Aneurin Bevan University Health Board

HEALTH RECORDS MANAGEMENT POLICY

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1. Executive Summary

As required in statute, Aneurin Bevan Health Board takes its responsibility towards patient confidentiality seriously and patient records should always be held in a secure environment and accessed on a need to know basis.

Health records are a valuable resource because of the information that they contain. They are essential to the delivery of high quality evidence based health care. Health records are contemporaneous and for the basis for the organisation's accountability for clinical care. They are evidential documents and as such must comply with legislative requirements, professional standards and guidelines. It is essential to the operation of the organisation to be able to identify and locate information that is critical for current decision making and to determine which policies and procedures are followed during the delivery of clinical care.

Health records management is the process of managing records throughout their life cycle, from their creation, usage, maintenance and storage to their ultimate destruction or permanent preservation.

Legislation has a significant effect on record keeping arrangements in NHS organisations and Aneurin Bevan Health Board must ensure that health records management policies and procedures are fully compliant with legislation and government policy on the management of information, namely:

- Medical Reports Act 1988;
- The Computer Misuse Act 1990;
- Access to Health Records Act 1990;
- Data Protection Act 1998;
- Human Rights Act 2000;
- Freedom of Information (non statutory code S.46 Code of Practice on Records and Information Management)
- Healthcare Inspectorate Wales
- Welsh Assembly Government (Ministerial Letters, Circulars and Policies);
- Caldicott: Principles into Practice;
- Information Sharing Protocols - Wales Accord on the Sharing of Personal Information
- Data Accreditation and Data Quality
- PRIMAP Standards
- Information Security Assurance - ISO 27001/2 Information security management (formerly BS7799)

This policy should be read in conjunction with the organisation's Clinical Record Keeping Policy and the Retention Schedule for non-Clinical and Clinical Records.

2 Scope of the Policy:

This policy sets out best practice for the creation, utilisation, retention and disposal of health records. The Policy applies to all records held within the Acute, Community, Child Health, Mental Health and Learning Disability Services. It applies to all health records regardless of format, of all types and in all locations where it is used to:

- Support patient care and the continuity of care
- support day to day corporate activities which underpin delivery of care
- support evidence based practice
- support epidemiology
- meet legal requirements and regulatory requirements
- assist medical and other audits
- support improvements in clinical effectiveness through research

3 Definition of a Health Record

A health record is everything (paper or electronic) that contains information which has been created or gathered as a result any aspect of the delivery of patient care, including:

- personal health records (electronic, microfilm, scanned images and paper based)
- radiology and imaging reports, photographs and other images
- audio and video tapes, cassettes, CDROM etc
- computer databases, output and disks and all other electronic records
- material intended for short term or transitory use including notes and 'spare copies of documents'.

This list is not exhaustive.

The health record should be constructed to contain sufficient information to identify the patient, provide a clinical history, details of investigations, treatment and medication.

4 Aims of Health Records Management System

The aim of this health records policy to ensure that procedures are in place to bring together the health professionals and accurate, relevant and reliable patient documentation at the correct time and place to support patient care. In achieving this aim, Aneurin Bevan Health Board employees should fulfil statutory and other legal requirements, ensuring patient safety and safe custody and confidentiality of patient information at all times.

The aims of our health records management system are to ensure that:

- **health records are available when needed –** from which the Health Board is able to form a reconstruction of activities or events that have taken place
- **health records can be accessed –** health records and the information within them can be located and displayed in a way which is consistent with the records initial use and that the current version is identified where multiple volumes exist;
- **health records can be interpreted –** the context of the record can be interpreted; who created or added to the health record and when, during which business process, and how the health record is related to other health records
- **health records can be trusted –** the health record reliably represents the information that was actually used in or created by the business process, and the record integrity and authenticity can be demonstrated;
- **health records can be maintained through time –** the qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the health record is needed, perhaps permanently despite changes of format;
- **health records are secure –** from unauthorised and inadvertent alteration and erasure. Access and disclosure are properly controlled and audit trails will track all use and changes to ensure that health records are held in a robust format;
- **health records are retained and disposed of appropriately –** using consistent documented retention and disposal procedures which include provision of appraisal and permanent preservation for health records with archival value;
- **staff are trained –** all staff within the organisation are made aware of their responsibilities for health record keeping and management.

