Healthier Communities, Outstanding Care

Sherwood Forest Hospitals NHS Foundation Trust

HEALTH RECORDS MANAGEMENT POLICY

POLICY

Reference	GV/007
Approving Body	Information Governance Committee
Date Approved	8th November 2019
Issue Date	November 2019
Version	8
Summary of Changes from Previous Version	Adapted to new template and updates to associated documents. The majority of previous appendices have now been changed to a procedure document to support this policy.
Supersedes	7 and all previous versions
Document Category	Governance
Consultation Undertaken	Medical Records Advisory Group Patient Services Governance Committee D&O Governance Committee Information Governance Committee Nursing and Midwifery Committee Clinical Lead for ICT Clinical Coding Manager Safeguarding Lead
Date of Completion of Equality Impact Assessment	17.05.19
Date of Environmental Impact Assessment (if applicable)	17.05.19
Legal and/or Accreditation Implications	Required for NHS Data Security and Protection Toolkit
Target Audience	All users of medical records
Review Date	November 2022 Extended to 19/09/2024
Sponsor (Position)	Caldicott Guardian
Author (Position & Name)	Patient Services Manager
Lead Division/ Directorate	Diagnostics & Outpatients
Lead Specialty/ Service/ Department	Patient Services

Position of Person able to provide Further Guidance/Information	Patient Services Manager

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Procedures for the Management of Medical Records/SFH Case Notes and associated processes	October 2019

CONTENTS

1.0 INTRODUCTION

1.1 Health records are a valuable resource because of the information they contain.

High quality information underpins the delivery of high quality evidence based health care, and many other key service deliverables. Information is of greatest value when it is accurate, up to date and accessible when needed. An effective health records management service ensures that information is properly managed and available when needed:

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

1.2 All NHS records are public records under the Public Records Act of 1958. They must be kept in accordance with statutory and NHS guidelines, including:

- Public Records Act 1958
- Data Protection Act 2018
- Freedom of Information Act 2000
- NHS Code of Practice: Records Management 2009
- Caldicott2 Review of Patient Identifiable Information 2012
- Common Law Duty of Confidentiality
- Working Together for Safeguarding Children

1.3 This policy states how health records will be managed within Sherwood Forest Hospitals NHS Foundation Trust and provides guidance on filing within medical case notes.

1.4 This Policy is issued and maintained by the Caldicott Guardian (the sponsor) on behalf of the Trust, at the issue defined on the front sheet, which supersedes and replaces all previous versions. From version 5 onwards, this policy now incorporates the former “Policy for Filing within Case Notes”.

1.5 The primary purpose of keeping health records is for patient care. The record should detail the investigation, diagnosis, treatment and subsequent outcomes for the benefit of the patient and healthcare professionals involved in providing care.

Hence accurate filing and record keeping in case notes is essential to support the following:

- **Promoting safe care**
  Details of patient care must be filed in the correct set of case notes in a timely manner to ensure that clinicians are able to make appropriately informed decisions about patient care. All documentation must be secured in the appropriate section before the notes are sent on to the next destination.

- **Easy access to relevant information**
  Filing information in the correct location within the case notes enables clinicians to find specific details quickly and easily, thus supporting patient care.

- **Timely and accurate clinical coding**
  This can take place if patient care details are correctly recorded and associated documentation is appropriately filed. This in turn supports the Trust's financial stability as it supports clinical coding and thus contracting of services and payments by our commissioners.

- **Access to Health Records/Medico Legal Aspects**
  Patients may request access to their health records or copies may be requested to support medico legal claims. Accurate, neat and tidy case notes are essential to support this.

  Hence accurate filing is very important and tidy case notes are much less likely to cause harm to patients through information being overlooked or lost.

2.0 POLICY STATEMENT

2.1 The Sherwood Forest Hospitals NHS Foundation Trust, Board of Directors acknowledges the importance of health records and is committed to create, keep, make available to those entitled to access, maintain and dispose of records, commensurate with legal, operational and information needs.

2.2 This policy relates to the management of health records and filing within medical case notes held by the Trust and used within the local health community at King's Mill, Newark, Mansfield Community and Ashfield Community Hospitals (excluding the Chatsworth Unit at MCH). It also provides general associated advice in relation to the retrieval, tracking, retention and destruction of case notes.

