Policy Document Control Page

Title: Protocol for the Management of Mental Health and Specialist Services Health Records

Version: 3

Reference Number: CO93

Keywords
Records, management, record keeping, audit, transportation, health records, records lifecycle

Supersedes:
Description of Amendment(s):

- **Incorporating changes made following the publication by the Information Governance Alliance of the Records Management Code of Practice for Health and Social Care 2016**
- **Flowchart and procedure for archiving records off-site**
- **Inclusion of recording of Communication Needs from the Accessible Information standard**
- **Transferring notes between boroughs**
- **NB Currently retaining all records because of the Independent Inquiry into historical child sexual abuse)**

Important Notice
From May 2018 the UK will be adopting the European General Data Protection Regulations. These regulations will be replacing the Data Protection Act 1998. In the UK we are still awaiting some health sector specific guidance and instruction regarding GDPR, and as such have deemed that, unless there is a legal requirement or a fundamental change that is required in a policy, all policies, regardless of review date, shall remain current, valid and must be followed for the foreseeable future, to be reviewed prior to the implementation of GDPR from May 2018. Any queries in relation to this statement should be directed to the Trust Information Governance Manager.

Originator

Originated By: Carole McCarthy

Designation: Records Manager

Equality Impact Assessment (EIA) Process

Equality Relevance Assessment Undertaken by: Information Governance Manager
ERA undertaken on: 1st May 2015
ERA approved by EIA Work group on: 26th May 2015

Where policy deemed relevant to equality- NO
EIA undertaken by Carole McCarthy
EIA undertaken on
EIA approved by EIA work group on

Approval and Ratification

Referred for approval by: Records Manager

Date of Referral: 19/01/2017

Approved by: Information Governance Assurance Group

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Date Ratified by Executive Directors : 20th February 2017

Executive Director Lead: Medical Director

Circulation

Issue Date: 21st February 2017

Circulated by: Performance and Information

Issued to: An e-copy of this policy is sent to all wards and departments

Policy to be uploaded to the Trust's External Website? Yes

Review: Every 2 years

Review Date: 19th January 2019

Responsibility of: Carole McCarthy

Designation: Records Manager

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 21st February 2017

CONTENTS

PROTOCOL FOR THE MANAGEMENT OF MENTAL HEALTH & SPECIALIST SERVICES HEALTH RECORDS

1. Introduction

This document supports the Records Management Policy and focuses on Mental Health & Specialist Services. The guidance should be read in conjunction with the Records Management Policy (CO20); Retention Schedules (CO98); Missing Records Procedure (CO28); and the Protocol for the Management of the Removal / Transfer of Records and Information Storage Equipment when moving premise/ location (CO62).

2. Scope of this Protocol

The ISO standard, ISO 15489-1:2016 Information and documentation - Records Management defines a record as 'information created, received, and maintained as evidence and information by an organisation or person, in pursuance of legal obligations or in the transaction of business'.

The Data Protection Act 1998 (DPA) S68(2) defines a health 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'.

This guidance relates to all health records created by staff within Mental Health and Specialist Services of Pennine Care NHS Foundation Trust in all format's i.e. paper or electronic records.

3. Aims of this Protocol

It is the aim of this policy to provide best practice in the development and management of health records and which will allow staff to:

- Work in partnership with service user's, identifying needs and agreeing a joint care plan;
- Where appropriate, promote self-care, and empower service user's to take an active role in managing their care;
- Document fully the process of decision making and how informed consent has been given within the records, for all treatments and interventions that are planned and carried out;
- Ensure that the health record acts as an effective communication tool for other professionals involved in providing care for the same service user;
- Support high quality service user care and continuity of care;
- Provide an accurate, contemporaneous record of care interventions;
- Provide evidence to support a specific course of treatment or intervention;

- Ensure that service user confidentiality is maintained at all times, agreeing with the service user where specific information needs to be shared with other professionals and agencies to provide safe and effective care, and recording this process;
- Be aware that health records are legal documents, and have an understanding of how legal requirements must be met, including requests from service user's under Access to Health Records legislation;
- Understand what constitutes a record, the different types of health record, and the professional and local standards which apply to such records;
- Actively participate in clinical record audits.

This protocol provides the mechanism for staff to comply with the Health Records Lifecycle as specified within the Records Management Policy.

The key components are:

- Record creation;
- Record keeping;
- Record maintenance (including tracking of record movements);
- Access and disclosure
- Closure[1] and transfer;
- Appraisal;
- Archiving; and
- Disposal.

4. Health Record Creation

It is essential that a health record is created and maintained for all contacts with clients. This could be in any format i.e. paper health record; an electronic patient record (EPR) or a combination of both paper and electronic.

4.1 Electronic Patient Record

For guidance on creating and maintaining records on PARIS, please refer to the PARIS user guides available on the intranet via the ICT homepage. For all other EPR systems such as EMIS standard operating procedures and user guides should be made readily available to staff. If the referral is received in paper format then this will be scanned and uploaded and a record created on the clinical information system. (*Please refer to the CO94 Procedure for scanning and uploading documents to clinical information systems*).

[1] Closure – Records that have ceased to be active use other than for reference purposes. These records should be closed (i.e. made inactive and transferred to secondary storage).

4.2 Standardised Paper Health Records

If the health record is created on paper then a standardised health record folder with an agreed filing structure should be used if a service user is accepted into the service.

There are 6 folder designs:

- Hospital
- Community
- CAMHS – Healthy Young Minds
- Psychological Therapies – Healthy Minds
- Drug & Alcohol
- Rehabilitation & High Support
- Learning Disabilities

4.3 Initial Referrals and Assessment Folder

It is essential that the Trust has standard processes in place to ensure that the location of paper copies of referrals and assessments are known and available whenever needed. However, it is not always necessary to create a health record and an initial referral and assessment folder (IRAF) may be utilised in Mental Health and Specialist Services. The IRAF flowchart (Appendix 1) is to be used on receipt of a referral to establish if an Initial Referral and Assessment folder (IRAF) should be created or if a paper health record should be created (or accessed where a health record already exists).

- Where an IRAF is created it must contain the Surname, Forename, NHS number, Date of Birth of the individual referred and the date of referral and referrer.

- If a service user is assessed and a paper health record is not accessed or created the assessment can remain in the IRAF. If more than one assessment is filed the service should decide if a paper health record should be created and the information from the IRAF transferred.

- Referrals and assessments should not be held in any other media e.g. plastic wallets or sent without cover to the appropriate team.

- If information is removed from the IRAF due to it being filed in a paper health record, the IRAF can be reused and all details obliterated using a label placed over the original information.

- The IRAF must be tracked using whatever method is currently in use by the team/admin staff.

- The process for *inappropriate* referrals entering via the single point of entry would be a confirmation letter back to the GP explaining why the referral has not reached the threshold and copy of the correspondence retained by the service for 2 years.

4.4 RAID Records

It is essential that a copy of the health record for service user's admitted via RAID or similar service is filed within the paper health record to enable a full history to be maintained. If the client is known to services and already has a paper health record then this should be requested and the intervention filed within the hospital paper health record in the appropriate section. If no paper health record exists then an IRAF may be created as in 4.3 above. The service user's GP should also be routinely sent a summary of the record.

4.5 Electronic Clinical Documentation on Shared Drives

The characteristics of an electronic record allow strategies, policies and procedures to be established that will enable records to be authentic, reliable, integral and usable throughout their lifecycle. In order to ensure these characteristics are maintained, sufficient persistent metadata must be attached to each record.

The shared drive should not be used as a *complete* electronic patient record, nor should it be used to **store** clinical documentation beyond necessary retention.

Standardised documentation can be found on the intranet under Trust Approved Documents. As part of implementation, electronic copies of these documents have been provided to teams, for the purpose of amending certain aspects of the document, such as font size, field sizes; and for typing into where this is team practice.

These electronic documents may be used as long as the following guidelines are adhered to:

- When saving patient data electronically, save onto the shared network drive which is backed up daily and has suitable protection measures for saving patient identifiable information.

- Do not save any person identifiable data to the hard drive of any computer (usually known as the 'C' drive) as this is not secure.

- Save information onto the secured shared drive (usually known as the G Drive) so that other team members can carry on with patient care if the staff member is absent from work.

- Do not copy and paste clinical information from one review / care plan etc. to another as this can leads to incidents where another clients name is copied and pasted into the wrong document.

- The naming convention of the files should be surname, first name, NHS Number, date of document, document type, and title of document.

