CARE RECORDS MANAGEMENT POLICY (Electronic and Manual)

POLICY NUMBER & CATEGORY	C 12	Clinical
VERSION NUMBER & DATE	7	April 2019
RATIFYING COMMITTEE	Clinical Governance Committee	
DATE RATIFIED	April 2019	
NEXT REVIEW DATE	April 2022	
EXECUTIVE DIRECTOR	Medical Director	
POLICY LEAD	Head of Records and Clinical Coding	
FORMULATED VIA	Information Governance Steering Group (IGSG)	

POLICY STATEMENT

The Trust has a responsibility for ensuring that the risks associated with the management of care records, (from creation to disposal) are managed in a systematic and planned way, and in accordance with current legal requirements and professional best practice.
The policy does not cover clinical recording requirements in the either the paper or electronic Care Record. This policy relates to the physical and practical management of the record whether this is electronic or paper.

KEY POLICY ISSUES

- Arrangements for maintenance, use, storage and disposal of the records are set out to ensure compliance with legal and national NHS standards.
- Arrangements for sharing records with other organisations

THIS POLICY MUST BE READ IN CONJUNCTION WITH THE CARE RECORDS MANAGEMENT PROCEDURE DOCUMENT& OTHER ASSOCIATED DOCUMENTS

Contents

1. Introduction

Birmingham and Solihull Mental Health NHS Foundation Trust is dependent on its care records to operate efficiently and to account for its actions. This policy defines a structure for the Trust to ensure adequate care records are maintained, managed and controlled effectively and at best value, commensurate with legal, operational and information needs. This policy is designed to provide all professionals working within the Trust with information on the principles of good documentation and record keeping within their clinical practice as well as ensure consistent standards across professional groups and services, enabling information on service users to be recorded, received and viewed in a timely and accurate fashion.

1.1. Rationale

1.1.1 An effective care records management policy is intended to ensure that clinical information is properly managed and available.

1.1.2 An organisation's care records are a corporate memory, providing evidence of actions and decisions and representing a vital asset to support our daily functions and operations. They support policy formation and managerial decision-making, protect the interests of the Trust and the rights of service users, staff and members of the public who have dealings with us. They support consistency, continuity, efficiency and productivity and help us deliver our services in consistent and equitable ways.

1.1.3 Records management, through the proper control of the content, storage and volume of records, reduces vulnerability to legal challenge or financial loss and promotes best practice in terms of human and space resources through greater coordination of information and storage systems.

1.2. Scope

1.2.1. For the purpose of this document, 'care records' applies to the Supplementary Health Record (SHR) of a service user engaged with Birmingham and Solihull Mental Health NHS Foundation Trust. Previous terminology included medical notes, case notes, and clinical records and health records.

1.2.2. The Supplementary Health Record (SHR) supports the primary Care Record, RiO and must be used in conjunction with this. Information that cannot be directly captured into the primary Care Record must be stored within the SHR.

1.2.3. This policy relates to both the electronic patient record and the SHR which together provide a complete record of a Service Users care and interventions.

1.2.4. This includes information contained within the Enterprise Document and Records Management System (EDRMS) supplied by Hyland and will be referred to as 'OnBase' within this policy and subsequent procedures.

1.2.5. This policy relates to all patient data held in any format which may form part of the Care Record by the Trust, for example:
- paper records including,
  - Post it notes,
  - loose papers of any description,

- records in all electronic formats,
    - e-mail,
    - microfilms,
    - digital dictation recordings,
    - video/audio recordings,
    - x-rays and other images,
    - photographs,
    - OnBase,
    - registers etc.,

1.2.6. This document sets out a framework within which the staff responsible for managing the Trust's care records can develop specific policies and procedures to ensure that records are managed and controlled effectively, and at best value, commensurate with legal, operational and information needs, (see Appendix B).

Staff working within HMP Birmingham Healthcare, Winson Green, are excluded from the Trust's Care Records Policy.[1]

1.3. Principle

1.3.1. Records created in the course of the business of the Trust are corporate records and are public records under the terms of the Public Records Acts 1958 and 1967. This includes email messages and other electronic records. Further guidance in relation to electronic records is provided in section 3.4 of this document.

1.3.2. The Trust must ensure that it adheres to all legislation and guidance in relation to Records Management.

1.3.3. The Trust is committed to ensuring that it treats its service users, equitably and reasonably and that it does not discriminate against individuals or groups based on their ethnic origin, physical or mental abilities, gender, age, religious beliefs, or sexual orientation.

1.3.4. Staff are only permitted to access records where a legitimate reason exists, which for the majority for the Trust is for the provision of direct client care. It is not appropriate for staff to access their own records, records relating to family members, friends or colleagues please see *Confidentiality Policy*. To do so is a breach of confidentiality and is both a disciplinary matter and reportable to the ICO (Information Commissioners Office) who can bring a private prosecution against the individual if they feel the incident meets their criteria under Section 170 of the Data Protection Act 2018

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[1] In accordance with HMP Birmingham Healthcare they currently use System 1, electronic patient system, to record all their clinical activity, as per the HMP Birmingham Healthcare Policies and Procedures. Training on this system is provided by HMP Birmingham Healthcare.

2. Policy

2.1. All staff who are recording within the electronic patient record are expected to follow the procedures set out in the *Care Records Management and Procedures* document.

2.2. RiO is considered as the primary Care Record containing all current up to date clinical information. In this instance the paper Care Record (SHR) will be used to capture information that cannot be recorded directly onto RiO.

2.3. The Trust does not allow for information to be scanned and destroyed.

2.4. Should a Team have dispensation to scan, then once this information is scanned and uploaded into the patient electronic record e.g. RiO, CarePath, IAPTus, EMIS, it must be filed in the paper Care Record (SHR) in a timely manner.