2.3 All records created in the course of the business of the Trust are public records under the terms of the Public Records Act.

2.4 This policy does not address in detail the retention and ultimate destruction (or permanent preservation) of records. These matters are covered by a separate complementary Retention and Destruction Policy. It should be noted however, that at present the permanent destruction of medical records is on hold due to the requirements of the Goddard Enquiry. For further advice on this matter please contact the Information Governance Manager.

2.5 This policy does not address the management of corporate and administrative records. These records are covered by the separate complementary Corporate Records Policy.

2.6 **Accountability**

The Trust requires that adequate records are maintained to account fully and transparently for all actions and decisions, in particular:

- To protect legal and other rights of staff or those affected by those actions;
- To facilitate audit or examination;
- To provide credible and authoritative evidence if required by law;

2.7 **Quality**

The Trust requires that records are complete and accurate and the information they contain is reliable, relevant, fit for purpose and its authority can be guaranteed.

2.8 **Accessibility**

The Trust expects records, and the information they contain can be efficiently retrieved by those with a legitimate right of access, for as long as the records are held.

2.9 **Training**

The Trust requires all staff who are responsible for record-keeping to be made aware of their responsibilities through generic and Information Governance specific mandatory training programmes and guidance. Similarly, all staff will be made aware of their filing responsibilities through mandatory and induction training programmes and guidance

2.10 **Security**

There is an expectation that records will be kept secure at all times and only released to staff who have the right of access to them. Staff that regularly use case notes and need to keep them in their work area are responsible for their safe keeping and security. They are also to be kept secure from unauthorised or inadvertent alteration or erasure, that access and disclosure will be properly controlled and audit trails will track all use and changes. Records will be held in a robust format that remains readable for as long as the records are required.

2.11 **Performance Measurement**

The application of record management procedures are regularly monitored against agreed indicators and action taken to improve standards as necessary. Results of these will be reported to and discussed at the Medical Records Advisory Group and if relevant the Patient Services monthly Service Line Performance Meeting.

2.12 **Record Management and Filing Procedures**

A number of procedures covering specific aspects of records management have been included as appendices to this policy. These procedures form part of the policy and all staff that use case notes are expected to be aware of the procedures and adhere to them. In particular this will apply to those staff groups detailed in section 5.

Staff involved in or with any aspect of record management or filing in case notes should refer to the Procedures for the Management of Medical Records/SFH Case Notes and associated processes (page 4).

3.0 DEFINITIONS/ ABBREVIATIONS

The Policy	means Health Records Management Policy
The Trust	means Sherwood Forest Hospitals NHS Foundation Trust
Caldicott Guardian	individual appointed by the Chief Executive responsible for protecting patient information. This includes ensuring the protection of patient records and that appropriate standards are maintained and monitored.
'SIRO'	means Senior Information Risk Owner; responsible for leading and implementing the information risk management process and providing the Board assurance.
'IAO'	means Information Asset Owner; responsible for understanding and assessing the information they 'own' and providing the SIRO with assurance in relation to the security of that asset.
'IAA'	Information Asset Administrator; responsible for providing support to their IAOs in ensuring that IG policies are followed and that information risks and incidents are documented and escalated accordingly.
Obtaining and retrieval of notes	means by which case notes can be requested
Disposal and destruction	means by which notes are removed from file, checked, disposed of and destroyed.
Tracking of notes	means by which notes are electronically tracked from one location to another. The terminology within Medway PAS to support tracking is "send" and "receive".

4.0 ROLES AND RESPONSIBILITIES

4.1 Statutory Responsibility

The Secretary of State for Health and all NHS organisations have a duty under the Public Records Act 1958 (PRA) to make arrangements for the safe keeping and eventual disposal of all types of their records. This is carried out under the overall guidance and supervision of the Keeper of Public Records who is answerable to Parliament. All NHS records are public records under the terms of the PRA Schedules 3(1)-(2). Chief Executives and Senior Managers of all NHS organisations are personally accountable for records management within their organisation.

4.2 Managerial Responsibility

4.2.1 The Board of Directors has responsibility, to ensure and gain assurance that the Trust has in place robust arrangements for the management of records and that such arrangements are complied with.