- If a paper record is being maintained then this is the primary source of information and should be kept up to date as a complete record. Duplicates may be retained to support efficient service delivery but the service must agree a retention period for duplicates in the system (for up to a maximum of 3 years unless agreed with the Records Manager)

- If an electronic patient record is being used any documentation should be either typed directly into the system, or scanned and uploaded.

Any variation from the above must first be discussed and agreed with the Records Manager /Information Governance Department.

5. Professional Standards and Record Keeping

Record-keeping plays an integral part of the General Medical Council and Nursing, Midwifery and Allied Health Professionals' practice and is essential to the provision of safe and effective care.

Record keeping is integrated n the four professional standards in the new NMC Code of Conduct (2015)[2]:

- Prioritise People
- Practice Effectively
- Preserve Safety
- Promote Professionalism and Trust

When **prioritising people** it is imperative not only to gain informed consent but also to document that this consent has been gained before any care is carried out. This may be implied, verbal or written consent which needs to be documented.

Practising effectively means that we should ensure the care we provide is on evidence based practice, which should be explicitly recorded in the notes.

[2] NMC (2015) The Code Professional Standards of Practice and Behaviour for Nurses and Midwives NMC, London

Practitioners' verbal communication is generally good and consideration is usually given to any communication needs or different languages in a culturally sensitive manner. What is often less than successful is the documentation of these interactions between patient and clinicians. The standard of practising effectively requires staff to be able to communicate clearly and effectively in English – there is also an implied necessity for a good standard of grammar and spelling, as well as understanding the difference between fact and opinion.

The third standard highlights the need to **preserve patient and public safety**, working within the limits of your competence. For example: a district nurse identifies a patient who needs a referral to the mental health team. The referral must be based on an accurately documented assessment of the patient; this in turn will inform a smooth referral and assist the mental health team in their specialised assessment in a timely fashion.

The professional 'duty of candour' requires the Trust to be open and honest. The term 'duty of candour', is taken from the Francis Report (2013)[3] that obliges nurses to raise concerns immediately whenever a situation puts a patient or a member of public at risk.

The final standard of the Code urges clinicians to uphold the **reputation of the nursing profession and the Trust.** Clinicians who produce high-quality documentation demonstrate a personal commitment to the standards of practice and behaviour set in the Code, thereby upholding the reputation of the profession. Documentation is the Trust's main defence if assessments or decisions are ever scrutinised in complaints or legal cases.

The NMC refer to the 6 C's of Record Keeping which can be found in Appendix 2.

Similarly healthcare record standards have been endorsed as fit for purpose for the whole medical profession by the Academy of Medical Royal Colleges (AoMRC) and have been adopted by the Professional Record Standards Body for Health and Social Care (PRSB).[4]

6. The Trust Record Keeping Standards

The Trust expects that there will be accurate contemporaneous record-keeping in all formats regardless of which media they are held i.e. paper, electronic which means written as soon as possible after the event occurred, usually within 24 hours.

[3] www.kingsfund.org.uk/projects/francis-inquiry-report
[4] https://www.rcplondon.ac.uk/projects/healthcare-record-standards

6.1 Objectives of good record keeping

The objectives of good record keeping should link in with the Trust values and therefore should:

- Support effective clinical judgements and decisions leading to high standards of clinical care;
- Support patient care and communications;
- Make continuity of care easier
- Aid better communication and dissemination of info between multi-disciplinary teams;
- Improve quality;
- Help to improve accountability;
- Show how decisions related to client care were made;
- Support the delivery of services;
- Provide documentary evidence of services delivered;
- Help to identify risks, and enable early detection of complications;
- Supporting clinical audit, research, allocation of resources and performance planning;
- Help to address complaints or legal processes.

6.2 Information which should be recorded:

- **Reason for the referral to the service**
- **Evidence of Assessment** – that provides an overview of all relevant medical, social and family history, current treatment, communication needs, risk and allergy status and which outlines details of assessments, interventions or investigations, reason for request and result and any support which is needed to enable effective, accurate dialogue between a professional and a service user to take place.
- **A plan of care –** which demonstrates evidence based care, which is justified by a clear rationale and which outlines the desired outcomes. The plan should include information about measures taken to meet service user's needs and actions agreed with the service user, including consent to treatment where required.
- **Contacts:** It is essential that a health record is created and maintained for all contacts with service users including telephone contacts. The telephone case note on PARIS has been developed so that key activity information can be recorded whether this is with the patient or others involved within the delivery of patient care. It is also necessary to record any contacts with other professionals regarding a client within the health record.

Additional information which should be recorded:

- Medical alerts/ allergies/ adverse reactions
- Risk issues/ parental responsibility/ warning indicators/ communication needs
- Advice / information/ leaflets given to the service user;

- Problems and action taken to rectify them;
- Significant events;
- Name and job title, where reference is made to other individuals, for example, if there has been liaison with a social worker, the name and job title must be recorded;
- Medical observations: examinations, tests, diagnoses, prognoses, prescriptions, other treatments;
- Relevant disclosures by the service user – pertinent to understanding cause or effecting cure/treatment;
- Facts presented to the service user;
- Correspondence/ information received from the service user or other parties;
- Evidence of evaluation i.e. that demonstrates that care is regularly reviewed;
- Discharge summary / report that includes any arrangement for discharge or transfer of care;
- Relevant information from or regarding third parties where that information is necessary for the treatment and care of the service user e.g. family history/medical information regarding a relative.
- Completed consent forms should be kept with the patient's healthcare records. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and health professional.

6.3 Communication Needs

The Trust has signed up to the 'My communication and information needs passport' which should be completed if communication needs are identified working towards compliance with the Accessible Information Standard (SCCI 1605 Accessible Information)[5].

As part of the standard the Trust must do five things:

1. **Ask** people if they have any information or communication needs, and find out how to meet their needs

2. **Record** those needs in a set way on patient records in the 'My communication and information needs passport' (See Accessible Information Standard Policy) which should be filed at the front of the health record.

3. **Highlight** a person's health record, so it is clear that they have information or communication needs, and clearly explain how these should be met. This should be recorded on the alerts or demographics sheet in the health record and cross referenced to the section the communication and information needs passport is filed.

[5] https://www.england.nhs.uk/ourwork/accessibleinfo/

4. **Share** information about a person's needs with other Trust Teams/Departments, NHS and adult social care providers, when they have consent or permission to do so

5. **Act** to make sure that people get information in an accessible way and communication support if they need it.

6.4 Contemporaneous Health Records

The Trust expects that there will be accurate contemporaneous record-keeping in all formats regardless of which media they are held i.e. paper, electronic.

6.5 Record keeping standards (see Appendix 3)

Entries in health records both paper and electronic should:

- Be factual, consistent and accurate and where possible verified with the service user;
- Be written/typed as soon as possible after an event has occurred (usually within 24 hours), providing current information on the care and condition of the service user (if the date and time of the event differs from that of when the records are written/ typed up, this should be clearly documented in the body of the health record giving the reason for the delay);
- Be written/typed clearly, legibly
- Be written/ typed and filed in chronological order;
- Be complete i.e. have all demographics recorded i.e. service user first name and surname, any alias, date of birth, sex etc.;
- The use of abbreviations/ acronyms should be avoided, however, where they are used the health professional must be able to offer a full explanation e.g. when a service user requests access to their records;
- Be readable on any photocopies or scanned documents. Be written, wherever possible, with the involvement of the service user or carer and in terms that the service user or carer will be able to understand;
- Identify problems that have arisen and the action taken to rectify them;
- Provide clear evidence of the care planned, the decisions made, the care delivered and the information shared;
- Provide evidence of actions agreed with the service user (including consent to treatment and/or consent to share);
- Contain the NHS number which must be included in all clinical correspondence;
- Never be falsified

In addition, paper health records regardless of format should:

- Clearly identify the author of the entry should be clearly identifiable by printing their name and designation alongside the first entry or by using the signature bank;
- Be written in such a manner that any alterations or additions are dated, timed and signed in such a way that the original entry can still be read clearly;
- Be accurately dated and timed using the 24 hour clock;
- Include the service user's surname, first name, date of birth and local patient identifier and/or NHS number on each page;
- Be written in such a way that the service user can access and understand taking into account any communication needs identified for example; information could be produced in large print.

6.6 Health records should *not* include:

- Jargon, meaningless phrases, irrelevant speculation and offensive subjective statements;
- Personal opinions regarding the service user (restrict to professional judgements on clinical matters);
- The name(s) of third parties involved in a serious incident should only be included if necessary for risk management and future clinical care;

6.6.1 Paper health records should *not* include:

- Plastic wallets or polypockets;
- Loose paper or post-it notes;
- Correspondence generated from legal papers and complaints (see section 6.9).