2.5. Any paper based records must be brought up to date before any handover of care responsibilities this includes ensuring that all filing is done. Should Teams/ Sites find filing after the paper Care Record has left the site/ Team then the record must be recalled back for the filing to be completed. There should be no outstanding filing older than 10 working days. Failure to file in a timely manner could result in undue Clinical Risk and may lead to disciplinary action.

2.6. Teams must retain the current SHR for service users they are currently treating. The SHR supports the information being captured in the electronic patient system.

2.7. All clinical notes on RiO need to validated by a qualified member of staff (see Care *Records Management and Procedures* document for further guidance)

2.8. All clinical notes should be recorded directly into the electronic patient record and not in the paper Care Record. Failure to do this could result in undue Clinical Risk and may lead to disciplinary action.

2.9. For staff who are recording in IAPTus, this system will be used to document all clinical care and interventions.

2.10. Key IAPTus documentation will be available to RiO uses via the Information From Others Systems (IFOS) interface.

2.11. For staff who are recording in CarePath (Illy), this system will be used to document all clinical care and interventions.

2.12. Key CarePath (Illy) documentation will be available to RiO uses via the Information From Others Systems (IFOS) interface.

2.13. For staff who are recording on EMIS, this system will be used to document all clinical care and interventions.

2.14. All staff are expected to follow the procedures set out and apply the standards from creation to disposal of records including standards for record keeping and storage.

2.15. Missing care records must be reported via the Trust incident reporting system and a *Missing Care Records* entry completed on the Trusts electronic Care Records Tracking (CRT) system.

2.16. Where records are to be shared with other organisations (e.g. social services and other NHS organisations) this must be done in accordance with documented and agreed information sharing protocols. Refer to the *Confidentiality Policy* and *Subject Access Requests* for guidance.

2.17. Care Records Home Base staff are responsible for the processing of Subject Access Requests according to the General Data Protection Regulations (GDPR) under Article 15 and the Data protection Act 2018, Section 45. This includes

Access to Health Records Requests which relates to records for deceased service users. Refer to the *Confidentiality Policy* and *Subject Access Requests* for further guidance.[2]

2.18. Care Records Home Base staff are not responsible for the processing of Subject Access Requests under the Data Protection Act 2018 where litigation against the Trust has been identified, unless directed by the Legal Team to do so, request for records in relation to Safeguarding matters, requests for access to notes in relation to Mental Health Act matters. Refer to the *Confidentiality Policy* and *Subject Access Requests* for further guidance.

2.19. All paper care records removed from the Trust to be used off-site must be entered on the electronic Care Records Tracking (CRT) system (see *Care Records Management and Procedures for further guidance*) and transported appropriately.

2.20. Records containing service users' identifiable information can be sent from a NHS.net email address to another NHS.net email address. If there is a requirement to send identifiable information regarding a service user externally from the Trust this can only be done from a secure account to another secure account (e.g. @pnn.police.uk. Further information can be obtained from *BSMHFT Safe Haven Guidelines*.

2.21. Any transfer of notes must be done securely. Further information can be obtained from *BSMHFT Safe Haven Guidelines*.

2.22. Where circumstances arise where is it absolutely not possible to return paper records to a Trust base at the end of a working day it is permissible for paper records to be held overnight by staff in their homes, but this must only be done in exceptional circumstances. Under no circumstances must paper records be left in staff vehicles overnight or when such vehicles are left unattended. The member of staff is responsible for the security of the records whilst they are in their possession.

2.23. Should the paper record be mislaid/ lost or stolen from a staff members home an incident form will need to be completed by the staff member and the incident recorded on the Data Security and Protection Toolkit, which may result in the incident being forwarded to the ICO.

2.24. A minimum of an annual audit will be undertaken in line with Data Security and Protection Toolkit.

2.25. It is acknowledge that with the introduction of OnBase that current practise will change to reflect this new way of working. Areas where the OnBase system has been implemented will be expected to follow revised Care Records Procedures

3. Procedures

3.1. There are strict procedures regarding the lifecycle management of Care Records which must be followed at all times. These include areas listed below and full details will be found in the *Care Records Procedures and Management* document. Failure to follows these may result in disciplinary action

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[2] Care Records Home Base staff are not responsible for the processing of Subject Access Requests under the Data Protection Act 2018 where litigation against the Trust has been identified, request for records in relation to Safeguarding matters, requests for access to notes in relation to Mental Health Act matters and Continuing Care. Refer to the *Confidentiality Policy* and *Subject Access Requests* for further guidance.

3.2. Areas covered in procedures;
- Structure of the Supplementary Health Record
- Creating Care Records
- Tracking Care Records
- Missing Care Records
- Record Storage
- Subject Access Requests – SARs (Access to Care Records)
- Transportation of Care Records
- Selection of Trust Care Records for Permanent Preservation
- Archiving Care Records
- Retention and Disposal of Care Records
- Schedule for Retention
- Process for Disposal
- OnBase, for applicable areas

3.1. Training
3.1.1. All staff must be aware of their record keeping responsibilities through generic and specific training programmes and guidance.
3.1.2. Clinical staff that are responsible for recording in the health record must complete mandatory e-learning training on Healthcare Record Keeping.
3.1.3. All staff new to the Trust will receive Healthcare Record Keeping training as part of their Trust Induction.
3.1.4. Healthcare Record Keeping Training supports the Fundamental Training Policy.

3.2. Implementation and Monitoring
3.2.1. The policy has been produced to ensure the Trust maintains effective records management systems. Managers in all areas where care records are created and maintained must ensure that staff are adequately trained, aware of, and work within the Trust's policy requirements.
3.2.2. The policy, endorsed by the Information Governance Assurance Group (IGAG), clearly sets out auditable requirements to:

- Measure compliance.
- Support ongoing development and improvement.

