CLINICAL POLICY
Health Records and Clinical Record Keeping

Policy Number	CLP005
Version:	V11
Purpose:	To increase awareness of record keeping and data quality standards and provide best practice guidance for ensuring data quality within electronic and manual systems
Consultation:	Clinical Policy Group, Trust Legal Services, Clinical Systems, CCIO, Caldicott Guardian
Approved by:	Clinical Policy Group
Date approved:	16/01/2024
Author / Reviewer:	Paul Griffith-Williams, Head Information Governance and Records
Date issued:	24/01/2024
Review date:	01/01/2027
Audience:	All Trust colleagues in all locations
Dissemination:	The Policy will be available on the trust intranet, and its update will be published on the Clinical Policy update bulletin
Impact Assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version History *(Version history prior to Amalgamation of the Health and Social Care Records Policy and Clinical Record Keeping Policy available in archives)*

Version	Date Issued	Reason for Change
V10	29/10/2020	CLP047 Health and Social Care Records Policy Amalgamated with CLP005 Physical Health – Clinical Record Keeping Policy
V10.1	29/07/2021	Minor Amendment – addition of new paragraph at Section 6.19, other sections re-numbered
V10.2	24/08/2023	Extension of 3 months to review date to allow a comprehensive review
V11	24/01/2024	Policy review and update by Paul Griffiths-Williams / Update to some retention dates in line with Records Management Code of Practice 2021

SUMMARY
This policy describes a framework to ensure that health records and record keeping in this trust are maintained to the highest quality standards. This policy applies to all aspects of health records in any format or media type (e.g. electronic, paper, audio, video), from their

creation, through their life cycle and to disposal. It is important that health record-keeping processes are controlled effectively to comply with clinical, legal, operational and information needs.

This policy is applicable to all colleagues working for, or with, this Trust who record, handle, store, support or otherwise have access to patient level information.

Application of and adherence to this policy will ensure that:

- Health records are readily and safely available to all colleagues when needing to access them.
- Health records are contemporaneous, concise, and unambiguous.
- Health records integrity can be trusted.
- Health records are maintained through time.
- Health records remain secure and confidential.
- Health records are retained and disposed of appropriately.
- All colleagues creating health records are trained, competent and aware of their responsibilities for record keeping and record management.
- Colleagues are supported and enabled to complete clinical recording in line with best practice and their professional regulatory bodies guidance.

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ABBREVIATIONS

Abbreviation	*Full Description*
GHC	Gloucestershire Health and Care NHS Foundation Trust
EPR	Electronic Patient Record
RMCoP	Records Management Code of Practice

1. INTRODUCTION

1.1 Record keeping is an essential element to provide patients with high quality care and services. Record keeping also promotes effective communication between health and social care professionals of the heath and care provided and needs of their patients. The accuracy, confidentiality, and integrity of the record, alongside timeliness, completeness of record keeping is fundamental to high quality patient care.

1.2 Individual professions and services may have professional and/or regulatory body record-keeping standards which should be referred to and adhered to in conjunction with this policy.

1.3 All patients receiving care from the Trust have a right to expect that any health and care record about them is confidential, accurate, complete, valid, up-to-date, available, stored securely and retained for an appropriate length of time.

1.4 All health records must be kept in accordance with the following legal and professional obligations:

- The Public Records Act 1958
- The UK General Data Protection Regulations 2021 (UKGDPR) and the six principles relating to personal data:
    - Processed lawfully, fairly, and transparently (in relation to the data subject), (lawfulness, fairness, and transparency principle).
    - Collected for a specific, explicit, and legitimate purpose, with no further processing in a manner incompatible with those purposes (purpose limitation principle).
    - Adequate, relevant, and limited to what is necessary in relation to the purpose for which they are processed (data minimisation principle).
    - Accurate and where necessary kept up to date, every reasonable step must

be taken to ensure inaccurate data, having regard to the purpose are erased or rectified without delay (accuracy principle).
    - Kept in a form which permits identification of data subjects for no longer than is necessary for the purpose processed. Subject to appropriate technical and organisational measures required to safeguard the rights and freedoms of the data subject (storage limitation principle) and
    - Processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage using appropriate technical or organisational measures (integrity and confidentiality principle).

The controller shall be responsible for and be able to demonstrate compliance with the principles (accountability principle).

- The Data Protection Act 2018 (DPA)
- The Access to Health Records Act 1990
- The Human Rights Act 1998
- Common Law Duty of Confidentiality
- Confidentiality: NHS Code of Practice
- Codes of Practice for handling confidential information in health and care
- Identifying and Specifying Requirements for Offsite Storage of Physical Records, the National Archives 2009
- The 8 Caldicott Principles 2020:
    - Justify the purpose(s) for using confidential information.
    - Use confidential information only when it is necessary.
    - Use the minimum necessary confidential information.
    - Access to confidential information should be on a strict need-to-know basis.
    - Everyone with access to confidential information should be aware of their responsibilities.
    - Comply with the law.
    - The duty to share information for individual care is as important as the duty to protect patient confidentiality; and
    - Inform patients and service users about how their confidential information is used.
- Records Management Code of Practice (RMCoP) for Health and Social Care.
- Professional Codes of Conduct.
- Regulatory Body Standards on Record Keeping.

1.5 A health record can be recorded in electronic or manual form (paper case notes) or in a mixture of both. It may include, but is not limited to, such things as:

- Handwritten clinical notes
- Electronic health records (including scanned records)
- Emails
- Letters/reports to and from health professionals
- Laboratory reports
- X-rays
- Printouts from monitoring equipment
- Photographs

- Audio visual media, e.g. audio and video tapes, digital recordings, CDs, and DVDs
- Recordings of telephone conversations; and
- Text or other messaging.

Some of these elements are covered by bespoke Trust policy guidance which should be read in conjunction with this policy.