NB. A summary of the record keeping standards can be found in Appendix 3.

6.7 Logging Queries in Health Records

If staff recognise that an error has occurred or there is an anomaly within the paper health record they are handling they should highlight this to a senior member of staff who should then log an incident and investigate the matter. The purpose of this is to make timely improvements to information quality by providing a record of quality issues for review and correction and identifying training gaps and weaknesses. Similarly if the error has occurred in the electronic patient record a call must be logged with the ICT Service Desk. A system is in place to merge any duplicate records in the PARIS EPR system.

6.8 Volumising procedure (i.e. splitting and cross-referencing oversized paper health records.

Paper health records should not be in excess of 8cms thick because they are unmanageable in the operational clinical area and should be therefore split into volumes as follows: -

1. The paper health record should be split on a chronological basis with the most recent documentation in the latest volume and the paper health record should be checked meticulously for current episodes of care as both an inpatient and an outpatient.
2. The newly created volume must contain the full risk assessment, care plans and most recent CPA forms and further information cross referenced to the previous volume. For information regarding Mental Health Act documentation please see Appendix 4.
3. The 'old' volume of paper health record should be checked for loose filing and all documentation secured to the body of the folder in the appropriate location.
4. The volumes should then be clearly marked "Volume 1", "Volume 2" on the outside front cover in the area provided with the start and end date of Volume 1 and the start date of Volume 2 being clearly recorded on the front cover of the paper health records.
5. Older volumes should be crossed through and "Volume Closed" written clearly on the front cover. No further documentation should be inserted into closed volumes.
6. The closed volume should have year of last attendance sticker affixed, which corresponds to the year of the last documented attendance in that volume. (nb. When culling paper health records for destruction, all volumes must be destroyed. This sticker will only refer to the date the retention period is calculated from if it is the last volume of paper health records.)
7. If the paper health records are tracked electronically this should be updated to indicate that there are multiple volumes.
8. The most recent volume should always be used and tracked electronically, where appropriate in the normal way.
9. If older volumes are requested these must also be tracked electronically, where appropriate.
10. All volumes should be retained in the borough that the client received the most recent treatment

6.9 Filing of Legal Papers and Complaints

a. Complaints

Where a patient or client complains about a service, it is necessary to keep a separate file relating to the complaint and subsequent

investigation. 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.

Where multiple teams are involved in the complaint handling, all the associated records must be amalgamated to form a single record. This will prevent the situation where one part of the organisation does not know what the other has done. It is common for the patient or client to ask to see a copy of their complaint file and it will be easier to deal with if all the relevant material is in one file. Where complaints are referred to the Ombudsman Service a single file will be easier to refer to. The ICO has issued guidance on complaints files and who can have access to them, which will drive what must be stored in them[6].

b. Mental Health Act

Reports prepared pursuant to the Mental Health Act, the Mental Capacity Act and the relevant Codes to those Acts including the deprivation of Liberty Safeguards will form part of, and should be filed in the paper health record or scanned and uploaded to the electronic patient record. (See Appendix 4 for MHA documentation)

c. Criminal Justice

On occasion documents will be received or prepared in relation to public or private family proceedings or as part of the Criminal Justice procedure. In most cases the disclosure of such documentation is strictly limited by law, and the documents do not form part of the health record. These documents may be filed within the Third Party section of the paper health record, if no such section currently exists in the file a Third Party divider should be added to the paper health record. Such documentation must not be disclosed without first obtaining advice from the Information Governance Manager. The unauthorised disclosure of such records may be contempt of court.

[6] https://ico.org.uk/media/for-organisations/documents/1179/access_to_information_held_in_complaint_files.pdf

6.10 Unregistered practitioners e.g. Students and Health Care Support Workers (HCSW)

When working with unregistered practitioners, such as student nurses or healthcare assistants, registered practitioners are accountable for ensuring the unregistered practitioner is competent to carry out any care delegated, and to document the care. If an unregistered practitioner is deemed competent this should be documented in their supervision records. The unregistered practitioner is then accountable for both the care provided and its documentation. It is not necessary for registered practitioners to countersign unregistered practitioners' recorded entries in patient notes (RCN, 2013), but they must regularly document their own on-going assessment and evaluation of patient's progress.
If the unregistered practitioner is not yet considered competent in record keeping then the entries made into the health records must be countersigned (NMC guidelines).

6.11 Monitoring

Management supervision will be the monitoring process for ensuring that a contemporaneous complete record of care is being adhered to. Any non-conformance to the required health care record standards will be addressed through management supervision. In addition service areas will be expected to complete local audits on an annual basis ensuring that a contemporaneous complete record of care is being documented within the health care record. Additional audits will also take place as identified in section 14 (Records Audit and Monitoring).

6.12 Checking information with service users

In order to maintain the integrity of information and to ensure that service user data remains as up to date as possible it is essential that staff check details held on the electronic records management system and any other key systems with the source. The source will usually be the service user (or their guardians), or may be their health records or clinical correspondence. These checks should occur whenever the service user presents or where their health records are being updated, for example:

- Outpatient appointments
- Home visits
- If the service user telephones to book an appointment
- On admission
- Whenever referrals are received via GP letters, as GP's are often the first to know about changes of address etc.

7. Record Maintenance including tracking and record movements

7.1 Hospital & RHSD mental health paper health records are currently tracked using the Trust's electronic tracking functionality in PARIS. Guidance on tracking of hospital paper health records can be obtained from the ICT Department. Paper health records are created on PARIS, starting at volume 1 and as additional physical volumes created the electronic system should mirror the physical volumes. On creation of the volumes a storage location is chosen from the drop down menu e.g. the local records library. When a verbal request is made to the current location of the paper health records, the volume requested is electronically tracked to the requesting location. The paper health records should be received into the new location. When this location has finished with the paper health records they should be dispatched back to the library or to their next destination.

7.2 Healthy Young Minds (CAMHS), Drug & Alcohol, Community, Learning Disabilities and Healthy Minds (Psychological Therapies) are required to use manual tracking systems for any paper records still in use such as 'tracer cards' (for an example see Appendix 5) or 'booking in/out' books.

7.3 Tracking mechanisms should record the following (minimum) information:

- NHS number or local identifier ;
- Volume number;
- Surname & forename(s);
- Date of birth;
- The person, unit or department, or place to whom it is being sent;
- The date and time of the transfer;
- Method of transportation i.e. by hand including the name of the healthcare professional who has taken them; internal post, special delivery or courier;
- Purpose removed for.

7.4 Transferring notes between boroughs

When a patient is being transferred between boroughs all volumes should follow the patient and therefore the onus is on the 'home' borough to arrange the safe transportation of paper health records to the receiving borough in a timely manner.

7.5 24 hour / 7 day retrieval of paper health records

Retrieval of paper health records outside office hours can be made by contacting the Senior Nurse/bleep holder on call via the main hospital switchboards. Each area should have a 24/7 access to paper health records procedure in place.

7.6 Missing Record Procedure

The Missing Record Procedure provides a consistent approach to searching and reporting missing paper health records. This procedure should be used when a health record is unavailable when it is required for use either clinically or for administration purposes. If one record is reported as unavailable then it would be reported as per the Incident Reporting, Management & Investigation Policy (CO10) as a Grade 4 incident and the Missing Record Procedure as laid out in the Missing Record Procedure CO28 must be followed. If multiple records are reported as missing at any one time then an Investigation Report (IR) must be completed as per the Incident Reporting, Management & Investigation Policy (CO10).

7.7 Tracking systems should be reviewed / implemented in liaison with the Information Asset Administrator (IAA).

7.8 All tracking systems will be monitored and reviewed by the Records Manager or Information Asset Administrator's on an annual basis.

7.9 Any paper health records tracking issues highlighted via services or via the Trust incident reporting mechanism will be regularly reported to the Records Manager who would develop an action plan. Any themes would be monitored by the Information Asset Manager's (IAM's) and IAA's who would agree the action plans on a quarterly basis.

8. Access and Disclosure

8.1 Transferring Health Records or Information

The Information Sharing Policy and the Confidentiality Policy contains the guidance for sharing information with other health professionals or NHS bodies. If a team or external organisation requires access to clinical information this can be provided without consent where, as stipulated in the Data Protection Act 1998,

'"The processing is necessary for medical purposes (including the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of health care services) and is undertaken by – (a) a health professional; or (b) a person who owes a duty of confidentiality which is equivalent to that which would arise if that person were a health

professional." This would therefore include admin staff, social care staff, probation, prison etc.

The key is that it must be for a medical purpose.