3.2.3. Monitoring adherence to this policy is the responsibility of the Information Governance Assurance Group (IGAG).

3.3. Confidentiality and Security of Records
3.3.1. All NHS bodies and those carrying out functions on behalf of the NHS have a common law duty of confidentiality. Everyone working for or with the Trust who records, handles, stores or otherwise accesses patient information has a personal common law duty of confidence to service users. This duty of

confidence continues after the death of the patient. Trust staff are advised of their responsibilities on commencement of their employment and is reflected in their contracts.

3.3.2.   The implementation of the Data Protection Act 2018 and the General Data Protection Regulations (GDPR) covers both computerised and paper based personal data and establishes a set of principles with which users of personal information must comply. The Act also imposes statutory restrictions on the use of personal information, which must not be used for purposes other than those declared in the Trust's Data Protection registration.

3.3.3.   The guidelines contained within this policy underpin the principles of the Data Protection Act and GDPR and ensures that personal information is accurate, up to date and retrievable in a timely manner.

3.3.4.   Through the Caldicott Guardian and the Head of Information Governance/ Data Protection Officer, the Trust must also ensure that information is shared "on a need to know" basis and that it is continuously improving confidentiality and security procedures governing access to and storage of clinical information, see the *Confidentiality policy*.

3.3.5.   Managers must ensure that all staff are made aware of their responsibilities regarding confidentiality and security of records. Support and guidance can be provided either by the Trust Caldicott Guardian or Head of Information Governance/ Data Protection Officer.

3.3.6.   Access to any Care Record, both paper and electronic, will be in line with the *Confidentiality policy*.

3.3.7.   All Home Base areas are secure environments and only authorised staff are allowed to access.

3.3.8.   Any Trust sites/ Teams that are due to move/ close must ensure that a member of staff is nominated to lead on the move/ closer. This is to ensure that the records that are held on site are securely stored and transferred across sites and that any disposal or off-site semi-permanent storage occurs as per Trust guidance.

3.3.9.   Once the Team has moved/ closed there will be an inspection of the site to ensure that no identifiable information remains – however the management of this information and the obligation to ensure that it has been securely removed from site prior to the Team/ site moving/ closing remains the responsibility of the nominated staff lead for the move/ closure.

3.4. Electronic Records (Including E-Mail)

3.4.1.   Electronic information is subject to the same principles as paper records in terms of minimum retention as defined by the Department of Health.

3.4.2.   The electronic patient record must be used to store all Trust generated documents wherever possible including correspondence and reports. A paper copy of these documents should not be printed out and filed within the paper care record unless a patient signature is required, (refer to *Care Records Management and Procedures* 'Saving/Uploading Documents into RiO').

3.4.3. There will be a minimal amount of information being filed within the paper care record, for example, paper correspondence received into the Trust.

3.4.4. The electronic patient record is a crucial part of the care recording process as it makes up-to-date information available to appropriate staff in real time across dispersed care settings. It is therefore of vital importance that key elements of electronic records are kept accurate and up-to-date, including, but not limited to, service user demographic details, current care plan and care coordinator details. Details of specific requirements are included in the Trust *Data Quality Policy* and associated standards and procedure documents.

3.4.5. Any email correspondence relating to the provision of clinical care for a service user should uploaded and stored in the patients electronic system i.e. RiO, CarePath or IAPTus.

3.4.6. Emails should be regarded as a temporary means of communication. Any information transmitted by email that falls into a category shown in the retention schedule should be absorbed into a mainstream filing system, which is subject to the requirements laid out in this policy. Any information sent by email that is intended to have some permanence should be transmitted as a file attachment to aid this process. Neither the sender nor recipient should save the email, with the attachment, in email format.

3.5. Distribution

3.5.1. All Executive Directors, Divisional Directors, Programme Directors, Clinical Directors, Service Managers, Allied Health Professional Managers, Nurses/ Modern Matrons, Consultants, Psychologists, Care Record Staff, Clinical Governance, Risk Management, Research, Service and Clinical Managers, ICT Services, Equality and Diversity lead.

3.5.2. A copy of this policy can be found on the Intranet or a copy can be obtained from the Head of Records and Clinical Coding.

3.6. Review

3.6.1. This policy will be reviewed as a minimum every three years

3.6.2. This policy will be reviewed once new developments and procedures have come into place. Any new legislation and guidance from the Department of Health and NHS Information Authority will be reflected in this policy and disseminated throughout the Trust. Appropriate training will be given where necessary. Any queries with this policy please contact the Head of Records and Clinical Coding.

4. Roles and Responsibilities

4.1. Please see appendix B for full details

5. Development and Consultation Process

CONSULTATION SUMMARY		
Date policy issued for consultation	April 2019	
Number of versions produced for consultation	1	
Committees / meetings where policy formally discussed	Date(s)	
Clinical Governance Committee Information Governance Steering Group Information Governance Assurance Group	7th May 2019 22nd March 2019 8th March 2019	
Where received	Summary of feedback	Actions / Response
Policy Development Management Group (PDMG)	Amendment to *Glossary, *Versions in Bibliography, *Inclusion of lost records from home being recorded on the Data Security and Protection Toolkit.	Policy updated where applicable.