1.6 The purpose of a health records is to:

- Facilitate effective communication between service users and professionals and all agencies involved in the provision of health and care to the individual and to ensure their high quality safe and effective care of individuals.
- Provide accurate, current, comprehensive, and concise information concerning the condition, health and care of the service user and associated observations.
- Provide a record of any problems that arise, and the action taken in response to them.
- Provide evidence of care required, intervention by professional practitioners and the service user's responses and wishes.
- Include a record of any factors (physical, psychological, or social) that appear to affect the health and care of the service user.
- Record the chronology of events relating to health and care, along with the reasons for any decisions made.
- Support standard setting, quality assessment, assurance, and audit.
- Provide a baseline record against which improvement or deterioration may be judged.
    - Identify factors which jeopardise standards or place the service user at risk.
    - Provide evidence of the need, in specific cases, for practitioners with special knowledge and skills.
    - Aid service user involvement in their own care; and
    - Provide evidence to answer possible complaints which may be made.

2. PURPOSE

2.1 The purpose of this policy is to set out the standards for all elements of a health and care record and must be adhered to by all colleagues working within the Trust. It applies to all colleagues working for this Trust and for partner organisations contributing to the health and care records for which this Trust is responsible (the controller).

3. SCOPE

3.1 This policy applies to all Trust colleagues, and to those of partner organisations accessing or contributing to the Trust's health records, in all locations.

4. DUTIES

4.1 General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition **GHC** will ensure that:

- All employees have access to up-to-date evidence based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements is provided.

Managers and Heads of Service will ensure that:

- All staff are aware of and have access to policy documents.
- All staff access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency, and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GHC policy
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent comply with the Mental Capacity Act (2005) – see section on MCA Compliance below.

4.2 Roles, Responsibilities and Accountability Specific to this Policy

Chief Executive:
The Chief Executive has overall responsibility for records management within the Trust. As the Accountable Officer, the Chief Executive is responsible for the management of the organisation and for ensuring appropriate mechanisms to support service delivery and continuity. Health records management is central to this, as it ensures the availability of the Trust to provide appropriate and accurate information about the health and care of its service users.

Director of Finance:
As the Senior Information Risk Owner (SIRO), the Director of Finance is the named Director with overall responsibility for information risk within the Trust. The SIRO is also responsible for ensuring the securing of all health and care records.

Caldicott Guardian:
The Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient information and enabling appropriate information access and sharing. They play a key role in ensuring that the Trust satisfies the highest practicable standards for handling patient-identifiable health and care information. The Medical Director is this Trust's Caldicott Guardian.

Heads of Profession:
Heads of Profession are responsible for ensuring that colleagues employed within their respective professional areas are working according to Trust policy and to relevant regulatory and professional guidelines on health and care record keeping practices.

Head of Information Governance and Records:
The Head of Information Governance and Records acts as the Trust's lead for

information governance, records management, and data protection.

Head of Clinical Systems:
The Head of Clinical Systems is responsible for overseeing safe, confidential systems of patient data recording within electronic patient records (EPR) systems. They are responsible for ensuring that Registration Authority practices are embedded where access to clinical systems is required.

Deputy Head of Information Governance and Records:
The Deputy Head of Information Governance and Records is responsible for the systems of management of paper and electronic health and care records and associated policies.

Managers and Professional Leads:
All Managers and Professional Leads are responsible for ensuring that this policy and supporting professional standards and guidelines are included in local processes to ensure ongoing compliance and the maintenance of high-quality health and care records. Line managers will be responsible for ensuring that all their staff comply with the standards set out in this policy and that all users of health and care records have:

- Appropriate initial and refresher training
- reasonable workload
- complete annual data security and awareness training; and
- access to appropriate and up-to-date documentation.

Colleagues:
All Trust colleagues, whether clinical, social care or administrative, who create, receive, and use health and care records have records management responsibilities. All colleagues have a confidentiality clause within their contracts of employment, they also sign a confidentiality declaration when applying for Trust EPR access. All colleagues must take appropriate steps to ensure information, which they enter in service user's health and care record, is accurate and timely. All colleagues are responsible for ensuring they undertake appropriate training on record keeping, EPR systems and data security and awareness. All Colleagues are responsible for ensuring they take appropriate steps to safeguard their smartcard and password.

Pre-Registration Students and Unregistered Clinical Workforce:
Whilst registered practitioners remain accountable for the healthcare that they delegate to pre-registration students and unregistered members of the clinical workforce they are also responsible for ensuring these practitioners maintain high quality health and care records and adhere to the standards in this policy. The Royal College of Nursing advises that supervision and countersignatures are required until the health care assistant, assistant practitioner or student are deemed competent at the healthcare activity and record keeping.

Students and unregistered members of the clinical workforce have access rights to relevant EPRs to assist in the provision of healthcare to our service users. All entries, however, must be reviewed by a supervising health professional, and where the system allows validated the entry. This is until the unregistered colleague is deemed competent and is authorised to validate their own entries.

Administrative Staff:
Administrative staff are permitted to provide administrative support to clinicians and clinical teams, to include adding documents or reports, sending letters as requested by a clinician or head of service and document in the health and care record relevant service user contact.

5. MENTAL CAPACITY ACT COMPLIANCE

5.1 Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person able to consent to the care, treatment or accommodation that is proposed? (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) Mental Capacity Act 2005 (legislation.gov.uk).
- Where there are concerns that the person may not have mental capacity to make the specific decision, complete and record a formal mental capacity assessment.
- Where it has been evidenced that a person lacks the mental capacity to make the specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk).
- Establish if there is an attorney under a relevant and registered Lasting Power of Attorney or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) Office of the Public Guardian - GOV.UK (www.gov.uk).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the persons best interests by other people. To be legally binding the person must have been over 18 when it was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.
- Where the decision relates to a child or young person under the age of 16, the MCA does not apply. In these cases, the competence of the child or young person must be considered under Gillick competence. If the child or young person is deemed not to have the competence to make the decision then those who hold Parental Responsibility will make the decision, assuming it falls within the Zone of Parental control. Where the decision relates to treatment which is life sustaining or which will prevent significant long-term damage to a child or young person under 18 their refusal to consent can be overridden even if they have capacity or competence to consent.