5 Health Records Life Cycle Process

Health records are confidential documents and should be clearly identifiable, accessible and retrievable. They should be authentic, meaningful, authoritative, adequate for their purpose and correctly reflect what was communicated, decided or done. They should be unalterable and after an action has occurred nothing for the health records should be deleted or altered. Information added to an existing hard copy health record should be signed and dated. Health Records systems should be secure and their creation, management, storage and disposal should comply with current legislation.

5.1 Creation

A comprehensive health record is created and maintained for every patient attending health services to provide an up to date and chronological account of the patient's care.

- Patient demographic data for each registration should be recorded on the master patient index of the patient administration or departmental system. The minimum patient demographic data should include: surname, forename, sex, date of birth, home address, postcode, NNN and or PAS/departmental number.
- Within the Mental Health & Learning Disabilities Division, the same dataset applies on the E-Pex System
- The organisation should use the NNN as a partial validation tool.
- Where there is more than one local identifier or case record per patient, a system is in place to ensure that the existence of all other health records is known
- The paper health record has a standard case record folder constructed of robust material which can withstand handling and transport and has secure anchorage points to protect against loss or damage to documentation; inside pockets and flaps are being phased out with the rollout of the new folder to discourage misfiling and loss of documentation.
- There is a designated area within the health record for health professionals to record actual or suspected clinical alerts or risk factors.
- There is a locally agreed format for the filing of the information in the health record which facilitates ease of access to all clinical information. Clear instructions regarding the order of filing is contained within the folder.

- Machine generated reports and recordings such as CTG, ECG and laboratory reports are stored in the secure pouch found within the record.
- The electronic Clinical Workstation System is password protected and passwords are changed at regular intervals. An audit trail of access, amendments or updates is available and reports can be taken from the system.

5.2 Storage

Health record storage areas should provide a safe working environment with secure storage that allows health records to be retrieved as and when required. These areas should only be accessible to authorised staff and should conform to agree standards e.g. BS 5454 to protect records from damp, fire, flood and chemical contamination.

- Health records storage areas and office accommodation should conform to all current legislation and guidance regarding health and safety
- Regular risk assessments are undertaken in line with the risk management strategy.
- Racking, where this is in use, is stable and of strong enough construction to support the weight of the health records and mostly complies with current health and safety regulations
- There are safety step ladders and stools appropriate to the number of staff employed and to the size of the different storage areas.
- The staff are trained in the manual handling procedures associated with the library areas.
- Equipment within the department conforms to the appropriate legislation and equipment checks are routinely conducted.
- Access to the libraries is restricted to authorised personnel. The keys/access codes to areas that are locked are made available to staff to facilitate the retrieval of health records during the out-of-hours service.
- The health records areas should be capable of accommodating the current needs and annual growth of health records.
- Health records must be stored securely when in clinical areas, offices and arrangements made within these areas to allow retrieval of records when required.

5.3 Management

Maintaining the health record is vital to patient care. The health records system has well defined procedures for the ongoing management of the

health record from initiation to final disposal in accordance with legislation.

- Whenever possible, separate areas are maintained for current and non-current health records in use within the organisation;
- There are documented procedures for the safe storage and retrieval of health records;
- There are documented procedures for the digitisation of health records and these meet the requirements of BIP:10008 Evidential Weight and Legal Admissibility of Electronic Information.
- There are documented procedures for the tracking of records within the organisation and audit is used to highlight any issues that arise as a result of non compliance
- There is a documented procedure for the splitting of fat folders and cross referencing of the volumes. Closed volumes are suitably labelled.
- There is a documented procedure relating to the return of the patient held record when an episode of care is complete.
- The responsibility for the filing of loose documentation rests with the staff who generate the information. Each person who uses the record and adds to the record has the responsibility to maintain the record and file any information into the appropriate place within the record. This is part of the overall recordkeeping standards of the organisation.
- Health records staff will routinely split large folders or re-cover a record if the outer cover is not of a good standard.
- There are documented procedures for the transportation of health records within and outwith the organisation
- There are documented procedures for the handling of subject access and Access to Health Records requests with clear responsibility for responding by fully trained, dedicated staff who process requests in accordance with the law;
- There are documented procedures for the retention, archiving and destruction of health records in accordance with national guidelines. The method of destruction ensures that confidentiality is maintained at all times.
- There is a set of performance indicators which demonstrate the efficiency of the health records service which include health record availability, use of temporary folders and timescales for receipt of health records at wards for emergency admissions.