6. Reference Documents

6.1. *Department of Health, Records Management:* NHS Code of Practice for Health and Social Care (DoH 2016).
6.2. Care Quality Commission standards
6.3. Care Quality Commission: Data Security Review 2016
6.4. NHS England: Five Year Forward View 2014.
6.5. Department of Health- Operational productivity and performance in English NHS acute hospitals: Unwarranted variations (2016)

7. Bibliography

7.1. Access to Healthcare Records Act 1990;
7.2. Audit Commission, Setting the Record Straight, 1995;
7.3. BSMHFT Save Haven Guidelines V4;
7.4. Caldicott Review of Patient Identifiable information, 1997;
7.5. Care Quality Commission Standards
7.6. Care Records Development Board (2005)
7.7. Data Security and Protection Toolkit
7.8. Data Protection Act 2018;

7.9. Department of Health: NHS Confidentiality Code of Practice, 2003;

7.10. Department of Health: Record Management, NHS Code of Practice, 2016

7.11. Ethics Advisory Group Third Party Information and NCRS – initial scoping paper;

7.12. Freedom of Information Act 2000;

7.13. General Data Protection Regulations 2018

7.14. Guidance for Access to Health Records Requests under the Data Protection Act;

7.15. HSC 1999/053 'For the Record' – Managing Records in NHS Trusts and Health Authorities;

7.16. Maintaining Good Medical Practice, London GMC 1998;

7.17. Public Records Acts 1958 and 1967;

7.18. National Data Guardian Review of Data Security, Consents and Opt-out (2016)

7.19. Nursing and Midwifery Council (2005) Guidelines for Record Keeping;

7.20. Nursing and Midwifery Council Guidelines on Documentation and Record Keeping (2002);

7.21. Section 31, Partnership Agreement (2004);

8. Glossary

8.1. ACCESS
The availability of, or permission to consult, records. (The National Archives, Records Management Standard RMS1.1).

8.2. APPRAISAL
The process of evaluating an organization's activities to determine which records should be kept, and for how long, to meet the needs of the organization, the requirements of Government accountability and the expectations of researchers and other users of the records. (The National Archives, Records Management Standard RMS 1.1).

The process of distinguishing records of continuing value from those of no value so that the latter may be eliminated. (The National Archives, Definitions in the Context of the Seamless Flow Programme).

8.3. Seamless Flow Programme, The National Archives
The Seamless Flow Programme involves the creation of a seamless flow of digital records from creation in government departments, to preservation in the archives, through to delivery on the web. The programme is about linking together existing components and automating manual processes. The process of developing the seamless flow approach will allow the review and streamlining of other aspects of its architecture – notably catalogues and web searching. The development of an internet-based delivery system for digital records is a key component of The National Archives' response to the Government's 2005 target.

8.4. ARCHIVES
Those records that are appraised as having permanent value for evidence of ongoing rights or obligations, for historical or statistical research or as part of the corporate memory of the organization. (The National Archives, Records Management Standard RMS 3.1).

It is a legal requirement for NHS records selected as archives to be held in a repository approved by The National Archives; see Place of Deposit below.

8.5. AUTHENTICITY
An authentic record is one that can be proven:
- to be what it purports to be;
- to have been created or sent by the person purported to have created or sent it;
- to have been created or sent at the time purported.

To ensure the authenticity of records, organizations should implement and document policies and procedures which control the creation, receipt, transmission, maintenance and disposition of records to ensure that record creators are authorized and identifiable and that records are protected against unauthorized addition, deletion, alteration, use and concealment. (BS ISO 15489-1:2016(en)).

8.6. CLASSIFICATION
The systematic identification and arrangement of business activities and/or records into categories according to logically structured conventions, methods and procedural rules represented in a classification system. (BS ISO 15489-1:20016(en)).

8.7. CONVERSION (see also MIGRATION)
The process of changing records from one medium to another, or from one format to another. (BS ISO 15489-1:2016(en)).

8.8. CORPORATE RECORDS
Records (other than health records) that are of, or relating to, an organization's business activities covering all the functions, processes, activities and transactions of the organization and of its employees.

8.9. CURRENT RECORDS
Records necessary for conducting the current and ongoing business of an organization.

8.10. DESTRUCTION
The process of eliminating or deleting records beyond any possible reconstruction. (BS ISO 15489-1.2016(en)).

8.11. DISPOSAL

Disposal is the implementation of appraisal and review decisions. These comprise the destruction of records and the transfer of custody of records (including the transfer of selected records to an archive institution). They may also include the movement of records from one system to another (for example, paper to electronic). (The National Archives, Records Management Standard RMS1.1).

8.12. DISPOSITION
A range of processes associated with implementing records retention, destruction or transfer decisions, which are documented in disposition authorities or other instruments. (BS ISO 15489-1:2016(en)).

8.13. ELECTRONIC RECORD MANAGEMENT SYSTEM
A system that manages electronic records throughout their lifecycle, from creation and capture through to their disposal or permanent retention, and which retains their integrity and authenticity while ensuring that they remain accessible. (The National Archives, Definitions in the Context of the Seamless Flow Programme).

8.14. FILE
An organized unit of documents grouped together either for current use by the creator or in the process of archival arrangement, because they relate to the same subject, activity or transaction. A file is usually the basic unit within a records series.

8.15. FILING SYSTEM
A plan for organizing records so that they can be found when needed. (The National Archives, Records Management Standard RMS 1.1).

8.16. HEALTH RECORD
A single record with a unique identifier containing information relating to the physical or mental health of a given patient who can be identified from that information and which has been recorded by, or on behalf of, a health professional, in connection with the care of that patient. This may comprise text, sound, image and/or paper and must contain sufficient information to support the diagnosis, justify the treatment and facilitate the ongoing care of the patient to whom it refers.

8.17. HOME BASES
Storage of records prior to archiving off-site records, will be in one of number of designated 'home bases', managed by the Head of Records and Clinical Coding.

8.18. INDEXING
The process of establishing access points to facilitate retrieval of records and/or information. (BS ISO 15489-1:2016(en)).