6. HEALTH RECORDS FORMATS (Electronic and Paper)

6.1 The primary form of health record in all services is the appropriate EPR. The main

EPRs used by the Trust, presently, are:

- CHAT Health
- IAPTus
- Lilie
- Modus
- RiO
- SOEL Health
- SystmOne
- Tompson Screening Tool.

6.2 Photographs and digital images obtained for the purposes of assessment and treatment should be uploaded to an EPR. If the EPR does not support this, the images should be stored in a shared, restricted access, Trust secure file location and referenced along with the location in the relevant service user's EPR.

6.3 Paper case notes were the primary form before the implementation of the relevant EPRs and will be retained to provide historic information in line with the retention guidance in the Records Management Code of Practice (RMCoP) an extract is in section 13.

6.4 Before the introduction of SystmOne, inpatient care in community hospitals was recorded in paper case notes (known as 'MRN records') which are a shared record with Gloucestershire Hospitals NHS Foundation Trust.

6.5 The EPR may be supported by subsidiary paper case notes in one or more of the following situations:

- Any service – when the EPR is not available due to planned or unplanned downtime. (See Guidance to follow when Clinical Systems are unavailable, on the Trust intranet).
- Mental health inpatient wards – copy of current Mental Health Act documents of patients subject to that Act.
- Learning Disabilities Service – permanent storage of consultants' handwritten continuation sheets.
- Community Nursing - prescription and drug charts, end of life and shared care records.
- Any service – other documents awaiting scanning and/or uploading to the EPR, after which they may be destroyed.
- Sexual health – other documents associated with legal requirements or safe care.
- Where a service user has made a request for a set of paper notes in place or an EPR.
- Where a clinician has a need to maintain handwritten paper notes, in a bound book, before formal transcribing into the formal patient record; and,
- Any service – copy of documents already scanned and/or uploaded to the EPR but available to clinicians for easy reference.

Within mental health services, unless the subsidiary paper case notes are being kept for the final reason listed above only, they must be tracked on Case Note Tracking (see section 11).

6.6 Some individuals may express concern about the use of an EPR to store and access information. The DPA gives any individual the right to object to how their information is processed. This can include objecting to what data is collected, what the data is used for and who has access to it. This is addressed in the *Policy on Requests to Opt out of Electronic Health Care Records*.

7. STANDARDS FOR RECORD KEEPING

7.1 Clinical recording standards ensure that the health and social care records inform any health or care professional, involved with the service user, and responsible for providing high quality healthcare, what that care is or has been and any key features or risks.

7.2 Primary Health Record

Mandatory Identification Data:
Each Health Record must contain the following identification data as soon as they are available. If the record is part of an EPR, the system should be designed to include these details automatically.

- NHS number
- local unique Patient Identifier (i.e. system number, usually system generated)
- name in full, title and preferred name
- date of birth
- full address and postcode.

N.B. for Sexual Health and HIV Services the NHS Number is not mandatory as pseudonyms can be used.

Other Identification Data:
Each health record should contain the following identification data or be recorded as not known or not applicable:

- Ethnic group, as identified by the patient
- gender and at birth if different
- contact telephone numbers for home, work, and mobile telephone numbers, if agreed by patient
- carer
- next-of-kin
- name, address, and telephone number of a person(s) to contact in an emergency by a member of staff; and
- GP – name and address/telephone number.

Basic Information about Children must also Include:

- The name of the child's primary carer and who has parental responsibility if the parents are not living together.
- Relevant details if the child is Looked After or subject to a Child in Need or Child Protection Plan; and
- the name of the child's nursery or school.

N.B. some service may not be furnished with this information for legitimate reasons and as such unable to record.

7.3 If an adult service user has access to children, the health record must include the following information of any child 'cared for' or having regular contact with the service user, where possible the below should be obtained:

- Full name
- date of birth
- school
- GP
- relevant details if the child is Looked After or subject to a Child in need or Child Protection Plan.

N.B. This does not include where the individual's profession gives rise to regular contact.

7.4 Additional information is to be collected on the primary health record format in line with the:

- Assessment and Care Management Policy
- Assessing and Managing Clinical Risk and Safety Policy
- Policy for Ordering, Prescribing and Administering Medicines (POPAM)
- Specific EPR guidance.

7.5 Applicable to all Formats of Health Records

7.6 The service user's NHS number or where NHS number is not the primary identifier the relevant system-based identifier will be included in all documents, forms, and correspondence, this is to ensure that all documentation can be correctly attributed to the right service user's healthcare record.

7.7 Each contact/intervention will be documented and, if not automatically recorded by an electronic system, the date and time of each entry will be documented (including where clinical notes are maintained). All entries will be made in chronological order and contemporaneously (i.e. during, or at the end, of clinical contact) or within 24 hours of the events to which they relate. If they are to be followed by a letter, the original entries will include all important and relevant clinical and risk information.

7.8 Where there is no entry for a significant period in the healthcare record of a service user, who remains open to a service, the next entry must explain why there is a gap.

7.9 Abbreviations should not be used unless the full text is written/typed when first used during an entry. The abbreviation may be put in brackets next to the initial full entry and used through the remainder of that entry.

7.10 Statements within records must only be written from a clinical or professional perspective, and with opinions being professional. Personal opinions of the clinician should not be included.

7.11 Third party information should be appropriately identified as being from the third party, including opinions or unverified statements.

7.12 Where the third party has advised they wish the disclosure to be kept confidential it should be marked as such by the clinician.

7.13 It should be possible to trace the decision-making process through the records. However, it is not always possible to record every verbal exchange, and discretion should be used in identifying those decisions which are of sufficient significance to require recording.

7.14 Emails are increasingly used as a means of communication about health and social care in place of conversations and letters. All significant emails should be referred to in the health record. If the email is considered to be of great significance to the record of healthcare, a copy should be saved and uploaded to the EPR.

7.15 Where a service has received approval for patient contact by WhatsApp or texting, external to an EPR, the message and responses are required to be transposed into the clinical record.