5 4 Archiving and Disposal of Health Records

There is a documented policy on the retention, destruction and/or archiving of health records in accordance with the Welsh Health Circular

[2000]71: For the Record. The method of destruction ensures that confidentiality is maintained at all times. The policy specifies the timescales for the retention of all types of health records and media and the procedure for transfer between media.

6 Legal and Professional Obligations

All NHS Health Records are public records under the Public Records Act. The Health Board will take actions as necessary to comply with legal and professional obligations such as:

- The Data Protection Act 1998;
- The Common Law Duty of Confidentiality and
- The Confidentiality Code of Practice
- Access to Health Records Act 1990

and any new legislation affecting health records management as it arises.

7 Roles and Responsibilities

7.1 Data Controller

The Chief Executive Officer has overall accountability for ensuring that health record management operates correctly/legally within the Health Board. The CEO may delegate responsibility for management and organisation of the health records services to the Caldicott Guardian or another Director who will be responsible for ensuring that appropriate mechanisms are in place to support service delivery and continuity. Health records management is key to this as it will ensure appropriate and accurate information is available as required.

7.2 Caldicott Guardian

The Health Board's Caldicott Guardian has a particular responsibility for reflecting patients' interest regarding the use of patient identifiable information. The Caldicott Guardian has responsibility for:

- Ensuring the Health Board is fulfilling all legal obligations in managing patients' health records;
- Agreeing and reviewing internal protocols governing the protection and use of patient identifiable information by Health Board staff;
- Agreeing and reviewing protocols governing the disclosure of patient information across organisational boundaries e.g. with social services and other partner organisations, contributing to the local provision of care (WASPI)

- Developing the Health Boards security and confidentiality policies through the Clinical and Information Governance Frameworks;
- Representing confidentiality requirements and issues to the Board, advising on annual improvement plans and agreeing and presenting outcome reports.

7.3 Information Governance Committee/Health Records Committee

The Health Board's Information Governance Committee and Health Records Committee are responsible for ensuring that the Health Records Management Policy is implemented through endorsement of the policy and review of the life cycle process of the health record whether in paper or electronic format.

7.4 Designated Officer

The designated officer (Head of Health Records) holds a health records qualification or is suitably trained in health records practices. This officer has professional responsibility for the overall development and maintenance of health records management practices within the organisation and for ensuring that related policies and procedures conform to the latest legislation and standards on data protection, confidentiality and health records practice. This office is accountable for ensuring that the release of all patient clinical information for data subject access and provision of records for medico-legal purposes is in accordance with the legislation.

7.5 Staff Responsibility for Record Keeping

All NHS employees are responsible for any health records which they create or use. This responsibility is established and defined by the law (Public Records Act 1967 and Section 118 of the Government of Wales Act 1998). Furthermore as an employee of the NHS, any health records created by an employee are public records.

All Health Board staff, whether clinical or administrative, who create, receive and use health records have records management responsibilities. All staff must ensure that they keep appropriate records of their work and manage those records in keeping with this policy and with any guidance subsequently produced.

Everyone working for or within the NHS who records, handles, stores or otherwise comes across patient information has a personal common law duty of confidence to patients and to his or her employer. The duty of

confidence continues even after the death of the patient of after the employee or contractor has left the NHS.

Breach of this policy will mean that the Health Board is not safeguarding information entrusted to it, which could render the Health Board liable to prosecution. It is therefore essential that staff within the organisation with responsibility for record management comply with the policy or they may be subject to disciplinary procedures.