The patient should be made aware of and not object to the disclosure. This will enable compliance with the common law duty of confidentiality.

8.2 Copying of Health Records

Procedures to be followed when dealing with requests for access to health records as laid down by the Data Protection Act 1998, in relation to living individuals and the Access to Health Records Act 1990 in relation to requests made on behalf of the deceased are to be found in detail in the Access to Health Records Policy (CO2)

If a service user is being assessed by or receiving treatment outside of the Trust, relevant documentation can be copied and sent to the health professional concerned by the local health professional involved with the client. Original paper health records must not be sent outside of the Trust unless agreed with the Caldicott Guardian.

8.3 Collating Records Following the Death of a Service User

Wherever possible, following the death of a service user, paper health records should be collated and filed together. The paper health records should be marked 'deceased' and a date of death added.

In the event of a serious untoward incident (SUI) involving a client relating to a sudden unexplained death, homicide, or a child safeguarding case it is the responsibility of the Trust to ensure that the paper / electronic health records are secured or locked down to prevent any alterations being made that could have an adverse impact on members of staff involved in the care of that client or any other person e.g. client, carer or other party. The service can make a copy of the notes but the originals must be sent to the requestor within one working day which is either corporate governance or the legal department. The paper health records should be marked with a 'Do not destroy' sticker on the cover.

8.4 Drawings / Pictures

Drawings or artwork that has been provided by the service user during the course of their treatment can be returned to the service user on request.

9. Storing Current Paper Records

When a record is in constant or regular use, or is likely to be needed quickly, it makes sense to keep it within the area responsible for the related work. Storage equipment for current records will usually be adjacent to users i.e. their desk drawers or nearby cabinets, to enable information to be appropriately filed so that it can be retrieved when it is next required. Records must always be kept securely and when a room containing records is left unattended, it should be locked. A sensible balance should be achieved between the needs for security and accessibility. If non Pennine Care staff have access to your building during the day or out of hours then records must be secure either in a locked filing cabinet or locked roller racking or in a locked records library.

There is a wide range of suitable office filing equipment available. The following factors should be taken into account:

- Compliance with Health & Safety regulations (must be the top priority)
- Security (especially for confidential material) e.g. lockable filing cabinets made of a fire resistant material
- The user's needs
- Type(s) of records to be stored
- Their size and quantities
- Usage and frequency of retrievals
- Suitability, space efficiency and price.

On no account should records be left unattended in consulting rooms or patient accessible areas.

10. Closure and Transfer

10.1 Paper health records in transit

Pennine Care NHS Foundation Trust original paper health records should not be sent outside of the Trust. Any external organisations requiring access to the health records must either view them on Pennine Care premises or be sent a photocopy as referenced in the Access to Health Records Policy (CO2) or the Information Sharing Policy (CO13).

10.2 Safe Transportation of Health Records

- If paper health records are being delivered to another location they should be enclosed in tamper proof envelopes or satchels and sealed for transfer. Any paper health records that may be damaged

in transit should be enclosed in suitable padding or containers. For secure internal transport of paper health records please use form (Appendix 8).

- The procedure and associated forms for sending paper health records externally by Royal Mail Special Delivery or by secure courier can be found in Appendices 6 - 9.
- For larger quantities, paper health records should be boxed in suitable boxes or containers for their protection. All archive boxes should be labelled with a list of contents and destruction year.
- Each box or tamper proof envelope should be addressed clearly and marked confidential with the senders name and address on the reverse of the envelope.
- If paper health records are to be transported via secure couriers; only contracted couriers should be used, who have agreed to the information governance arrangements around Data Protection. A signature should be obtained on collection & delivery of paper health records (please see Appendix 9)

10.3 ***Taxi's should not be used to transport paper health records.***

10.4 Taking paper health records off site

- Consideration must be given to whether clinicians need to take the health record offsite in the first instance and then also if the whole record is necessary.
- However, it is recognised that there is a need for clinicians or senior management staff to take paper health records off-site as part of their work. In order to manage this process and ensure staff have been made aware of their responsibilities to ensure security of the paper health records there is an authorisation form at Appendix 10 that should be completed. The form would only need to be completed as a one-off and not each time health records are taken off-site unless it is a temporary requirement. This form will remain in the supervision file.
- Security of these health records should be paramount. Ideally, only those paper health records required for visiting service users in the community should be removed and not for general administration purposes e.g. writing reports.
- Common sense in relation to the security of paper health records should be used when taking them off-site. Consideration should be given to storing the health records safely within your vehicle so that they cannot be seen. Try to plan your journey so that health records are not left unattended however, if this is unavoidable they must be secured within the vehicle e.g. locked in the boot.

- **Paper health records/ person identifiable information must not be left in the vehicle overnight.**
- When travelling on public transport paper health records must be stored out of sight, in a suitable secure bag and must be closely monitored.
- **If the paper health record is to be taken home (with the approval of the line manager), they must be stored securely within the home.** Care must be taken in order that other members of the family or visitors to the house cannot gain access to the health records.
- Staff must return health records to the department prior to commencement of annual leave or leaving the Trust.
- It is essential that any such health records are tracked out of the department so that staff are aware of the location of the record. See Tracking Records (Section 7).
- Paper health records should be carried in an appropriate case and not carried 'loosely', as this increases the risk of dropping the record and losing some of the contents.
- Health records / reports / letters should be kept in a sealed envelope or tamper proof bag and marked 'private and confidential'.
- Consideration must be given as to whether it is necessary to transport the record at all. For example, at the end of a tribunal meeting reports should be handed in to be confidentially destroyed.

11. Appraisal

Appraisal refers to the process of determining whether records are worthy of permanent archival preservation**.** Please see the guidance in the Retention Schedule CO98.

11.1 Marking health records for permanent preservation

The IAA's are responsible for ensuring staff are aware of the mechanism in place for identifying and marking these health records to ensure they are not destroyed. The paper health record will be labelled with a fluorescent green label marked DO NOT DESTROY to ensure that when health records are being appraised before destruction they are easily identifiable.

11.2 Electronic Health Records

Electronic records can be appraised if they are arranged in an organised filing system which can differentiate the year the records were created and the subject of the record. If electronic records have been organised in an effective file plan or an electronic record keeping system, this process will be made much easier. Decisions

can then be applied to an entire class of records rather than reviewing each record in turn

11.3 Appraisal of Healthy Young Minds (CAMHS) health records

Once a Healthy Young Minds (CAMHS) health record has reached the end of its retention period, i.e. 20 years from the date of last contact, or until the child's 26th birthday, whichever is the longer period; before it can be destroyed it is necessary to check if the service user is now known to Adult services.

If the Healthy Young Minds (CAMHS) service user is not known to adult services when the end of the retention period is reached the Healthy Young Minds (CAMHS) health record can be destroyed in line with the recommended retention period

If it is found that the Healthy Young Minds (CAMHS) service user is known to Adult services the paper health record must be retained in line with the adult paper health record.

12. Archiving

12.1 Storage of paper archived health records

When paper health records become 'inactive' (i.e. patients are discharged from a service) there is a period of time that they will be retained within the service due to the likelihood of patients being re-referred to the service and therefore it is essential that the service has the paper health records easily accessible. This period of time will be determined by the service depending on availability of storage space within the services and is usually 5 years for Mental Health & Specialist Services. When paper health records are no longer required to be retained within the service, the records are archived and thus become 'archive health records'.

12.2 Off-site storage of paper archived health records.

Once the paper health records have been 'inactive' for 5 years they can be sent for external off-site storage (any exceptions must be agreed with the Records Manager). The procedure for sending archive paper health records to offsite storage can be found in Appendix 11 and the flowcharts explaining summarising this can be found in Appendix 12, 13 & 14.

12.3 Deceased paper health records

Once a complete paper health record of a deceased client is ready i.e. contains all the necessary filing and documentation it can be sent to the Deceased library as appropriate. Paper health records are stored onsite for up to 8 years in the Deceased Library . Any IRAF's should

be retained by the service for 2 years. See Appendix 15 for the procedure for sending paper health records to the Deceased Library.

12.4 Do not destroy paper health records

These are sent to offsite storage for permanent preservation; please see the procedure for sending archive paper health records to offsite storage can be found in Appendix 11.

13. Disposal

(NB Currently retaining all records because of the Independent Inquiry into historical child sexual abuse)

13.1 Paper records

When health records are destroyed a record should be kept of the service user's name, a description of the record and the date the record was destroyed. This list of destroyed records should be retained permanently and held securely within the department/ service area. A template has been provided on the Records Management Homepage: http://portal/ig/recordsmgt/Pages/default.aspx.