8.19. INFORMATION AUDIT

An information audit looks at the means by which an information survey will be carried out and what the survey is intended to capture.

8.20. INFORMATION COMMISSIONER
The Information Commissioner enforces and oversees the Data Protection Act 2018 and the Freedom of Information Act 2000.

8.21. INFORMATION SURVEY/RECORDS AUDIT
A comprehensive gathering of information about records created or processed by an organization. (The National Archives, Records Management Standards and Guidance – Introduction Standards for the Management of Government Records) It helps an organization to promote control over its records, and provides valuable data for developing records appraisal and disposal procedures. It will also help to:

- Identify where and when health and other records are generated and stored within the organization and how they are ultimately archived and/or disposed of;
- Accurately chart the current situation in respect of records storage and retention organization-wide, to make recommendations on the way forward and the resource implications to meet existing and future demands of the records management function.

8.22. INTEGRITY OF RECORDS
The integrity of a record refers to its being complete and unaltered. It is necessary that a record be protected against unauthorized alteration. Records management policies and procedures should specify what additions or annotations may be made to a record after it is created, under what circumstances additions or annotations may be authorized and who is authorized to make them. Any unauthorized annotation, addition or deletion to a record should be explicitly identifiable and traceable.

8.23. JOINTLY HELD RECORDS
A record held jointly by health and social care professionals, for example in a Mental Health and Social Care Trust. A jointly held record should be retained for the longest period for that type of record, i.e. if social care has a longer retention period than health, the record should be held for the longer period.

8.24. MICROFORM
Records in the form of microfilm or microfiche, including aperture cards.

8.25. MIGRATION (see also CONVERSION)
The act of moving records from one system to another, while maintaining the records' authenticity, integrity, reliability and usability. (BS ISO 15489-1:2016(en)).

8.26. MINUTES (MASTER COPIES)
Master copies are the copies held by the secretariat of the meeting, i.e. the person or department who actually takes, writes and issues the minutes.

8.27. MINUTES (REFERENCE COPIES)
Copies of minutes held by individual attendees at a given meeting.

8.28. NHS CARE RECORDS SERVICE
The NHS Care Records Service (NHS CRS) will connect all GPs, acute, community and mental health NHS trusts in a single, secure national system that will enable individual electronic patient record details to be accessed by authorized personnel, at the appropriate level, anywhere in England, via use of a unique identifier. The unique identifier to be employed throughout the NHS and its associated systems is the NHS number.

8.29. NHS NUMBER
Introduced in 1996, the NHS number is a unique 10-character number assigned to every individual registered with the NHS in England (and Wales). The first nine characters are the identifier and the tenth is a check digit used to confirm the number's validity. Babies born in England and Wales are allocated an NHS number by Maternity Units, at the point of Statutory Birth Notification.

The NHS number is used as the common identifier for patients across different NHS organizations and is a key component in the implementation of the NHS CRS.

8.30. NHS RECORDS (Public Records Act)
All NHS records are public records under the terms of the Public Records Act 1958 sections 3(1)–(2). All records created and used by NHS employees are public records.

8.31. PAPER RECORDS
Records in the form of files, volumes, folders, bundles, maps, plans, charts, etc.

8.32. PERMANENT RETENTION
Records may not ordinarily be retained for more than 20 years. However, the Public Records Act provides for records, which are still in current use to be legally retained. Additionally, under separate legislation, records may need to be retained for longer than 20 years, for example Occupational Health Records relating to the COSSH (Control of Substances Hazardous to Health) Regulations, or records required for variant CJD surveillance.

8.33. PERSONAL DATA
Data which relates to a living individual who can be identified from that data or from data and from other information which is in the possession of, or is likely to come into the possession of the data controller (eg our Trust) (Data Protection Act).

8.34. PLACE OF DEPOSIT
A record office, which has been approved for the deposit of public records in accordance with section 4(1) of the Public Records Act 1958. This is usually the record

office of the relevant (i.e. county, borough, or unitary) local authority. A list of those repositories recognized by The National Archives for the deposit of NHS archives is in Annex E. Contact details for them are to be found in the ARCHON directory on its website:

http://discovery.nationalarchives.gov.uk/find-an-archive

An organization wishing to have records preserved as archives should consult with The National Archives in the first instance, unless that organization has an existing working relationship with an approved Place of Deposit.

Some individual hospitals have themselves been appointed as a Place of Deposit. In practice, these have tended to be those larger hospitals, which can commit the resources necessary to provide appropriate conditions of storage and access and to place them under the care of a professionally qualified archivist. The National Archives can provide advice to any organization wishing to apply for Place of Deposit status. Further information about the work of archivists in NHS Trusts is available from the Health Archives Group.

8.35. PRESENTATION
The transfer to a third party (for example a University) of public records which have been rejected by The National Archives but which are not destroyed, under section 3(6) of the Public Records Act 1958.

8.36. PRESERVATION
Processes and operations involved in ensuring the technical and intellectual survival of authentic records through time. (BS ISO 15489-1:2016(en)).

8.37. PROTECTIVE MARKING
The process of determining security and privacy restrictions on records.

8.38. PUBLICATION SCHEME
A publication scheme is required of all NHS organizations under the Freedom of Information Act. It details information, which is available to the public now or will be in the future, where it can be obtained from and the format it is or will be available in. Schemes must be approved by the Information Commissioner and reviewed periodically to make sure they are accurate and up to date.

8.39. PUBLIC RECORDS
Records as defined in the Public Records Act 1958 or subsequently determined as public records by The National Archives.

Records of NHS organizations (and those of predecessor bodies to NHS organizations) are defined as public records under the terms of the Public Records Act 1958 sections 3(1)–(2). NHS records are not owned by the NHS organization that

created them and may not be retained for longer than 20 years without formal approval by The National Archives, (The National Archives).

Records of services supplied within NHS organizations but by outside contractors are not defined as public records, but are subject to the Freedom of Information Act.

8.40. PUBLIC RECORDS ACT 1958
For further information, including the text of the Act, see The National Archives' website:

www.nationalarchives.gov.uk/policy/act

8.41. RECORDS
Information created, received and maintained as evidence and information by an organization or person, in pursuance of legal obligations, or in the transaction of business. (BS ISO 15489.1).

An NHS record is anything, which contains information (in any media), which has been created or gathered as a result of any aspect of the work of NHS employees – including consultants, agency or casual staff.

8.42. RECORDS MANAGEMENT
Field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and disposition of records, including processes for capturing and maintaining evidence of and information about business activities and transactions in the form of records. (BS ISO 15489-1:2016(en)).

8.43. RECORD SERIES
A series is the main grouping of records with a common function or subject – formerly known as 'class'. (The National Archives)

Documents arranged in accordance with a filing system or maintained as a unit because they result from the same accumulation or filing process, or the same activity, because they have a particular form, or because of some other relationship arising out of their creation, receipt or use. (International Council on Archives' (ICA) General International Standard Archival Description or ISAD(G)).

https://www.ica.org/en/terminology-0

A series comprises the record of all the activities that are instances of a single process. A series may be large or small: it is distinguished not by its size, but by the fact that it provides evidence of a particular process. If an activity takes place that is unique, rather than an instance of a process, its records form a series in their own right. (Elizabeth Shepherd and Geoffrey Yeo, Managing Records: a handbook of principles and practice (Facet 2003)).

8.44. RECORD SYSTEM/RECORD-KEEPING SYSTEM
An information system, which captures, manages and provides access to records through time. (The National Archives, Records Management: Standards and Guidance – Introduction Standards for the Management of Government Records).

Records created by the organization should be arranged in a record-keeping system that will enable the organization to obtain the maximum benefit from the quick and easy retrieval of information. Record-keeping systems should contain descriptive and technical documentation to enable the system and the records to be understood and to be operated efficiently, and to provide an administrative context for effective management of the records, including a documented set of rules for referencing, titling, indexing and, if appropriate, the protective marking of records. These should be easily understood to enable the efficient retrieval of information and to maintain security and confidentiality.

8.45. REDACTION
The process of removing, withholding or hiding parts of a record due to either the application of a Freedom of Information Act exemption or a decision by The National Archives to restrict access where sensitivity, copyright or data protection issues arise. (The National Archives, Definitions in the Context of the Seamless Flow Programme).

8.46. REGISTRATION
Registration is the act of giving a record a unique identifier on its entry into a record-keeping system.

8.47. RETENTION
The continued storage and maintenance of records for as long as they are required by the creating or holding organization until their eventual disposal, according to their administrative, legal, financial and historical evaluation.

8.48. REVIEW
The examination of records to determine whether they should be destroyed, retained for a further period, transferred to an archival establishment, or presented to a third party (for example a University).

8.49. SATELLITE BASES
BSMHFT premises which act as satellite to a specified home base. All Records staff will have responsibility for promoting good record keeping across its satellite bases.

8.50. SUPPLEMENTARY HEALTH RECORD
A paper care record that is used in conjunction with electronic patient record to store documents; that cannot be captured directly into the electronic record, that have been scanned into the electronic record but need to be retained for legal reasons, for

information that is received in paper format from external sources for example service users, external healthcare providers and local government agencies.

8.51. TRACKING
Creating, capturing and maintaining information about the movement and use of records, (BS ISO 15489-1:2001(E)).

8.52. TRANSFER OF RECORDS
Transfer (custody) – Change of custody, ownership and/or responsibility for records, (BS ISO 15489-1:2016(en)).

Transfer (movement) – Moving records from one location to another, (BS ISO 15489-1:2016(en)).

Records identified as more appropriately held, as archives should be offered to The National Archives, which will make a decision regarding their long-term preservation.

8.53. WEEDING
The process of removing inactive/non-current health records from the active/current or primary records storage area to a designated secondary storage area after a locally agreed timescale after the date of last entry in the record.

9. Audit and Assurance

9.1. The auditing of records will help to ensure that the standard of the records are maintained and will serve to identify any areas for improvement and staff development. It is the responsibility of Head of Records and Clinical Coding to ensure that records are audited regularly.

9.2. A minimum of an annual audit will be undertaken in line with Data Security and Protection Toolkit.

9.3. All Records staff are responsible for regular, localised monitoring of the quality of documentation and adherence to this policy. In particular staff should periodically undertake quality control checks to ensure that the standards, as detailed in this policy, are maintained.

9.4. The results of audits will be reported to the Trust Board through the Information Governance Steering Group.

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Data Security and	Head of Records	Reports	Annual	Information

Protection Toolkit	and Clinical Coding	Generated from RiO		Governance Steering Group (IGSG)

APPENDICES

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect

http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	Care Records Management Policy		
Person Completing this proposal	Maria Kane	Role or title	Head of Records and Clinical Coding
Division	PMO	Service Area	Records Department
Date Started	12th March 2019	Date completed	12th March 2019
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
To provide a structure and process by which the management of Care Records can take place and be audited			
Who will benefit from the proposal?			
All staff, service users, stakeholders and visitors			
Impacts on different Personal Protected Characteristics – *Helpful Questions:*			
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*		*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*	
Please click in the relevant impact box or leave blank if you feel there is no particular impact.			