Each Division, directorate, department, member of staff who holds patient information in the form of a record, separate from the main physical record or electronic record is required to complete a Manual Inventory Form on an annual basis. This must be returned to the Head of Health Records as this forms the basis of an asset register for the organisation's records holdings. The holder of the record must comply with the regulations

8 Retention and Destruction Schedules

It is a fundamental requirement that all of the Health Board's health records are maintained for a minimum period of time for clinical, legal, operational, research and safety reasons. The length of time for retaining health records depends on the record type.

The Health Board has adopted the minimum retention periods as set out in the Non-Clinical and Clinical Record Retention Schedule. The Health Board retention schedule will be reviewed every three years or earlier in the light of legislative or Welsh Assembly Government changes. Records destroyed shall be recorded on the Patient Administration system. Destruction of eligible records shall be completed annually with archived records indicating the year for destruction. This will enable those pending destruction to be identified. Any decision to retain/destroy records outside of the periods specified will be approved and fully documented.

9 Health Record Inventory

The Health Board requires to know what records are held, how they are kept and how the information contained within the record is being used. An up-to-date health records inventory will be maintained by the Head of Health Records. This will identify all record collections that exist within the organisation, the volume of records, the type of media on which they are held, their physical condition, their location, the physical and environmental conditions in which they are stored and the responsible manager. The Head of Health Records should be advised of new collections of records that are created or where management

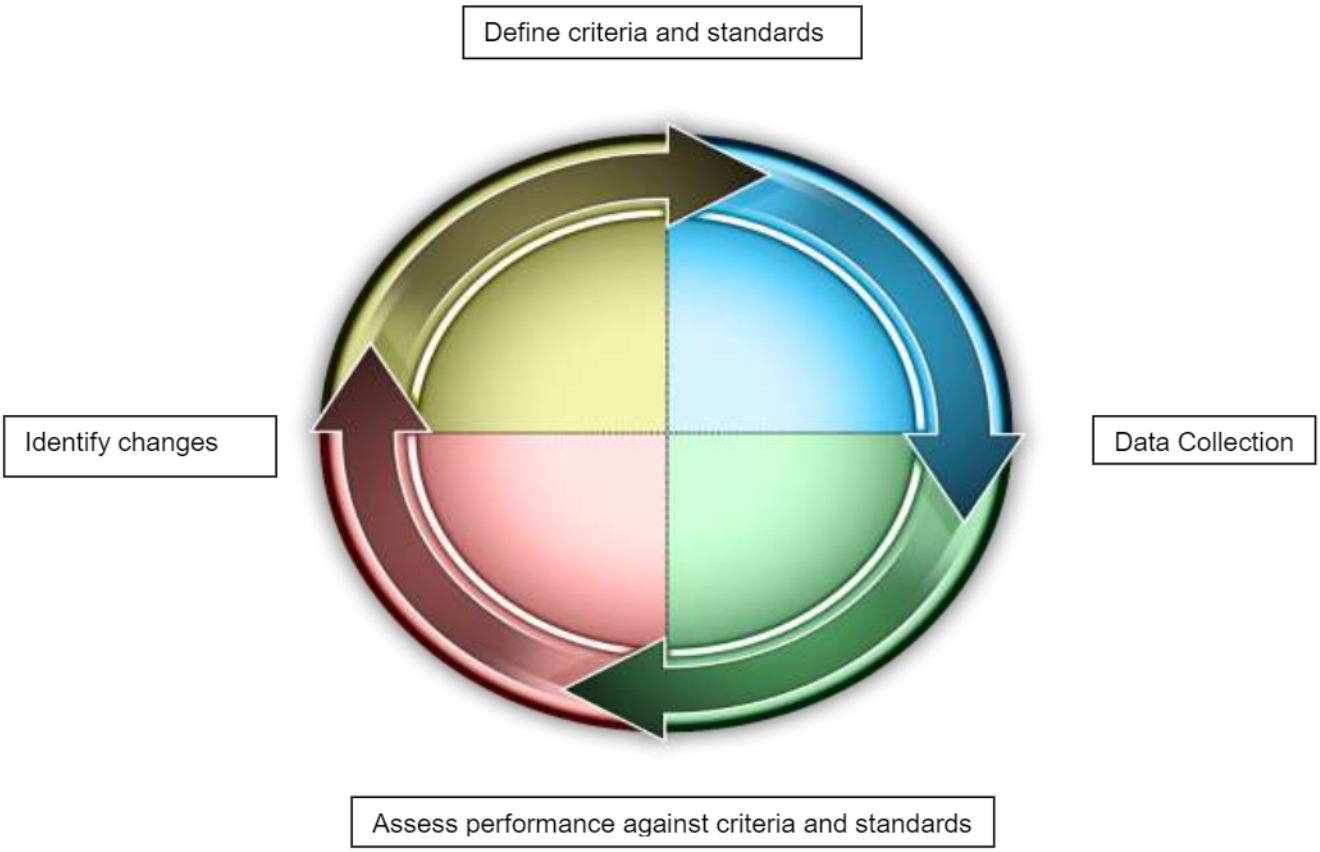
arrangements or physical locations change. Each Division, directorate, department, member of staff who holds patient information in the form of a record, separate from the main physical record or electronic record is required to complete a Manual Inventory Form on an annual basis.