7.16 Any information which it may be inappropriate to disclose to the service user such as third party confidential or if disclosure is likely to cause serious harm to the physical or mental health of the service user or any other person must be clearly indicated and marked not to be disclosed.

7.17 Where an entry is made recording the decision or discussion involving two or more professionals (i.e. MDT), a list of all people present and involved shall be recorded within the EPR.

7.18 Documentation relating to a service user's complaint should not be routinely placed in the health record but only if considered of strict clinical relevance to the service user's health needs, in accordance with the *Policy and Procedure on Handling and Resolving Complaints and Concerns*. This may include the initial complaint and the reply to it, but not necessarily other documentation. Any correspondence between clinicians and the Trust's legal advisors or a defence organisation about a claim will also be held separately[1].

7.19 Supervision records must not be included in a health record; (see the *Supervision Policy*).

7.20 If it is necessary to refer to another service user in the health record (most likely due to interactions between service users), his/her full name should not be entered but instead his/her initials and local identifier number. (This does not include references to a young person's parents).

7.21 If staff identify an error or anomaly within a record, they should, as appropriate:

- Raise it with the author of the record

[1] 'Complaint information should never be recorded in the clinical record. A complaint may be unfounded or involve third parties and the inclusion of that information in the clinical record will mean that the information will be preserved for the life of the record and could cause detrimental prejudice to the relationship between the patient and the health care team.' Page 46, RMCoP

- If an electronic record, contact the system manager; and/or
- Make a Datix Incident Report.

7.22 Any practitioner who requires clinical decision-making support or undertakes a clinically relevant conversation with a colleague as part of patient management, is expected to document the discussion comprehensively in the patient's clinical record, including the rationale for any decisions reached and the name of the person discussed with. It is the responsibility of the initiator of the discussion to document.

7.23 Applicable to EPRs Only
If an EPR requires entries to be validated, this should be done as soon as possible and within 72 hours at the latest. Staff who are authorised to validate their own entries should do so themselves. The health professional supervising unauthorised staff should ensure that validation takes place.

7.24 If a patient presents to the service and is unwilling/unable to identify themselves sufficiently for staff to trace them on the EPR or the national spine, staff should check the guidance for the specific EPR.

7.25 Applicable to Paper Case Notes Only
All case notes must contain a page of sticky labels including as a minimum:

- Name
- Date of Birth
- NHS number (or other identification number if NHS number is not used).

A label must be attached to each document within the case notes and to the outside of the folder.

7.26 All entries will be written or typed in black ink.

7.27 All entries should be signed, normally with a full identifiable signature. However certain documents, such as prescription charts, may require initials.

7.28 Any small errors can be scored out with a single line, dated, and initialled. Correction fluid must not be used.

7.29 Blank spaces on continuation sheets will be scored through.

7.30 Any paper health records must be held within official Trust case notes only.

7.31 When a set of case notes becomes too bulky, it may be split into two or more volumes. Each cover should clearly state the period covered in that volume. It may also indicate the number of that volume and the total number of volumes (e.g. volume 1 out of 3).

7.32 Before a ward/department sends a set of case notes to another ward/department, it should ensure that all pages are filed correctly, that originals of scanned documents have been confidentially destroyed and that there are no loose sheets. If a ward/department has loose paperwork, it should take responsibility for filing it.

8. CONFIDENTIALITY OF HEALTH RECORDS

8.1 All NHS bodies and those carrying out functions on behalf of the NHS have a common law duty of confidentiality to service users and a duty to maintain professional ethical standards of confidentiality. This means that all service user information, whether held on paper, computer, visually or audio recorded, or in the memory of the member of staff, must not normally be disclosed without the consent of the service user. Three circumstances making disclosure of confidential information lawful are:

- Where the individual to whom the information relates has consented (this can be implied consent).
- Where disclosure is in the overriding public interest.
- Where there is a legal duty to do so, for example a court order.

8.2 *Confidentiality - NHS Code of Practice* sets out what health and care organisations have to do to meet their responsibilities around confidentiality and patients' consent to use their health records.

8.3 Service users and, with their consent, other people have the right of access to their health records under the UKGDPR and DPA. Where the service user has died, the service user's representative and any person who may have a claim arising out of the service user's death have access to health records under the Access to Health Records Act 1990. Procedures for dealing with access requests are set out in the separate *Access to Health Records Policy*.

8.4 A number of individuals from statutory bodies (i.e. the CQC), advocates and solicitors are entitled to access the health records of individuals. This is also covered in the *Access to Health Records Policy*.

9. STORAGE OF PAPER HEALTH RECORDS

9.1 All case notes must be stored in locked and secure locations in line with the *Information Governance Management System Policy*.

9.2 Wards/departments should hold only those case notes with which they are currently working. Other case notes should be sent to the appropriate Health Records Library/Records Room.

9.3 Closed case notes may be sent by the Health Records Department to an off-site store belonging to an external provider and which complies with standards in *Identifying and Specifying Requirements for Offsite Storage of Physical Records*.

10. SENDING HEALTH RECORDS

10.1 External

If it is agreed, in accordance with the *Access to Health Records Policy*, that a patient or another service or organisation can have access to a Trust health record, section 7.4 of the *Information Governance Management System Policy* should be followed.

A copy of an EPR may be emailed in line with 7.4.1 of the above Policy.

Original paper case notes are sent only with the agreement of the Caldicott Guardian,

using ‘Special Delivery Guaranteed’ mail. Otherwise, copies should be sent by ‘Signed For’ post.

In all cases, section 8.4.3 of the above Policy should be followed. This includes:

- Checking that they are sending the correct information is being sent to the correct recipient and using the correct address.
- Marking envelopes ‘Private and Confidential’.
- If only the named recipient is to open the envelope, marking it ‘Addressee only’.
- Using and sealing the information in a robust envelope.
- Including a return address for the Trust (but not one that would indicate the care that the subject of the information is, or has been, in receipt of).