4.2.2 The Chief Executive has responsibility to implement robust and appropriate record management arrangements in accordance with national and statutory requirements.

4.2.3 The Chief Executive delegates this responsibility to Executive Directors, Divisional Directors and other Senior Managers within the Trust.

4.2.4 Each clinical Divisional General Manager and/or ***Information Asset Owner*** will nominate appropriate **Information Asset Administrators** for all information assets held, obtained, recorded, used or shared within their Division. ***Information Asset Owners and Administrators*** must have up-to-date knowledge of the laws and guidelines concerning confidentiality, data protection and freedom of information, and ensure that their staff are adequately trained through induction and adhere to this policy. Further information on the role and responsibilities of the IAOs and IAAs can be found in Appendix A of the Information Governance Management Framework.

4.2.5 The Patient Services Manager and Information Governance Manager will provide support and guidance for the implementation of this policy, and its subsequent on-going use.

4.3 Individual Responsibility of staff

All members of Trust staff are responsible for any record that they create or use. This responsibility is established at, and defined by, the law. Everyone working for the Trust and for the NHS generally who records, handles, stores or otherwise comes across information has a personal common law duty of confidence. The Data Protection Act places statutory restrictions on the use of personal information, including health information

4.4 Who Is Responsible For Filing In Case Notes?

Every member of staff who handles case notes as part of their daily routine is responsible for maintaining accurate and tidy medical records. It should also be noted that staff who keep records in their offices, wards or departments are responsible for the safekeeping and security of the records whilst in their possession. It is also important that the records can be easily accessed by admissions staff on an emergency basis. Hence leaving records in a locked office out of office hours is not acceptable unless the admissions team also have a key/digilock number etc.

Staff should refer to the **Procedures for the Management of Medical Records/SFH Case Notes and Associated Processes** as this provides *detailed information for each of the main staff groups* who are involved in filing within case notes.

5.0 APPROVAL

This document has been circulated widely for comment, updated accordingly and then approved by the Patient Services and Diagnostics and & Outpatients Governance Committees, and Medical Records Advisory Group has given final approval.

6.0 DOCUMENT REQUIREMENTS

6.1 This policy relates to the management of all health records of the Trust, including but not limited to:

- Patient health records (electronic or paper based; including those concerning all specialties)
- Records of private patients seen on NHS premises
- All registers e.g. birth registers, theatre registers, minor operations registers
- X-ray and imaging reports, outputs and images
- Photographs, slides and other images
- Microform (i.e. fiche / film)
- Audio and videotapes, cassettes and disks.
- Emails
- Digital records
- Computerised records

6.2 This policy relates to the management of health records and filing within medical case notes held by the Trust and used within the local health community at King's Mill, Newark, Mansfield Community and Ashfield Community Hospitals. It also provides general associated advice in relation to the retrieval, tracking, retention and destruction of case notes.

- All records created in the course of the business of the Trust are public records under the terms of the Public Records Act.

- This policy does not address the retention and ultimate destruction (or permanent preservation) of records. These matters are covered by a separate complementary Retention and Destruction of Records Policy.

- This policy does not address the management of administrative records. These records are covered by the separate complementary policy Corporate Records Management Policy'.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee / Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Case Note Tracking	Patient Services Manager	Audit	Monthly	MRAG
Availability of Case Notes for Clinics and Admissions	Patient Services Manager	Monitoring	Ongoing	Patent Services Service Line
Provision of Temporary case notes	Patient Services Manager	Monitoring	Ongoing	Patent Services Service Line

8.0 TRAINING AND IMPLEMENTATION

8.1 All staff that are responsible for record-keeping are made aware of their responsibilities through generic and IG specific mandatory training programmes and guidance. Similarly, all staff are made aware of their filing responsibilities through mandatory and induction training programmes and guidance. It is the responsibility of Departmental Managers to deliver such training although the mandatory training is provided on line and all patient administration staff are required to complete this annually.