The inventory survey form can be found at Appendix A.

10 Health Records Management Systems Audit

The Health Board will regularly audit the records management practices for compliance with this policy. Auditing health record policies and procedures will be done on a systematic basis. The audit will compare current operational practice against defined procedures conducted by Information Governance and internal audit. The audit cycle will include self assessment against the Healthcare Standards 19 and 20. Results will be returned to the Health Records Committee and IG Committee structure.

Audit Cycle:



11 Health Records Management Improvement Plan

The Health Board has formulated an Improvement Plan identifying programmed activity which encompasses the criteria within Healthcare Standard 20 and relates to each of the development areas with milestones and timescales for completion. Progress will be monitored through audit and compliance with the standards.

12 Health Records Policies and Procedures

The Head of Health Records is responsible for planning and documenting Health Records Department policies and procedures thus providing a standardisation of working practice across the Department. In this context a procedure is a structured, action orientated list of sequential steps involved in carrying out a specific task. This will ensure consistency of practice. Health Record Policies and procedures will be published on the Intranet for ease of access.

13 Training

All staff employed by the Health Board will receive information on their personal responsibilities for health records keeping. This includes the creation, use, storage, security and confidentiality of health records. Appropriate training will be given to all health records staff on the systems used to maintain records and these will meet local and national standards. All new employees to the Department will be given basic records practice training as part of the induction process. Training in the specifics of health records management for staff outwith the Department will be provided through Records Awareness sessions.

The policies and procedures relating to health records will form the basis for all health record system specific training. Record Service Managers within each hospital will audit compliance. All staff within ABUHB are welcome to attend training and provide feedback on this training provision.

14 Disaster Recovery

The Health Records Department has a Libraries Disaster Recovery Plan and identified staff who assume responsibilities for the records management during any disaster period to ensure that patient care is not compromised due to the loss of data.

15 Definitions and Acronyms

Health Record	Also referred to as: ▪ Medical record ▪ Case note ▪ Case record ▪ Patient record
PRIMAP	Patient Records and Information Management Accreditation Programme - The Healthcare Accreditation and Quality Unit (CHKS) Ltd administer a patient records and information management accreditation programme. This is a standards based programme of organisational development and support to health records departments both in acute and primary care settings. The programme is based on peer review methodology. Although not now a part of the programme, the standards outlined by the programme are relevant to the organisation and compliance promotes best practice.
CTG	Cardiotocograph (CTG) is a record of the fetal heart rate
ECG	Electrocardiogram
WASPI	Wales Accord for the Sharing of Personal Information - It is a framework that facilitates this by establishing agreed requirements and mechanisms for the exchange of personal information between parties in an "information sharing community". This community can be made up any number of organisations and these can be public sector, voluntary sector and private and independent organisations. There is no limitation to who is able to sign up to the WASPI and implement its requirements