10.2 Internal

Original paper health records may be sent within the Gloucestershire NHS community internal postal system:

- In a security wallet with a security tab system or in a securely sealed envelope/package.
- With the previous address erased or covered with self-adhesive labels in order to prevent delivery to the incorrect location.
- Clearly marked ‘confidential’.
- Clearly marked for the person for whom it is intended or addressed to the ‘department head’, ‘ward manager’, etc.

11. LOCATING AND TRACKING PAPER HEALTH RECORDS

11.1 Accurate recording and knowledge of the existence and whereabouts of all case notes is essential if the information they contain is to be located quickly and efficiently. It is very inconvenient and potentially dangerous when case notes cannot be found.

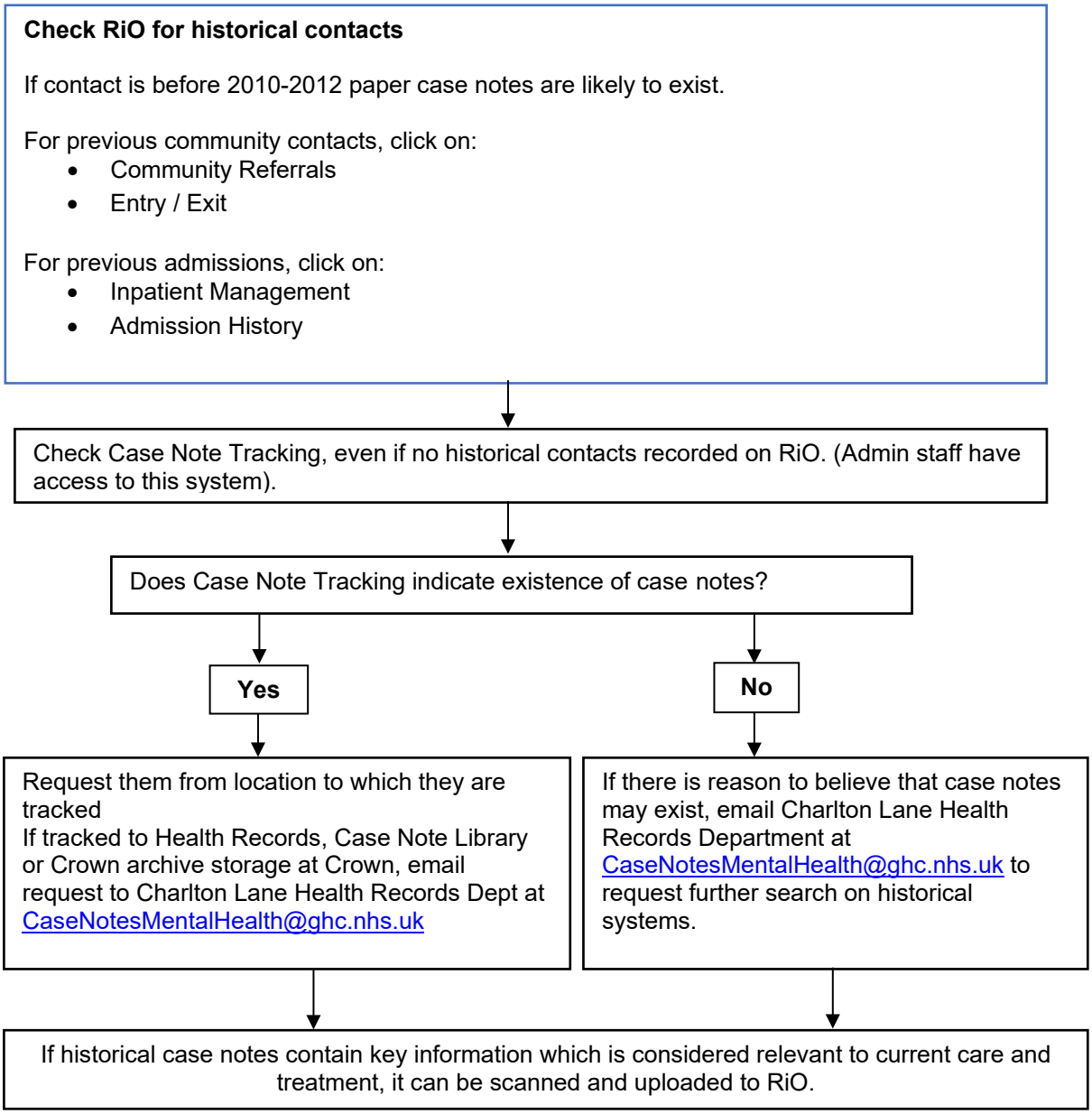
11.2 Mental Health Records

The movement and receipt of all case notes must be recorded on Case Note Tracking. There should be at least one member of staff within each mental health ward and department who is registered on Case Note Tracking and is familiar with the User Guide.

The basic principles of Case Note Tracking are that there should be an accurate description and up-to-date location for each volume of a service user’s case notes and that anybody:

- Sending case notes should ensure that they are tracked to the new location.
- Receiving case notes should ensure that their receipt is confirmed.
- Creating a new set of case notes should ensure that their details are added.
- Merging a subsidiary volume into another volume should ensure that this is shown.

11.3 Although an increasing amount of service user information is held on electronic systems available on all Trust sites at any time, relevant clinical information may still be held in case notes. The process for locating such mental health case notes is set out below.



11.4 Physical Health Records

'MRN' case notes shared with Gloucestershire Hospitals NHS Foundation Trust (GHFT) are tracked on GHFT's TrakCare.

Case notes sent for archive storage are tracked by the Records Administrator within the Records Department.

12. MISSING HEALTH RECORDS

12.1 Any occasions when a clinician sees a service user without the relevant health records (for example because the paper record is elsewhere or cannot be located) should be recorded on Datix.

12.2 It is essential that any member of staff receiving mental health case notes ensures that they have been tracked correctly and receipt confirmed on Case Note Tracking. This

will help to focus the search, should the case notes be lost.