It is important that confidentiality is safeguarded at every stage and that the method used to destroy paper health records is fully effective and secures their complete illegibility. A reputable disposal company should be used to remove confidential waste and will provide confidential waste bins or bags for removal.

13.2 Electronic Records

Records management is concerned with accounting for information so any destruction of hard assets, like computers and hard drives and backup tapes, must be auditable in respect of the information they hold. An electronic records management system will retain a metadata stub which will show what has been destroyed.

The ICO has indicated that if information is deleted from a live environment and cannot be readily accessed then this will suffice to remove information for the purposes of the DPA. Their advice is to only procure systems that will allow permanent deletion of records to allow compliance with the law.

14 Training and guidance

Record keeping training is provided to all staff who handle clinical records. The training is mandatory and must be repeated every 3 years.

Record keeping training is monitored through reports given to managers and the Information Governance Assurance Group.

15. Records Management Audit & Monitoring

The Trust will audit its records management practices by carrying out an annual Record Keeping Audit of the paper record, which evaluates practice and promotes high standards of health record documentation.

16. Review

This protocol will be reviewed by the Records Manager every two years (or sooner if new legislation, codes of practice or national standards are to be introduced).Any revisions of this policy will need to be approved at the Information Governance Assurance Group (IGAG) and will be ratified by the Executive Directors.

17: Associated Policies, Protocols and Procedures

CO2 - Access to Health Records Policy

CO4 - Confidentiality Policy

CO10 - Incident Reporting, Management & Investigation Policy

CO11 - Information Security Policy

CO13 - Information Sharing Policy

CO20 - Records Management Policy

CO27 - Freedom of Information Act Policy

CO28 - Missing Records Procedure

CO40- Production of Information for Patients Policy

CO44- Information Governance Policy

CO51- Electronic transfer of Person Identifiable Data Policy

CO59- Data Protection Policy

CO62- Protocol for the Management of the Removal/Transfer of Records & Information Storage Equipment when Moving Premises/ Location

CO94 – Procedure for scanning and uploading documents to clinical information systems

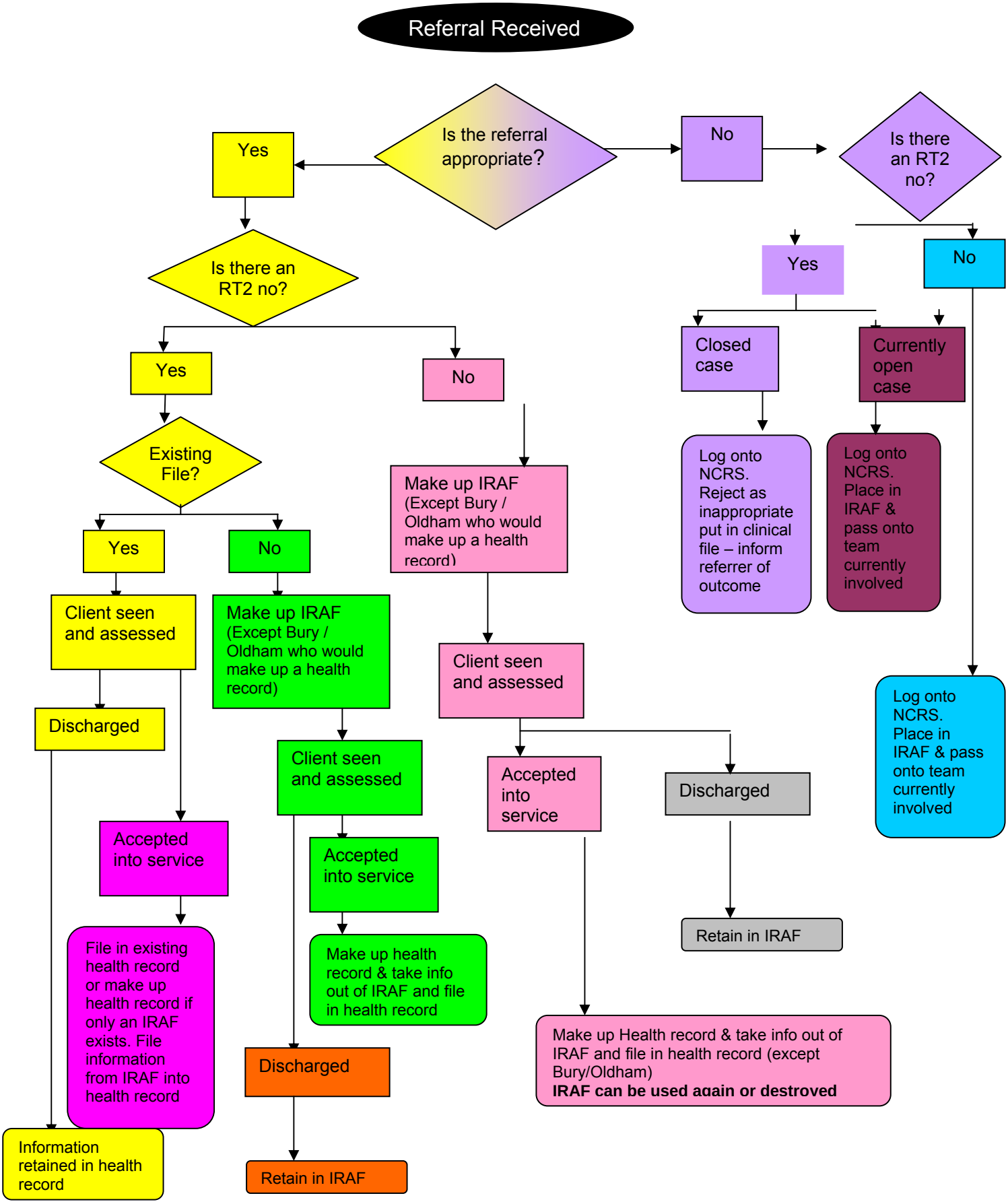
CO95 - Procedure for the transition from paper to electronic records and how to volumise.

CO98- Guidance for the retention of all clinical and corporate records

CL22- Protocol for the transition of patients from CAMHS to Adult Mental Health Services

HR46 - Clinical Supervision Policy

Appendix 1


Referral Received
Is the referral appropriate?
Yes
No
Is there an RT2 no?
Yes
No
Is there an RT2 no?
Yes
No
Closed case
Currently open case
Log onto NCRS. Reject as inappropriate put in clinical file – inform referrer of outcome
Log onto NCRS. Place in IRAF & pass onto team currently involved
Log onto NCRS. Place in IRAF & pass onto team currently involved
Existing File?
Yes
No
Client seen and assessed
Discharged
Accepted into service
File in existing health record or make up health record if only an IRAF exists. File information from IRAF into health record
Information retained in health record
Make up IRAF (Except Bury / Oldham who would make up a health record)
Client seen and assessed
Accepted into service
Make up health record & take info out of IRAF and file in health record
Discharged
Retain in IRAF
Make up IRAF (Except Bury / Oldham who would make up a health record)
Client seen and assessed
Accepted into service
Discharged
Retain in IRAF
Make up Health record & take info out of IRAF and file in health record (except Bury/Oldham)
IRAF can be used again or destroyed

Appendix 2

The 6C's of Record Keeping

Contemporaneous	**Right here …. write now** ➢ Documentation must be completed as soon after the event as is possible; reliance on memory will not protect you in the witness box
Continuity	**Tell the story…..'welcome to this patient's journey'** ➢ Produce an audit trail ➢ Remember to date and time (24 hour clock) all entries. Identify your patient correctly on each side of the notes (copies of each side may be made)
Correct	**Clear writing; clear message; clear communication; clear conscience** ➢ Write legible, accurate and factual notes; do not express opinions unless you have the expertise to substantiate them
Claim	**Your records; your registration…..own your records** ➢ Always include your name, designation and sign your entries ➢ If you make an error, own it – put a single line through it and initial it. If it is a *significant error* – put a single line through it, sign, date and time it
Candour	**Discontinue; document; share and treat** ➢ Preserve patient Safety. Remember, record-keeping is an aspect of patient care and should not simply identify a problem, but also signify escalation and progression of care
Contain	**Write safe; store safe** ➢ Confidential and correctly stored records are paramount ➢ Store all records according to Trust policy

Appendix 3

Pennine Care NHS
NHS Foundation Trust

Record Keeping Standards for paper health records
All entries in the health records are **signed**
The **signature** is **printed** alongside the 1st entry (or in the signature bank/stamp)
The **designation** is **printed** against the 1st entry (or in the signature bank/stamp)
The entry is accurately **dated** and **timed** using the **24 hour clock**
The entry is written in permanent **black** ink
The entry is **legible** (is clearly written / typed and can be read without difficulty or ambiguity), **accurate and complete**
Allergies, risks and sensitivities are recorded on the inside of the front cover in the section provided. No known allergies are also recorded.
Any **alterations or additions** are dated, timed and signed. The original entry can still be read clearly
Jargon, meaningless phrases, irrelevant speculation, offensive or subjective statements are avoided
The **NHS Number** is on all history sheets
The service user's **name** (both first name and surname) is on all sheets
The service user's **NHS number** is on **all clinical correspondence**
All **demographics** are recorded i.e. **service user first name** and **surname, any alias, date of birth, sex, ethnic category, religion, disability, address and postcode, telephone number, GP Practice, NHS number, local identifier, next of kin or emergency contact name etc.**
It is recorded whether the patient has a **child** within the family, in the household or cared for by a patient. For any child, their **surname, first name address, age, primary carer, GP, school** are recorded
There are **no plastic wallets** or **polypockets** in the paper health record. Attachments should **not be stapled** to the front cover
The paper health record is **robust** (it is in a good state of repair with no tears). Hole reinforcements are used when necessary
Machine produced recordings are **mounted** and **securely stored**
Health records are **not in excess of 8cm thick** (as they become unmanageable and should be split into volumes)
Volumes must be **numbered** appropriately and the newly created volume must contain the full risk assessment, care plans and most recent CPA forms and further information cross referenced to the previous volume
All Hospital health records must be **tracked** electronically. All other health records should be tracked according to your current practice

Appendix 4

Pennine Care NHS
NHS Foundation Trust

Guidance for staff responsible for archiving volumes of patients notes – Mental Health Act Documentation

Following a Care Quality Commission visit the Commissioner documented that he was unable to check the legality of a patient's detention as all the documentation regarding their current/on-going detention period was not available in the file.

All documentation regarding the patient's current/on-going detention and treatment needs to be accessible in the current volume of the patients' medical notes on the ward, and therefore brought forward when a new volume is created. The following has been produced to help with this process. This guidance should be used in conjunction with a current Mental Health Act ward summary/ward view, which can be obtained from your MHL office.

The following documentation listed below should be brought forward into the current file. There may be a mixture of pre and post forms this will depend on the detention period.

If the patient's detention period started after 3rd November 2008 – Current Statutory MHA Forms

Original detention papers S3
1 x A6 Application
1 x A7 Joint medical recommendation or
2 x A8 Form 11 Single medical recommendation
1 x H3 Record of detention in hospital

Renewal forms - H5 the initial section papers above will expire following 6 months from receipt of the H3. At every renewal point there should be a further form H5.

Transfer forms
H4 for transfers between different Trusts
Form 19(3) for transfers between Pennine Care Sites.

If the patient's detention period started prior to 3rd November 2008 – Old Statutory MHA Forms

Original detention papers S3
1 x Form 9 Application
1 x Form 10 Joint medical recommendation or 2 x Form 11 Single medical recommendation
1 x Form 14 Receipt

Renewal forms Form 30 - the initial section papers above will expire following 6 months from receipt of Form 14. At every renewal point there should be a further Form 30 and then yearly renewals. Following the 3/11/08 these will become a H5 form.

Transfer forms Form 24 for transfers between different Trusts
Form 19(3) for transfers between Pennine Care sites.

Forms relating to all detention periods

Treatment Forms

This should be the current form in place. The date and type of form can be found on the ward summary in the Consent to treatment column. There should be no laminated copies of treatment forms within the notes. Superseded forms should have been struck through so it is obvious they are no longer in use. It is usually that these forms will either be a T2 or T3.

The current capacity and consent form should also be brought into the current file again the date of this form is found on the ward summary/ward view information.

S132 rights

S132 rights are usually filed in the Nursing notes to assist in the revisiting of patient rights. The latest form should be brought forward in the current nursing notes to ensure that this can continue.

You do not need to bring forward any of the following.

Tribunal and Hospital Managers reports
Letters regarding forms or dates of hearings
Second opinion request forms
Hospital managers decision forms
Tribunal decisions.

Appendix 5

Tracer Card

Pennine Care NHS
NHS Foundation Trust

(Can be used for health or personnel records)

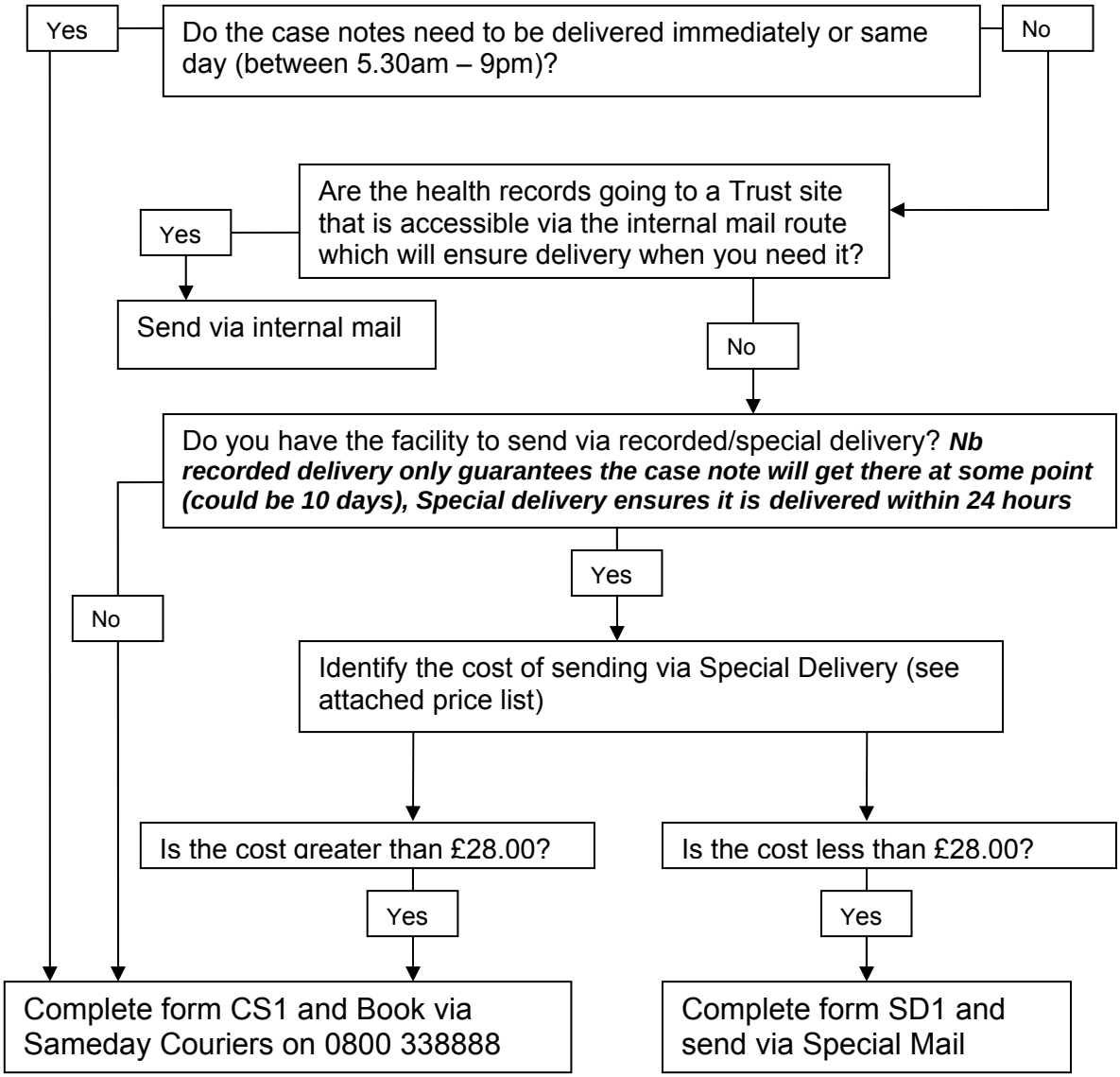
Surname:	**Forename:**	**Date of birth:**	**NHS or Employee Number:**				
Taken by (name and contact no.)	Destination	Date out	Date returned	Taken by (name and contact no.)	Destination	Date out	Date returned

Appendix 6

Pennine Care NHS
NHS Foundation Trust

PROCEDURE FOR SENDING HEALTH RECORDS (ORIGINAL OR COPIES)

In order to ensure the safe transportation of health records the Trust has implemented a courier provider service to transport health records in the Greater Manchester area that are not covered by the Trust internal mail delivery system. Should you need to send health records or copies the following procedure applies:



NB. Tamper proof envelopes or suitable cover should be used at all times to ensure confidentiality of health records. PLEASE ENSURE THE ENVELOPE CONTAINS THE FULL ADDRESS OF THE DELIVERY LOCATION IN ADDITION TO THE COMPLETED FORM.