Personal Protected Characteristic	No/Minimum Impact	Negative Impact	Positive Impact	Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.
Age	0			

Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	0			
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	0			
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	0			
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	0			
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	0			
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	0			
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	0			
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				

Transgender or Gender Reassignment	0			
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights	0			
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				0
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**				
Action Planning:				
How could you minimise or remove any negative impact identified even if this is of low significance?				
N/A				
How will any impact or planned actions be monitored and reviewed?				
N/A				

How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Through the involvement of all in the development and review of the policy and audit results
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at hr.support@bsmhft.nhs.uk. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Roles and Responsibilities for the Management of Care Records

Corporate Responsibilities

- Board level responsibility for records management is clearly defined and there are clear lines of accountability for care records management throughout the organisation, leading to the Board.

- The Trust has a particular responsibility for ensuring that it corporately meets its legal responsibilities, and for the adoption of internal and external governance requirements.

- The Trust is obliged to set out guidelines for creation, usage, storage and disposal of all care records generated and received.

Chief Executive

The Chief Executive has overall responsibility for care records management in the Trust. As the officer accountable, she/ he is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity. Records management is the key to this, as it will ensure appropriate, accurate information is available when requested.

Executive Director of Finance

Is responsible at Trust Board and Executive level for:

- Trust strategic direction of care records management;
- Provide information of care records developments;
- Agreeing action plans to address clinical issues relating to records management arising from reviews by Care Quality Commission and other agencies;

Head of Records and Clinical Coding

Is accountable to the Deputy Head of PMO;

- Professional lead for overseeing the development and management of records and ensuring that the Trust complies with the requirements of legislation affecting operations and management of records, with supporting policies and procedural guidance.
- Involving records management within the broader Information Governance framework within the organisation.
- Directing all centralised records functions;

- Steering the records management work programme;
- Where electronic records or paper based records systems are in operation outside of the Trust, be responsible for operating an effective records management program, including operation of retention and disposal program that is compliant with Trust policy and strategy, and relevant national standards.

Divisional, Programme Service and Clinical Directors

The current NHS Records Management, Code of Practice and the supporting Records Management Roadmap Framework, specifies that Chief Executives and their Senior Managers "should personally oversee the actions needed to raise the profile of, and support improvement in, standards of records management".

Directors have responsibility for ensuring that:

- The Trust's care records management policy, standards, guidance, and procedures have been implemented throughout their service;

- Formal responsibility for operational management of care records activities within individual divisions assigned to personnel with appropriate skills, e.g. Care Records Managers, Administration Managers, Clerical Supervisors, Clinical Managers, Ward Managers and where appropriate should form part of job content within job descriptions.

- Consideration of care records management principles requires timely inclusion into Divisional objectives, plans, and developments to ensure appropriate resource allocation and good practice. This is particularly important when setting up, decommissioning, or relocating clinical services.

Caldicott Guardian

- The Trust's Caldicott Guardian has a particular responsibility for reflecting patients' interests regarding the use of patient identifiable information. The role of Caldicott Guardian is accountable to the Chief Executive. The Trust's Caldicott Guardian is the Medical Director. They are responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.
  The Caldicott Guardian is responsible for:

- Approving and ensuring national and local protocols on handling and management of personal information are in place. The Caldicott Guardian reports to the Trust Board.
- Advising the Information Governance Steering Group, and other relevant group on local guidance and protocols on confidentiality.

Records Staff

Records staff are responsible for the administration and operations of records management, in particular maintaining good records management practices, and promoting compliance with this policy, protocols, and procedures in such a way as to ensure the easy, appropriate, and timely retrieval of information.

Records staff are responsible for:

- Monitoring and reviewing compliance;

- Providing advice on records management requirements and records management programme, and improvement issues;

- Implementing records management policies and procedures.

Chair of the Information Governance Assurance Group;

The chair is responsible for:

- Chairing and convening the IGAG.

- Monitoring overall progress on action plans, policies improvement, and programs on behalf of the Trust Board through the Chair of IGSG.

- Providing two-way communications between the IGAG and other standing committees and key decision-making groups.

Service Support, Service and Clinical Managers

The responsibility for local care records management is devolved to the relevant directors, divisional programme managers, and department managers. Heads of Departments, other units and business functions within the Trust who have overall responsibility for the management of care records generated by their activities, i.e. for ensuring that records controlled within their unit are managed in a way which meets the aims of the Trust's care records management policies.

Managers at all levels are responsible for;

Operating care records management procedures, covering both electronic and hard copy records, that:

- Are efficient and fit for purpose;

- Comply with the Trust care records management policy and standards;
- Appropriate resources exist within the area for fulfilling the responsibilities for managing care records;
- Communicate local care records management procedures;
- Ensuring that staff follow procedures for the management and storage of electronic and paper records;
- Ensuring regular review and authorised destruction of any locally managed care records in existence are undertaken with reference to the care records management policy.

All Staff

- Everyone who is employed by the Trust has a responsibility for Trust care records and must abide by, and consistently apply the strategy and supporting policy requirements.

- All employees are responsible for any records they may create or use. This responsibility is established and defined by the law. Any records created by employees are public records. They must ensure that the records are kept up-to date and in good condition to have any real value to the Trust.

- Every person working for, or within the Trust, who records, uses, stores or otherwise comes across information, has a personal common law duty of confidence as well as adhering to the GDPR/ Data Protection Act 2018.

- Every employee's contract of employment clearly identifies individual responsibilities for compliance with information governance requirements, i.e. legislation, regulations, common law duties and professional codes of practice.

Legal and Professional Obligations

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

- Public Records Act 1958;
- Data Protection Act 2018;
- General Data Protection Regulations 2018
- Freedom of Information Act 2000;
- Common Law Duty of Confidentiality;
- The NHS Confidentiality Code of Practice,
- Any new legislation affecting records management as it arises.