12.3 In the event of a set of case notes being lost, it is the responsibility of the individual/department to whom they were last tracked to carry out a thorough search. This should include:

- The Care Coordinator, who may be able to identify when the records were last accessed.
- All locations where care has been provided in the last year.
- All locations to which the case notes have been tracked in the last year.
- The Records Department.

12.4 If the health records can still not be found, the person carrying out the search must inform the appropriate Records Team within 72 hours, who will:

- Inform the Head of Information Governance and Records, who will assess and carry out any notifications.
- Keep a record of the loss.
- If 'MRN' case notes, inform their Gloucestershire Hospitals Trust counterpart.
- Inform the appropriate Service Director.
- Complete a Datix report.

12.5 The Records Manager will ensure that the service user is informed of the loss.

12.6 If the lost case notes are subsequently found, the service user, the Head of Information Governance and Records should be informed.

13. RETENTION AND DESTRUCTION OF HEALTH RECORDS

13.1 The statutory period for retaining records set by the Public Records Act 1958 is 20 years from the last date at which content was added. *Records Management Code of Practice for Health and Social Care* 2016 lists minimum retention periods for a range of different records. Record types relevant to this Trust's current and former services are:

Record type	Retention period	Action at end of retention period	Notes
Adult health records not covered by any other section in this schedule	8 years	Review	Records involving pioneering or innovative treatment may have archival value, and their long-term preservation should be discussed with the local Place of Deposit (PoD) or The National Archive.
Children's records including midwife, health visiting and school nursing	25th or 26th birthday	Review	The basic health and social care retention requirement is to retain until 25th birthday or if the patient was 17 at the conclusion of treatment, until their 26th birthday.
Dental records – clinical care	11 years	Review, and destroy if no longer required	Based on Limitations Act 1980. This applies to all dental care settings and the BSA.

Electronic Patient Records System (EPR)	See Notes	Destroy	Where the electronic system has the capacity to destroy records in line with the retention schedule and where a metadata stub can remain demonstrating that a record has been destroyed, then the Code should be followed in the same way for electronic records as for paper records with a log being kept of the records destroyed. If the system does not have the capacity, then once the records have reached the end of their retention periods, they should be inaccessible to users of the system and upon decommissioning, the system (along with audit trails) should be retained for the retention period of the last entry related to the schedule.
Integrated care records - all organisations contribute to the same single instance of the record	Retain for period of longest specialty	Review and consider transfer to PoD	The retention time will vary depending upon which type of health and care settings have contributed to the record. Areas that use this model must have a way of identifying the longest retention period applicable to the record.
Integrated records – all organisations contribute to the same record, but keep a level of separation (refer to notes)	Retain for relevant specialty period	Review and consider transfer to PoD	This is where all organisations contribute into the same record system but have their own area to contribute to and the system still shows a contemporaneous view of the patient record.
Mental Health Records	20 years or 10 years after the patient has died	Review and if no longer needed destroy	Covers records made where the person has been cared for under the mental health Act 1983 as amended by the Mental Health Act 2007 Retention solely for any persons who have been sectioned under the Mental Health Act 1983 must be considerably longer where the case is ongoing, or the potential for recurrence is high. **GHC will retain the health records of all inpatients for 20 years. If the health records of a patient who has been treated in only the community have not been added to after eight years, it will be assumed that that person has made a full recovery, with the records being retained for 8 years after discharge.**
Contraception, sexual health, Family Planning and Genito-Urinary Medicine (GUM)	8 or 10 years (see Notes)	Review and if no longer needed destroy	8 years for the basic retention but increased to 10 in cases of implants or medical devices. If this is a record of a child, treat as a child record as above.

Sexual Assault Referral Centres (SARC)	30 Years, or 10 years after death (if known)	Review and destroy if no longer required	These records need to be kept for medico-legal reasons because an individual may not be in a position to bring a case against the alleged perpetrator for a long time after the event. Once the retention period is reached, a decision needs to be made about continued retention. Records cannot be kept indefinitely just in case an individual might bring a case. Some individuals may never bring a case and indefinite retention may be seen as a breach of UKGDPR (keeping information longer than necessary). Consideration also needs to be given to the Police and Criminal Evidence Act 1984, Human Tissue Act 2004, and Criminal Procedure and Investigations Act 1996 legal requirements (other laws and regulations may also need to be taken into account).
Medical record of a patient with Creutzfeldt-Jakob Disease (CJD)	30 years or 8 years after the patient has died	Review and consider transfer to a PoD	For the purposes of clinical care the diagnosis records of CJD must be retained.

13.2 Old HMP Gloucester Prison Health Records

Prison records should be treated as hospital episodes and may be destroyed after the appropriate retention has been applied. The assumption is that a discharge note has been sent to the GP. Where a patient is sent to prison the GP record must not be destroyed but rather held until release or normal retention periods of GP records have been met.

13.3 Appraisal

At the end of the retention period, the Health Records Department, in liaison with the Caldicott Guardian and/or Information Governance Manager, will decide what to do with each record; this decision-making process is called appraisal. There will be one of three outcomes after appraisal:

- Destroy / delete
- To keep for a longer period
- To transfer to a place of deposit appointed under the Public Records Act 1958.

An accurate record must be kept of all appraisal decisions.

13.4 Destroy / Delete

Paper records can be destroyed to an international standard and to *BSIA EN15713:2009 – Secure Destruction of Confidential Material*. They can be incinerated, pulped, or shredded (using a crosscut shredder) under confidential conditions. The confidential waste service provided to this Trust meets these standards.

For EPRs, the Information Commissioners Office (ICO) has indicated that if information is deleted from a live environment and cannot be readily accessed, this will suffice to remove information for the purposes of the DPA (*ICO Deleting personal data*). At

present there are two ways of permanently destroying digital information – overwriting the media a sufficient number of times or the physical destruction of the media (*HSCIC Destruction and Disposal of Sensitive Data*).