Appendix 7

Pennine Care NHS
NHS Foundation Trust

FOR INTERNAL USE ONLY

CONFIDENTIAL/SENSITIVE DATA MAIL FOR HAND DELIVERY VIA THE INTERNAL POSTAL ROUTE i.e., Borough to Borough.

Please complete this form for any mail to be hand delivered within the internal postal route by the Trust HQ Postman *(the form should be stapled to the envelope/parcel)*

REQUESTED BY: ……..(Please print name)

Tamper proof envelope code no(s).	
Contents: e.g. health record identifier and volume (DO NOT USE PATIENT INDENTIFIABLE INFORMATION)	
Delivery location:	

Signature on collection:		
Print name:		***Date***

Signature on delivery:		
Print name:		***Date***

Appendix 8

Pennine Care NHS
NHS Foundation Trust

HEALTH RECORDS TO BE DELIVERED VIA ROYAL MAIL SPECIAL DELIVERY

Contact Name: …….. Tel No. ……

Job Title: ……Location: …….....

……

Signature:…… Date: ……

FOR DELIVERY TO:

Name:
……

Full Address

……

…….Postcode: ……

To arrive by 9am ☐

1pm ☐

Nb. If not ticked delivery by 1pm will be assumed

Tamper Proof Envelope code number	

Cost of postage: …… **SD1**

Appendix 9

Pennine Care NHS
NHS Foundation Trust

HEALTH RECORDS FOR HAND DELIVERY VIA COURIER SERVICE

Date:

Pickup and delivery: Urgent (immediately) ☐
Same day (between 5.30am and 9.00pm) ☐
Within 24 hours (from receipt of form) ☐

PICK UP ADDRESS (***please give FULL address,*** *including postcode****)***

……

…… Closing time of pick up point ……

Contact Name: …… Tel No. ……At pick up point

Contact Name: …….. Date: ……Of person booking

Signature: …… Date: ……

Booking area : Healthy Young Minds ☐ Drug & Alcohol Team ☐ Forensic and High Support ☐ Trust HQ ☐ Bury ☐ Oldham ☐ Rochdale ☐ Stockport ☐ Tameside ☐

Signature of Courier: …… Job no. ……..

(provided by Courier)

Date and time of pickup: ……

FOR DELIVERY TO:

Name: ……Tel No. ……

Full Address
……

……Postcode: ……

Closing time of delivery address: ……

No of parcels/boxes	
Cost (given by courier)	
Tamper Proof Envelope code number	

SAMEDAY PLC COURIERS 0800 338888 CS1

Appendix 10

Pennine Care NHS
NHS Foundation Trust

AUTHORISATION FORM
FOR TAKING RECORDS OFF SITE

I request authorisation to take the below mentioned records off-site in order to carry out the duties of my post. I have read and agree to abide by the guidance in the Protocol for Mental Health & Specialist Services Health Records on taking records off-site (section 8).

Signed: ……..

Name: Job Title:

Location: Date:

Reason for taking records off-site:
e.g. home visit

Record type:
e.g. Community record

I authorise the above named member of staff to take the above records off-site (please tick one of the following options).

☐ This is a one-off authorisation for all records of this type necessary to carry out the duties required of the post.

☐ This authorisation is temporary in order for the above staff member to carry out the duties required of the post, from ……..(date) to …….(date)

Signed: ……..

Line Manager Name: Job Title:

Location: Date:

(To be filed in staff supervision file)

Pennine Care NHS
NHS Foundation Trust

Archiving Paper Health Record Procedure for Mental Health & Specialist Services

1. Introduction

The procedure was developed to support Pennine Care NHS Foundation Trust Mental Health & Specialist Services manage the archive and retention process for paper health records ensuring that essential documents are retained and disposed of in line with Trust policy and good practice. This document should be read in conjunction with the Trust Records Management Policy (CO20), the Protocol for the Management of Mental Health & Specialist Services Health Records (CO93) and Guidance for the Retention of all Clinical and Corporate Records (CO98).

The retention of health records is an essential part of the record lifecycle process. All NHS organisations are duty bound to keep NHS records for a minimum number of years. Health records are required to be kept for a certain period either because of statutory requirement or because they may be needed for administrative purposes during this time.

2. Rationale

Compliance with the Freedom of Information Act 2000 and the Data Protection Act 1998 require robust records management. This document supports compliance with CQC, NHS Litigation Authority and Information Governance Alliance standards for the maintenance and storage of records.

3. Aims

The aim of this guidance is to disseminate good practice, create uniformity across the Trust, raise awareness and achieve compliance with the required standards. Paper health records from Mental Health & Specialist Services will only be considered for off-site storage if they have been closed for a period of 5 years. This is because it is expensive to retrieve health records when they have left Pennine Care and stored off site.

4. Scope

These guidelines cover all health records/information in all media types. Deceased health records will continue to be archived at Newton Wood House.

This procedure refers to archiving at the external facilities procured by the Trust.

5. Procedure for archiving paper health records

5.1 Preparation of records for archiving

Each service is responsible for keeping a detailed electronic inventory of the health records sent to off-site storage.

When health records are due to be archived it is essential that retention periods are clearly indicated for the health records that are to be archived. Services should consult the Trust's retention schedules and where required liaise with the Records Management department to ensure that health records are retained in line with the good practice**.**

All volumes for an individual client should be secured together in the same box for that service/department. The patient's NHS number and the date of birth must be included to enable cross referencing to their electronic record and other paper records.

5.2 Archive Year

Adult health records
Health records should be considered for off-site storage after the client has been discharged for 5 years in Mental Health & Specialist Services. For all health records except those relating to children; the archive year is the calendar year in which the last entry was made. The review date is calculated from the **date of the last entry in the record.** The review date is the January in the appropriate number of years later. For example a health record with the last entry during April 2013 with a 20 year retention period will be due for review for destruction in January 2034. **Only records with the same review date should be stored in the same box.** Do not include health records with different years of discharge in the same box unless agreed with the Records Manager. This is to simplify review and facilitate easy review and destruction.

Healthy Young Minds (CAMHS) Health Records
The retention period for children's health records is calculated from the birth date of the child, and so should be archived by year of birth. Health records for children up to the age of 17 years of age should be retained until the year of their 26th birthday.

Corporate Records such as Financial
For financial and some administrative records it is more appropriate to archive by financial year (FY) i.e. 1st April to 31st March. Boxes of such records should be marked with financial year (e.g. FY 2009-10). The review date will be 1st April of the year appropriate to the type of record.

Diaries (clinical) - The owner's name, service and base must be written clearly on the diary. At the end of the year diaries should be collected and stored securely at the service base. Diaries should be securely destroyed after 2 years. Diaries should not be used for the recording of clinical information. However, if such information is in a diary it must be copied into the patient's health records (to enable the diary to be destroyed).

6. Obtaining Archive Boxes

All health records destined for off-site storage should be stored in approved off-site storage archive boxes. These should be ordered via the: http://portal/ig/recordsmgt/Pages/default.aspx on the intranet. **On no account should crates or transfer cases be sent for commercial**

storage due to the greatly increased costs involved. For health and safety reasons archived boxes should be of a size and weight which can be moved and carried by a member of staff.

7 Preparing and packing the health records

7.1 Tidy up the health records

Health records should be 'weeded' or "culled" before archiving. This means removing documents which have no archival value (e.g. duplicates). Records should remain intact in their original folders. Any loose documentation should be removed from lever arch files, box-files, binders; and plastic wallets and secured together. Ensure all the papers contained within the health record relate to the patient whose name is on the front of the health record. If documents are misfiled this may make retrieval impossible and result in the wrong health records being destroyed or preserved for longer than the retention schedule recommends. Ensure there are no loose sheets, paper clips or elastic bands within a file. Secure if necessary with a treasury tag. Where practicable, papers stapled together. Copies of health records already held elsewhere should not be archived.

7.2 Arrange health records by retention /destroy date

Ensure health records placed in the box have the same retention period (destroy date).