Core Standards for Records Keeping and Record Keeping Guidance

Core Standards for Paper Record Keeping

- All writing in care records will be legible.
- All entries will be in black permanent ink.
- All entries will be signed
- Practitioners will print their name and designation / job title under their signature.
- All entries will record the time of entry and be dated (time and date should be recorded together).
- The 24 hour clock must be used when timing entries.
- Errors will be crossed through with a single line, initialled and dated, (correction fluid must not be used under any circumstances).
- Errors must be corrected at the time of entry and not retrospectively.
- Spaces/lines (gaps) should not be left between entries.
- All entries will be recorded in full. Abbreviations will not be used.
- Entries made by students or trainees will be countersigned by professional staff.
- All entries will be recorded within 24 hours or preferably at the time of activity taking place.

Record Keeping Guidelines – Paper

1   Every sheet in the care record, including multi-professional continuing clinical record sheets, will bear the full name of the service user, their NHS number (where known) and trust identification number, written legibly in black ink or using a service user identification label.

2   An entry will be made in the Care Records at every contact – including failed contacts, clinic attendances, home visits etc., and following telephone contacts. Before a service user is seen by a member of staff for a planned, appointment the care records should be requested.

3   For in-patients, a documented entry to the Health Record should be made by nursing staff at the end of each shift in line with Nursing & Midwifery Council (NMC) guidelines. All entries should be made immediately or within 24 hours.

4   All entries within the paper Care Record will be made sequentially without unnecessary gaps. (Where a gap is unavoidable, the gap should be ruled through, signed, and dated to avoid recording data out of order).

5   All items of service user documentation will be filed securely, within the Care Record. Paper d*ocumentation must NOT be stored in plastic wallets under any circumstances.*

6   All records will be filed in chronological order within each appropriate section – most recent on top.

7   Records from all professional groups will be stored together in the care record to ensure that the service users' clinical information is kept together. This will ensure that vital pieces of information are not missing when key decisions are made.

8   The records will contain clinically relevant information only and will not include additional information such as financial information unless absolutely necessary in which case it will be filed in the Legal Section of the paper Health Record.

9   Judgements of a personal nature will not be used in the records. Comments about a service user will be objective, factual and be relevant to their clinical assessment and treatment.

10   Wherever possible, records should be written with the involvement of the service user. The service user should be aware of the issues documented in the care records wherever possible and should have the opportunity to discuss these issues with the clinician.

11   Records of service users for whom there is litigation pending, or where the records are being retained for research purposes, should be clearly identified as such.

12   When investigations are requested, the requests should be clearly recorded at the time in the care records. The test reports should be initialled and dated as having been seen by the responsible consultant or lead clinician *before* they are filed.

13   All machine-produced tracings (e.g. E.E.G) should be stored in the paper Care Record.

Guidelines for Handling Corrections, Errors, Omissions, and Other Documentation Problems.

There will be times when problems or mistakes occur and changes or clarifications to documentation will be necessary. Proper procedures must be followed in handling these situations.

Error Correction Procedure

1. Draw a single line through the entry (thin pen line)
2. Date, time and sign the entry.
3. Document the correct information.

Always make sure that the inaccurate information is still legible. **Do not** obliterate or otherwise delete the original entry by blacking out with marker, using correction fluid or writing over it.

Core Standards for Electronic Record Keeping

- All entries must be validated
- Errors must be corrected when identified
- All entries will be recorded in full. Abbreviations must not be used.
- Entries made by students or trainees must be validated by professional staff.
- All entries will be recorded within 24 hours or preferably at the time of activity taking place.

Record Keeping Guidelines

1 An entry will be made in the electronic patient record at every contact – including failed contacts, clinic attendances, home visits etc., and following telephone contacts. Before a service user is seen by a member of staff for a planned, appointment the care records should be requested.
2 For in-patients, a documented entry in RiO should be made by nursing staff at the end of each shift in line with Nursing & Midwifery Council (NMC) guidelines. All entries should be made immediately or within 24 hours.
3 Records from all professional groups will be stored together in the electronic patient record to ensure that the service users' clinical information is kept together. This will ensure that vital pieces of information are not missing when key decisions are made.
4 The records will contain clinically relevant information only and will not include additional information such as financial information unless absolutely necessary in which case it will be filed in the Legal Section of the paper Health Record.
5 Comments about a service user will be objective, factual and be relevant to their clinical assessment and treatment.
6 When investigations are requested, the requests should be clearly recorded at the time in the care records. The test reports should be initialled and dated as having been seen by the responsible consultant or lead clinician *before* they are filed.

Guidelines for Handling Corrections, Errors, Omissions, and Other Documentation Problems.

There will be times when problems or mistakes occur and changes or clarifications to documentation will be necessary. Proper procedures must be followed in handling these situations.

Handling Omissions in Documentation – Paper and Electronic

At times it may be necessary to make an entry that is late (out of sequence) or provide additional documentation to supplement or clarify entries previously written.

When a pertinent entry has been missed, requires further clarification or not written in a timely manner, an appropriate entry should be used to record the information within the health record and explain why.

Amendments

An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry. With this type of correction, a previous note has been made and the addendum provides additional information to address a specific situation of incident. When making an addendum:

- Document the current date and time.
- Write "addendum" and state the reason for the addendum referring back to the original entry.
- Identify any sources of information used to support the addendum.
- When writing an addendum, complete it as soon after the original note as possible.
- In an electronic system it is recommended that organisations have a link to the original entry or symbol by the original entry to indicate the amendment.

Timeliness Standards for Data Entering into RiO

Please refer to the Data Quality Policy for information regarding the timeliness standards for entering information into the electronic record.