16 References

Access to Health Records Act 1990
http://www.opsi.gov.uk/acts/acts1990/Ukpga_19900023_en_1.htm

Data Protection Act 1998:
http://www.opsi.gov.uk/acts/acts1998/ukpga_19980029_en_1

Human Rights Act 2000
http://www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1

Caldicott – Principles into Practice
http://www.wales.nhs.uk/sites3/page.cfm?orgid=783&pid=31175

Medical Reports Act 1988
http://www.opsi.gov.uk/acts/acts1988/ukpga_19880028_en_1

PRIMAP (Patient Records and Information Management Accreditation Programme)
http://www.chks.co.uk

Public Records Act 1967
http://www.nationalarchives.gov.uk/policy/act/

The Computer Misuse Act 19
http://www.opsi.gov.uk/acts/acts1990/Ukpga_19900018_en_1.htm90

Healthcare Standards for Wales
http://www.hiw.org.uk/Documents/477/Healthcare%20Standards%20for%20Wales.pdf

BS 10008 Evidential Weight and Legal Admissibility of Electronic Information
http://www.bsigroup.co.uk/en-GB/bs-10008-legal-admissibility-of-electronic-information/

Appendix 1

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

PHYSICAL HEALTH RECORDS INVENTORY FORM

This inventory concerns records held on physical media including: paper, x-ray film, microfiche, optical disks, CDs, DVDs, video and audio tape. It excludes records held digitally within computer systems and centralised network storage systems.

A form is to be completed for ***each type of*** record held.

Directorate		Location	
Department/Service			
Contact Name		Telephone Number	

1.	Do you store physical health records in the Department? (Records held within the department on physical media as listed above).	Yes		If Yes, please complete and return the questionnaire				
		No		If No, you do not need to answer any other questions, please sign at the end and return the questionnaire				
2.	Name/type of record e.g. OT, DN client							
3.	Who is responsible for managing these records within your dept? Typically, this person will be the manager of the dept. or you may have a records manager. (Please note: this is NOT the Health Records Dept.)	Name:						
		Job Title:						
		Tel No:						
4.	Format of the record	Paper			Film / X-Ray			
		Microfilm			Other (please specify below)			
		Removable magnetic media						
5.	Why are the records created / held?	Patient care / patient admin			Legal Requirement			
		Clinical Audit			Business / Corporate			

		Research			Other (please specify below)		
		Central Returns					
6.	From where does the information within the record originate?	Generated within the Department					
		Transferred from within the organisation (ABUHB)					
		Transferred from an external organisation (please specify)					
7.	Does the record contain personal data / information?	Yes			No		
		If yes, is it about the	Patient		Family		
			Friends, Associates		Others		
8.	Is there a register/index of the records held?	Yes			No		
9.	How many records of this type do you hold in your dept?						
10.	Where are the records stored? e.g. cupboard in corridor, filing cabinet in sister's office. (Please list all areas)						
11.	Is the storage area accessible to the public?	Yes			No		
12.	Is the storage area secure?	Yes			No		
13.	Is access to the record restricted to within the directorate/department?	Yes			No		
14.	Is the record or information it contains shared With others?	Yes			No		
	If yes, with whom is it shared and why? (Please list organisations and depts. e.g. Newport LA Social Services, Social Worker. ABUHB District Nurse						
15.	Do you have a record tracking system?	Yes			No		
		If yes, is it					
		Paper based?			Electronic?		

FURTHER COMMENTS
If you have further comments or questions regarding the information you hold (e.g. creation, maintenance, storage, retention, disposal etc.) please specify below.
Please return the form to: *Information Governance Unit* *Aneurin Bevan University Health Board* *B Block, 2nd Floor* *Mamhilad House* *Mamhilad Park Estate* *Pontypool* *NP4 0YP* *Tel: 01495 765 5324 e-mail: infogov.abb@wales.nhs.uk*

Completed by:

Date returned: