

1.15 Duplicate Records

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

If they are, and there are duplicate electronic records, raise a call with the ICT Service Desk, who will assign the task to an appropriate team to carry out any merging of electronic records.

If there are duplicate paper records, the different sets of case notes must be merged in chronological order. A member of the Medical Records team must carry this out. The earliest Casenote Folder 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.

1.16 Appraisal and Disposal

The Trust will observe the retention schedules and disposal actions stated in the **Records Management Code of Practice for Health & Social Care.** 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 usually be in the possession of the offsite storage provider when they come to the end of their 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.

When the records retention period is over, it should be noted that "disposal" does not necessarily mean "destruction". The Head of Information Governance / Data Protection Officer will determine whether records require permanent preservation under the Code of Practice, whether they are still in use and should be retained for a longer period, or whether they should be securely destroyed.

At the time of writing, it is notable that the 2016 version of the Code of Practice is in use, under which only the following classes of medical record are highlighted for permanent preservation:-

- Cancer / Oncology - the oncology records of any patient
- Medical record of a patient with Creutzfeldt-Jakob Disease (CJD)
- Pathology Reports/Information about Specimens and samples

The Head of Information Governance / Data Protection Officer will 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 Head of Information Governance / Data Protection Officer will arrange for those records selected for permanent preservation to be transferred to a recognised Place of Deposit – at the time of writing this is:-

West Yorkshire Archive Service
West Yorkshire History Centre
127 Kirkgate
Wakefield WF1 1JG

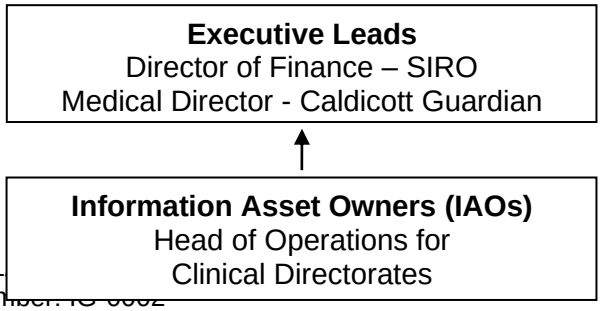
All teams should regularly review the health records in their possession. Whenever staff come across records still held on Trust premises that have passed their minimum retention periods they should contact the Medical Records Department and arrange for transport to either the Medical Records Department or offsite storage as appropriate.

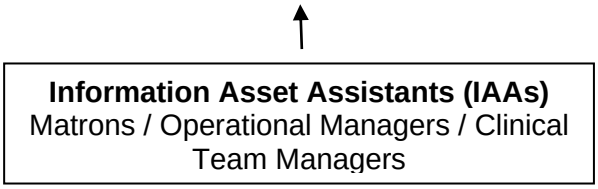
1.17 Ownership of Health Records

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 control within the Trust must be clearly defined.

The Information Commissioner's Office recommends that appropriately senior officers 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.

This is set out in the following diagram:-





1.18 Duties and Responsibilities

The Policy confers the following duties on Trust staff & officers:-

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 leadership 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.
Medical Records Manager	The Medical Records Manager is responsible for the overall development and maintenance of good Health Records management practices across the Trust and for maintaining and promoting compliance with this policy.
Head of Operations and Matrons / Operational Managers / Clinical Team Managers	Responsibility for local records management is devolved from the relevant Head of Operations (as Information Asset Owners) to the Matrons / Operational Managers / Clinical 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. Matrons / Operational Managers / Clinical Team

	Managers are also responsible for ensuring that audit recommendations about record-keeping are implemented in their area.
Head of Information Governance / DPO	Responsible for the authoring and updating of this policy as required, and to lead on matters of Data Protection and Information Governance as they apply to medical records.
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.

1.19 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 the **Compulsory Training Procedure – HR-0015.**

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

2 Appendices

(or the link to the relevant document(s) on staffnet)

Appendix A – Main Contacts

Medical Records Department
Newsam Centre
Seacroft Hospital
York Road
LEEDS LS14 6WB
0113 85 56308
medicalrecords.lypft@nhs.net

Archive Requests:
archiverequests.lypft@nhs.net

York Forensic Services Managed by LYPFT
Clifton House
Bluebeck Drive
YORK YO30 5RA
01904 611903

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

Health Records Manager:
Karen Lendill
Newsam Centre
Seacroft Hospital
York Road
LEEDS LS14 6WB
0113 85 56308
k.lendill@nhs.net

Head of Information Governance / Data Protection Officer
Carl Starbuck
1st Floor, North Wing, St Marys House
St Martins View
LEEDS LS7 3LA
0113 85 59771
carl.starbuck@nhs.net

Appendix B – 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 C – Post-Incident Records Lockdown Protocol

In the immediate aftermath of any serious 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 when an appropriate serious incident investigation is declared, necessitating records lockdown.

Staff local to the incident and other relevant parties – e.g. the Trust Medical 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 Medical Records Team 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 Medical Records Team will process the return from archive of any relevant record and are authorised by the Head of Information Governance (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 CareDirector 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 patient systems (CareDirector) is available on request. Contact the Head of Information Governance to arrange this.
- CareDirector 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.

Appendix D - Guidance on Delegating Record Keeping and Countersigning Records Within Clinical Information Systems

Record Keeping and Delegation

Accurate record keeping is integral to care delivery and should be completed as close to the time that care was delivered as possible. Record keeping can be delegated to Health Support Workers (HSW's), Associate Practitioners (AP's), and all learners so that they can document the care they provide.

The act of record keeping attracts the same principles as any other delegated task in the health care setting, including the need for ongoing supervision as appropriate.

Whilst the Registered Nurse (RN) and the Nursing Associate (NA) retain professional accountability for the appropriateness of the delegation of the task, the HSW, AP and learner takes on personal accountability for the content and quality of the records, in line with ***Nursing and Midwifery Council (NMC) guidance[1]*** and this policy.

Countersigning

A countersignature should enable identification of the registered nurse who has countersigned, i.e. not just initials. The NMC recommends that the person's name and job title should be printed alongside the first entry in a record.

When the Registered Nurse countersigns, they are confirming (NMC Code 11.3) that the outcome of any task delegated to someone else (in this instance record keeping) meets the required standard.

Registered nurses should only countersign if they have witnessed the activity or can validate that it took place.

Countersigning is not an automatic requirement[2] if a registered nurse is satisfied that:

- The non-registered member of staff has been trained to appropriate standards and is competent to produce such records as part of the overall provision of care then delegation of the record keeping activity will be appropriate and there will be no requirement for the registered nurse to countersign the notes.

- Whether it is in the patient's best interests for recording of care (as well as care provision) to be delegated.

If a registered nurse is satisfied the above criteria are met, then delegation of the record keeping activity will be appropriate and there will be no requirement for the registered nurse to countersign the notes.

If there is any doubt about the individual's competence, then supervision and countersignatures under the Performance Management Framework will be

required until they have received the appropriate level of training and are deemed competent to complete the activity by their management supervisor.

Record Keeping Competency

Students / Learners

All **Students / Learners must** have their entries countersigned by the person who has direct supervisory responsibility for the student/ learner or by the person who has delegated the task if they are different. (***NB*** It should be remembered that designated authority may change with shifts. Where supervisors delegate the responsibility for countersigning they must be assured that it will be competently carried out and recorded appropriately).

Non-Registered Staff

All non-registered staff must have their entries countersigned unless they meet the ***registered nurse criteria described***[2]. Competency can be demonstrated by the person having a recognised health / social care qualification (NVQ or equivalent) or having sufficient experience in their role; or through completion of the online record keeping training as evidence of baseline competence. Competency will however be decided by the person's manager at the point of care and will be monitored through supervision.

Bank / Agency Staff

All non-registered staff should complete once only priority on line record keeping training to achieve baseline competence. The clinical lead for the Temporary Staffing Department will have oversight of training records to ensure all staff have completed this. The clinical lead will complete 3 monthly checks pulled from COGNOS to check the quality of records using the 4C's tool.

Other Identified Staff

There are times when any staff member of any grade or discipline can have their entries countersigned if it is identified that they have failed to maintain their records to the expected standard of the Trust or in line with the standards set out by their own registering body for their profession. The timescale for records to be countersigned will be set out by their line manager or senior manager.

CareDirector

LYPFT's electronic patient record keeping system is CareDirector and it has a function to verify countersignatures. When the student / learner or any member of staff creates a case note that requires the record to be countersigned, the individual can enable the "responsible user" field to the name of their mentor or supervisor for the day.

The individual user should then save the note leaving the completion status as “in progress”. The case note will appear on the dashboard of the mentor or supervisor whom has been identified as “responsible user”. The mentor or supervisor can then open the note from the dashboard, read, edit if required and save with a status of “completed”. The note is now closed and cannot be changed. The information for the note will say e.g. “Created by student nurse” or ‘’Bank staff’’ and “Completed by Mentor / Supervisor”.

Oversight of Care and Treatment

Record keeping by a non-registered professional is a delegated activity and professional oversight should be a routine activity. Registrants are accountable for work delegated to others and verification of those activities delegated allows clinical assurance of care.

Whilst ***countersignatures are not an automatic requirement under the conditions described***[2] registrants are required to demonstrate that they have had oversight of the care plan and the interventions provided.

References for this Appendix:-

1. *NMC guidance: The Code Updated to reflect the regulation of nursing associates: 10 October 2018*

2. *RCN delegating record keeping and countersigning records: Publication date: June 2017 Review date: June 2020*

PART B

3 IDENTIFICATION OF STAKEHOLDERS

The table below should be used as a summary. List those involved in development, consultation, approval and ratification processes.

Stakeholder	Level of involvement
Medical Records team	Development & Consultation
Head of Information Governance / DPO	Author / Development
Information Governance Group (comprising) • Head of Information Governance / DPO • IG Support Officer • Chief Information Officer • Head of Performance Management & Informatics • Head of IT Service Delivery • ICT Service Desk Manager / RA Manager • ICT Network Support Manager	Consultation / Approval
Head of Nursing	Consultation
Staffside representative	Consultation
Policy & Procedure Group	Ratification

4 REFERENCES, EVIDENCE BASE

Records Management Code of Practice for Health & Social Care (2016)
https://digital.nhs.uk/binaries/content/assets/legacy/pdf/n/b/records-management-cop-hsc-2016.pdf

General Medical Council
Good Medical Practice, Domain 1: Knowledge, Skills and Performance: Record your work clearly, accurately and legibly
https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-1---knowledge-skills-and-performance#paragraph-19

Nursing and Midwifery Council
Record-Keeping Guidance
https://www.nmc.org.uk/standards/code/record-keeping/

College of Occupational Therapists

Keeping Records - guidance for occupational therapists (2017)
https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/keeping-records (membership log-on required)

Chartered Society of Physiotherapy
Record-keeping guidance
http://www.csp.org.uk/publications/record-keeping-guidance-0

British Psychological Society
Guidelines for clinical psychology services
https://shop.bps.org.uk/guidelines-for-clinical-psychology-services.html

Royal College of Physicians
Generic medical record keeping standards
https://www.rcplondon.ac.uk/projects/outputs/generic-medical-record-keeping-standards

The Public Records Acts 2005

Data Protection Act 2018

Human Rights Act 1998

Care Quality Commission – Essential Standards of Quality and Safety

NHS Digitial – Data Security & Protection Toolkit

NHS Litigation Authority – Risk Management Standards

NHS Care Records Guarantee

5 ASSOCIATED DOCUMENTATION (if relevant)

IG-0001 – Information Governance Policy

IG-0003 – Confidentiality Code of Conduct

IG-0006 - Data Quality Policy

IG-0008 – Medical Records Subject Access Request Procedures

IG-0009 – Safe Haven Guidance

IG-0010 – Data Protection Policy

6 STANDARDS/KEY PERFORMANCE INDICATORS (if relevant)

Rolling Programme of Record Keeping Audit

Our Medical Records Team undertake a rolling audit of paper records at all Trust sites, as recommended by RSM Tenon. These audits assess the construction and key points of good record keeping practice for paper records, reporting back to record-holding teams on performance and areas for improvement. Sub-optimal performance is reported to the Medical Director. The interval to subsequent audit is varied based on previous performance, with a rapid return when improvement is required.

Availability of Paper Records

All instances of missing paper records are reported via DATIX. This is reported monthly to the Information Governance Group.

Medical Records Subject Access Request Performance

Performance against statutory timescales for the servicing of Medical Records Subject Access Requests is reported monthly to the Information Governance Group.

Records Related IG Breaches

All instances of IG breaches or near-miss incidents are reported via DATIX. This is reported monthly to the Information Governance Group.

Information Governance Training

Trustwide training compliance is reported monthly to the Information Governance Group.

7. EQUALITY IMPACT

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. Consideration must be given to any potential impacts that the application of this policy/procedure might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Declaration: The potential impacts on the application of this policy/procedure have been fully considered for all nine protected groups. Through this process I have not identified any potential negative impacts for any of the nine protected groups.

Print name: Carl Starbuck

Job title: Head of Information Governance

Date: 07/02/2020

If any potential negative impacts are identified the Diversity Team must be contacted for advice and guidance: email; diversity.lypft@nhs.net.

CHECKLIST

To be completed and attached to any draft version of a procedural document when submitted to the appropriate group/committee to support its consideration and approval/ratification of the procedural document.

This checklist is part of the working papers.

	Title of document being newly created / reviewed:	Yes / No/
1.	**Title**	
	Is the title clear and unambiguous?	✓
	Is the procedural document in the correct format and style?	✓
2.	**Development Process**	
	Is there evidence of reasonable attempts to ensure relevant expertise has been used?	✓
3.	**Content**	
	Is the Purpose of the document clear?	✓
5.	**Approval**	
	Does the document identify which committee/group will approve it?	✓
6.	**Equality Impact Assessment**	
	Has the declaration been completed?	✓
7.	**Review Date**	
	Is the review date identified?	✓
	Is the frequency of review identified and acceptable?	✓
8.	**Overall Responsibility for the Document**	
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	✓

Name of the Chair of the Committee / Group approving			
If you are assured this document meets requirements and that it will provide an essential element in ensuring a safe and effective workforce, please sign and date below and forward to the chair of the committee/group where it will be ratified.			
Name	*Carl Starbuck*	Date	*07/02/2020*
Name of the chair of the Group/Committee ratifying			
If you are assured that the group or committee approving this procedural document have fulfilled its obligation please sign and date it and return to the procedural document author who will ensure the document is disseminated and uploaded onto Staffnet.			
Name	*Cath Hill*	Date	*18/11/2020*