No information must be destroyed if it is the subject of a request under the DPA and/or Freedom of Information Act (FOI) or any other legal process, such as an inquest following a death. The Independent Inquiry into Child Sexual Abuse has requested that large parts of the health and social care sector do not destroy any records that are under, or may fall into, the remit of the inquiry. Before any records are destroyed, a check for any further update from the inquiry should be made at www.iicsa.org.uk.

A brief description should be retained of all records which have been destroyed / deleted.

13.5 Keep for a Longer Period

In most cases it will be appropriate to destroy/delete health records immediately at the end of the minimum retention period unless they have been selected for transfer under the Public Records Act 1958. Further retention may be required to support reasonably foreseeable litigation, public inquiries, an ongoing DPA or FOI request or a similar exceptional statutory reason, such as a public inquiry.

The decision to retain must comply with the DPA and UKGDPR principles, be recorded, made in accordance with formal policies and procedures by authorised staff and set a specific period for further review. Health records may be retained by the Trust beyond the 20-year statutory period only with the approval of the Secretary of State, with applications being made to the National Archives office in the first instance. However, Retention Instrument 22 has been approved by the Secretary of State to permit extended retention of NHS patient records where this is mandated by the Code or is otherwise necessary for continued NHS operational use. If the Trust uses the provisions of the Instrument to extend retention, this must be documented in a published policy.

13.6 Transfer to a Place of Deposit

The Public Records Act 1958 requires organisations to select core records for permanent preservation at the relevant Place of Deposit appointed by the Secretary of State for Culture, Media, and Sport. Places of deposit are usually public archives services provided by the relevant local authority. The Health Records Department will therefore offer health records reaching their minimum retention periods to the appropriate archive, either:

- Gloucestershire Records Office, Clarence Row, Alvin Street, Gloucester, GL1 3DW; or
- Herefordshire Archive and Records Centre, Fir Tree Lane, Rotherwas, Hereford, HR2 6LA.

Health Records will normally remain closed at the Place of Deposit, meaning that access will not be given without the Trust's agreement until 100 years after the data subject's birth.

The Public Records Act 1958 is not designed to support the current operational

research activities of the NHS and records should not be selected if that is the only or primary purpose in doing so. It should only be considered where on or more of the factors listed below apply and for a sample or sub-set of records. Any records selected should normally be retained by the Trust under the terms of Retention Instrument 122 until the patient is known, or can be assumed, to be deceased.

The following factors should be taken into account when considering selection of health records:

- The Trust has an unusually long or complete run of records of a given type.
- The records relate to population or environmental factors peculiar to the locality.
- The records are likely to support research into rare or long-term conditions.
- The records relate to an event or issue of significant local or national importance (for example a public inquiry or a major incident).
- The records relate to the development of new or unusual treatments or approaches to care and/or the Trust is recognised as a national or international leader in the field of medicine concerned.
- The records throw particular light on the functioning, or failure, of the Trust, or the NHS in general, or
- The records relate to a significant piece of published research.

14. HANDLING DAMAGED CASE NOTES

14.1 Case notes which are clearly damaged (i.e. clearly marked by blood or other such substance that makes the record a health risk) should be removed from circulation immediately and taken to the Health Records Manager or Departmental Manager.

14.2 The manager, with a senior clinician, both wearing protective gloves, will assess the extent of the damage.

14.3 If the record is irretrievably damaged, the Information Governance Manager is to be advised and will oversee the ensuing process.

14.4 The affected documentation must be photocopied, and a new set of case notes created if necessary.

14.5 Photocopies of an original record will be stamped/written “This is a true record of the original” and then dated and signed by the individuals as in sections 14.2 and 14.3 above.

14.6 It must be recorded on the inside of the new set of case notes that copies have been taken. The following details are to be included:

- Why this process was undertaken
- Date
- Name, signature, and designation of the person overseeing this process
- Details of the number of pages copied.

14.7 The damaged record will be treated as confidential waste and the process recorded in the new file to include:

- Process of destruction
- Date
- Signatures of the individuals in sections 14.2 and 14.3 above.

14.8 Any service user whose record has been damaged and destroyed should be informed.

15. CASENOTES OF SERVICE USERS INVOLVED IN SERIOUS UNTOWARD INCIDENTS

15.1 Immediately after an incident has taken place, action must be taken to secure the health records so that they are available in their entirety for an investigation. If the health record consists partly or entirely of case notes, the service manager or on-call manager who has been informed of the incident will lock the case notes in a secure place.

15.2 If the case notes are required for on-going treatment, the service manager or on-call manager will liaise with a health records manager as soon as possible to provide the clinical team with a copy of relevant documents in a subsidiary set of case notes and to store the original case notes in the Health Records Department until they are required for an investigation. Clinicians may contact the Health Records Department to obtain further copies of items relevant to care.

15.3 If the case notes are not required for on-going treatment), the service or on-call manager should arrange for them to be taken to the Health Records Department as soon as possible for storage until they are required for an investigation. Original case notes should not normally be released to the mortuary, coroner, or police, but copies should be provided.

16. SCANNING

16.1 **Records Management Code of Practice** (RMCoP) recognises that NHS organisations may consider the option of scanning into electronic format records which exist in paper format, storing the scanned records in accordance with appropriate standards and then destroying the paper records.

Any scanning, the RMCoP advises organisations to take into account the need to protect the evidential value of the record by copying and storing the record in accordance with British Standards, in particular the 'Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically' (BIP 0008).

The current British Standard is BS10008, highlights several key issues, many of which relate to the organisation's information management planning and technical matters, which are addressed in paragraph 16.

The Trust is currently implementing an electronic document management system 'CITO' where all historic paper records are being scanned into and linked to the relevant clinical record. Future paper records, videos, images, audio recording will be saved into CITO. Once complete a full guide will be added to this policy.

Only those scanners provided by the Trust should be used.

All staff using scanners for records scanning should be advised of the following sections:

16.2 Before Scanning

- Stamp each document as 'scanned' and date/sign it.
- If document is a copy, stamp or write 'copy' on it.
- Remove any staples or paper clips which may interfere with the automatic feed.
- Any attachments (such as a stick-on note) should be removed from a document to be scanned separately.
- If the document is unlikely to be accepted by the automatic feed, for example because of the thinness of the paper, use the scanner's flat bed. Alternatively, photocopy the original and scan the copy.
- If the appearance of the original document is such that a scanned version may not be legible or clear, for example due to the ink colour, it may be necessary to set the scanner to a higher resolution or to create a clearer image on a photocopier.