8.2 The following groups of staff will be appropriately trained in the following aspects of case note management:

- Storage and security
- Notes retrieval and tracking
- Filing within case notes
- Retention and destruction

- Ward clerks/receptionists
- Clinical Diagnostic Coding staff
- Pathway Co-ordinators
- Clinical Typists
- Records Assistants
- Outpatient Receptionists
- Waiting list Clerks
- Pre-Operative Assessment Clerks
- Case Note Store Staff
- Cardio – respiratory Clerks
- Central Booking Clerks
- Service Desk support (in aspects relating to the merging of case notes)

8.3 Training on all aspects of this policy are included in an on line training package available in the Sherwood Forest Training Academy. Records of such training will be maintained by the training and Development Department for all patent administration staff for whom this is considered mandatory. Additional training may be required when the policy is amended and the on line training package may require update.

8.4 Destruction and disposal of records will be carried out by staff in the Case Note Store on both the King's Mill and Newark sites. The Patient Services Manager will ensure that only staff that have been appropriately trained carry out this task. Staff are no longer required to keep a record of case notes which have been destroyed as a report from Medway providing such information can be obtained as required. When a record is destroyed the case notes will be tracked to the location of "Destroyed" so that it is clear that this has happened. (See Procedures for the Management of Medical Records/SFH Case Notes and associated processes).

8.5 Divisional General Managers are to ensure that the staff detailed in 8.2 above:

- complete the mandatory training. Details of those attending said training will be provided to Divisional General Mangers by the Training and Development Department in order that compliance with.
- training requirements can be monitored. They will also be required to ensure that these staff groups undertake IG mandatory training on an annual basis. They will ensure that those staff who use case notes are trained in the case note tracking process or are aware how they can arrange for notes to be tracked when required.

8.6 Divisional Information Asset Owners are to identify needs for awareness training for any other staff groups within their Division as required. Identified needs will be supported by Information Governance and Patient Services as appropriate.

8.7 The Information Governance Manager and Patient Services Manager and Data Quality Manager, will co-ordinate training activities and highlight any gaps in training that need to be addressed.

9.0 IMPACT ASSESSMENTS

This document has been subject to an Equality Impact Assessment, see completed form at Appendix 1.

This document has been subject to an Environmental Impact Assessment, see completed form at Appendix 2.

10.0 EVIDENCE BASE AND RELATED SFHFT DOCUMENTS

Evidence Base:

This Policy has been developed with reference to:

- Public Records Act 1958 and 1967
- Data Protection Act 2018
- Freedom of Information Act 2000
- Access to Health Records Act 1990
- Caldicott2 Review of Patient Identifiable Information 2012
- Common Law Duty of Confidentiality
- A Clinician's Guide to Record Standards Part 2 published by the Academy of Medical Royal Colleges.
- NHSLA Risk Management Standards (Standard 1, Criterion 7)
- NHS Data Security and Protection Toolkit
- Records Management Code of Practice for health and social care 2016

Related SFHFT Documents:

This policy is to be used in conjunction with the following complementary policie and procedures:

- Procedures for the Management of medical Records /SFH Case Notes and associated processes
- Retention and Destruction Policy
- Information Security Policy
- Information Governance Policy
- Information Sharing Protocol
- Internet and Email Policy
- Freedom of Information Policy
- Access to Health Records Procedures
- Clinical Record Keeping Standards Policy
- Confidentiality Policy
- Subject Access policy
- Safe haven Policy
- Alert Policy
- Adoption Policy (in development)

11.0 APPENDICES

Please see contents table.

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Health Records Management Policy			
New or existing service/policy/procedure: existing policy			
Date of Assessment: 17th May 2019			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	N/A	N/A
Gender	None	N/A	N/A
Age	None	N/A	N/A
Religion	None	N/A	N/A
Disability	None	N/A	N/A
Sexuality	None	N/A	N/A
Pregnancy and Maternity	None	N/A	N/A
Gender Reassignment	None	N/A	N/A
Marriage and Civil Partnership	None	N/A	N/A

Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	N/A	N/A
What consultation with protected characteristic groups including patient groups have you carried out?	None	N/A	N/A
What data or information did you use in support of this EqIA?	None	N/A	N/A
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? **No**			
Level of impact Low Level of Impact.			
Name of Responsible Person undertaking this assessment: Ann Gray			
Signature:			
Date: **17th May 2019**			