16.3 After Scanning

- The scanned image must be saved in an appropriate L, M, or O drive folder.
- Once a document has been saved, the person who has scanned it, having satisfied themselves that the image is complete and legible, may confidentially destroy the original paper document and delete the scanned document from the L, M, or O drive.

17. HEALTH RECORDS OF TRANSGENDER PERSONS

17.1 A patient can request that their gender be changed by a statutory declaration, but this does not give them the same rights as those that can be made by the Gender Recognition Act 2004. The formal process (as defined by the Gender Recognition Act 2004) is that a Gender Reassignment Certificate is issued by a Gender Reassignment Panel.

17.2 However, the Primary Care Support England (PCSE) website advises (Adoptions and Gender Reassignment | PCSE (england.nhs.uk)) that patients may request to change gender on their health record at any time and do not need to have undergone any form of gender reassignment treatment in order to do so.

Following registration of new gender information at the GP practice, the PCSE will issue a new NHS number. The Trust must then transfer all previous medical information into a new health record. It is important to discuss with the patient what records are moved into the new health record.

18. HEALTH RECORDS OF ADOPTED PATIENTS

18.1 The health records of adopted people can be placed under a new last name only when an adoption order has been granted. Before an adoption order is granted, an alias may be used, but more commonly the birth names are used.

18.2 At present the GP would initiate any change of NHS number or identity if it was considered appropriate to do so, following the adoption.

18.3 It is important that any new records, if created, contain sufficient information to allow for continuity of care. Depending on the circumstances of the adoption, there may be a need to protect from disclosure any information about a third party. The PCSE advises that any information relating to the identity and whereabouts of the birth parents should not be included in the new record. Adoptions and Gender Reassignment | PCSE (england.nhs.uk).

19. DEFINITIONS

19.1 Health Record and Health Professional

The term 'health record' is defined by Section 68 of the DPA as any record which consists of information relating to the physical or mental health or condition of an individual and has been made by or on behalf of a health professional in connection with the care of that individual.

19.2 The term 'health professional' is defined by the DPA as any of the following:

- A registered medical practitioner (a "registered medical practitioner" includes any person who is provisionally registered under section 15 or 21 of the Medical Act 1983 and is engaged in such employment as is mentioned in subsection (3) of that section).
- A registered dentist as defined by section 53(1) of the Dentists Act 1984.
- A registered optician as defined by section 36(1) of the Opticians Act 1989.
- A registered pharmaceutical chemist as defined by section 24(1) of the Pharmacy Act 1954, or a registered person as defined by Article 2(2) of the Pharmacy (Northern Ireland) Order 1976.
- A registered nurse, midwife, or health visitor.
- A registered osteopath as defined by section 41 of the Osteopaths Act 1993.
- A registered chiropractor as defined by section 43 of the Chiropractors Act 1994.
- A clinical psychologist, child psychotherapist.
- A scientist employed by such a body as head of department, and
- Professions are now regulated by the Health and Care Professions Council (HCPC) and comprise:
    - Arts therapists (arts, music, and drama)
    - Biomedical scientists
    - Chiropodists / podiatrists
    - Clinical scientists
    - Dietitians
    - Hearing Aid Dispenser
    - Occupational therapists
    - Operating department practitioners
    - Orthoptists
    - Paramedics
    - Physiotherapists
    - Practitioner Psychologist
    - Prosthetists and orthotists
    - Radiographers, and
    - Speech and language therapists.

20. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Monitoring Requirements and Methodology	Frequency	Further Actions
Quality Assurance Group (QAG): Audits of data quality will be undertaken, and reports produced	Programme of audits is produced each year, with some being annual,	These will be for review by operational colleagues, performance team and clinical system managers
It is recommended that clinical record keeping audits are carried out on a six-monthly basis. This will enable an ongoing audit cycle. If, for some justified reason, this is not practical, these audits must be carried out every year as a minimum. The Clinical Record Keeping Audit planning process gives an overview of the recommended approach to planning a clinical record keeping audit.	6 monthly or Annually	These are reviewed by the QAG, and action plans reviewed.

21. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

21.1 To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

22. TRAINING

22.1 All new colleagues will receive training through corporate and local induction.

22.2 No colleague will be given access to an EPR until they have been fully trained in the system's use and have been made aware of their specific security responsibilities.

22.3 All staff are required to undertake annual Information Governance training, either by e-learning or using the Data Security and Awareness (Level 1) Workbook if they do not have access to a work computer.

22.4 Line managers will be responsible for arranging ongoing training for applicable staff in record keeping, case note handling and general health records practice in accordance with their personal development plan and departmental role requirements.

23. REFERENCES

Good Medical Practice (2006) General Medical Council

The Code (2015) Nursing and Midwifery Council

Standards of Conduct, Performance and Ethics (2008) Health Professions Council

Records Management Code of Practice for Health and Social Care 2016

Delegating Record Keeping and Countersigning Records (2014) Royal College of Nursing

Code of Practice on Confidential Information 2014

A Guide to Confidentiality in Health and Social Care 2013

24. ASSOCIATED DOCUMENTS

GHC Information Governance Access to Health Records Policy (IGR-01)

GHC Assessment and Care Management Policy (CLP247)

GHC Handling and Resolving Complaints and Concerns Policy and Procedure (CGP010)

GHC Incidents Policy including Serious Incidents (CGP001)

GHC Dealing with Requests from the Police for Person-identifiable Information Policy (IGP011)

GHC Digital Call Recording Policy (IGP010)

GHC Use of Photographs and Video Recording in Clinical Records Guideline (CLG007)

GHC Recording on Trust Premises Policy (IGP012)

GHC Information Governance Management System Policy (IGP001)