7.3 Place health records into the boxes in alphabetical order

Do not over pack the boxes or place too many health records within it – the lid must fit securely

7.4 Cataloguing contents of the boxes to be archived in off-site storage

A detailed inventory is required of the contents of each box; one copy in the box is retained in the box, a second electronic version kept by the department/service and copy emailed to art.helpdesk@nhs.net

Commence inputting. **Ensure the information is as accurate as possible**.

▼

Ensure names are spelt correctly

▼

Input the NHS number.

▼

Dates of birth should always follow the DD/MM/YEAR format, being aware that forward slashes should always be used and not full stops

▼

The date of discharge should follow the same format as the date of birth.

▼

On satisfactory completion, print a copy of the list, place in the box and leave ready for another member of staff to quality check.

If an amendment is required to a box that has already been indexed, all copies of the contents list must be updated. Once the boxes have been inventoried, quality checked, staff should **NOT** remove health records from the boxes.

7.5 Templates

Archiving spread sheets can be found on the Records Management page on the intranet**:**
http://portal/ig/recordsmgt/Pages/default.aspx

7.6 Referencing Archive Boxes

All boxes must be clearly **labelled.**
All boxes should have a bar code which is cross referenced to the spread sheet.
If boxes are received without the required information they will be returned to the Team.

7.7 Quality Control

The records continue to belong to the service even though they are archived. For retrieval purposes it is absolutely necessary that the spread sheets match the contents of the boxes. Before the boxes are sent to the Archiving Records Team it is necessary to double check the contents of the boxes and also send a copy of the spread sheet to art.helpdesk@nhs.net and retain a copy within your department.

8. Sending health records to the off-site storage

Contact the Helpdesk function at art.helpdesk@nhs.net

9. Quality Assurance

10% of all boxes will be checked by the records management team to see if the box contents match the spread sheets. If there are any discrepancies then the records management team reserve the right to return the boxes to services to make corrections.

10. Retrieval of archived health records from off-site storage

Records stored in the off-site storage company archive may be retrieved by the requestor by completion the retrieval form available on the intranet: : http://portal/ig/recordsmgt/Pages/default.aspx stating box number, name, NHS number and date of birth of the record, reason for requesting and the urgency of the request by contacting the Helpdesk function at art.helpdesk@nhs.net . The individual file or box containing the record will be delivered to the site.

A tracer should be left in the box to show when a paper health record is retrieved, giving the date of retrieval and contact details, document title (and/or other relevant information to identify the record which has been

retrieved or and patient's details (health records). The return date should also be recorded.

In most circumstances health records can be retrieved from commercial storage the next working day (and in an emergency can be retrieved the same day, although this has cost implications and should be avoided unless absolutely necessary).

The helpdesk function will monitor the retrieval of boxes to ensure this is not excessive resulting in increased costs. Services with retrievals from off-site storage of more than 10 boxes of records per month are considered to have very high retrievals rates. These services should liaise with the Records Manager to explore the possibility of receiving their health records from the off-site storage company via a scan on demand option as this may be a more cost effective solution.

11. Permanent withdrawal of boxes from off-site storage

If any box is retrieved permanently from commercial storage the Service/ Department Manager must inform both the Records Manager and the storage company that the retrieval is permanent. Failure to do so will incur unnecessary continued storage charges. (Permanent retrieval also incurs a retrieval charge.)

12. Returning boxes to the off-site storage

The records management function will liaise with the offsite storage provider to organise the return of the boxes.

13. Review and destruction of records

Health records stored in off-site storage must be reviewed at least annually, usually in January or April, to identify those records whose retention period has expired. The helpdesk will contact Service/Departmental Managers who will then need to authorise disposal. Health records must be destroyed via confidential waste.

Destruction of confidential records must be secure and complete. A destruction log must be kept. This can be found on the Records Management Homepage: http://portal/ig/recordsmgt/Pages/default.aspx

Health records must therefore be destroyed by shredding, combustion or pulping. Destruction certificates should be retained to provide legal proof of destruction in case the records are subsequently requested for disclosure, litigation purposes or under Freedom of Information or the Data Protection legislation.

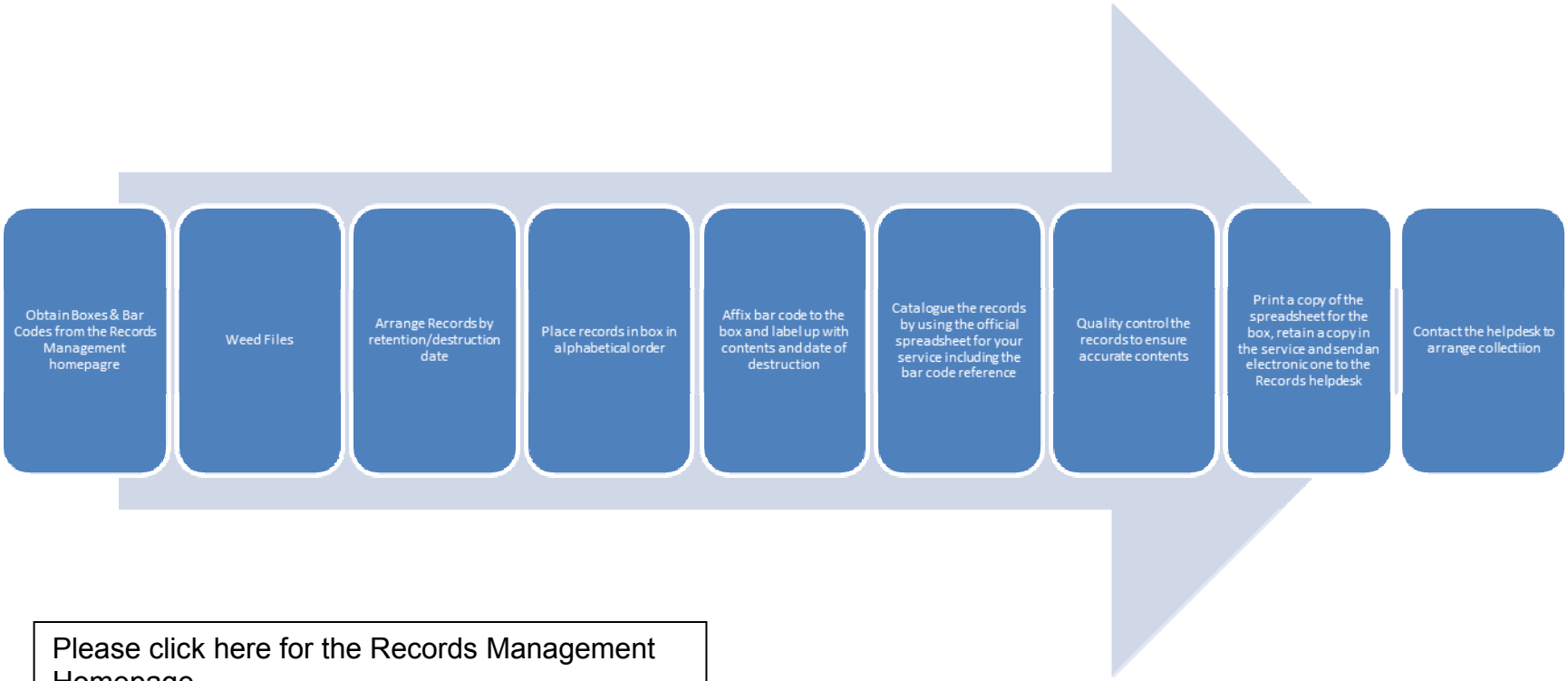
The following should be recorded: a list of the health records destroyed, when this took place, the name of the person who authorised destruction, who carried out the process and the reason for destruction.

If a health record is inappropriately destroyed (e.g. a record which is subject to a request under the Freedom of Information or Data Protection Acts) the appropriate Service or Department Manager must record this as an incident on Safeguard and carry out an investigation.

Appendix 12

Off-Site Archiving Records Procedure

Flowchart



Please click here for the Records Management Homepage
http://portal/ig/recordsmgt/Pages/default.aspx
For further help and advice, please contact:
helpdesk.art@nhs.net

Appendix 13

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PROCEDURE FOR SENDING PAPER HEALTH RECORDS TO THE DECEASED LIBRARY

- All health records to be sent to the archived records department should have the NHS number written on the front cover of the record
- Deceased health records should be less than 8 years old and clearly marked with date of death
- All archived paper health records must be clearly identified for example, “Rochdale Outpatients, Deceased June 2014”
- All archived health records must have a clear destruction date in accordance with the Retention & Disposal Schedules in the Records Management Policy
- All archived health records must have a full inventory made with a copy enclosed in the Archive Box and a copy retained by the owner to allow them to request retrieval of the records
- All archived health record boxes must be labelled with a broad description of the contents, e.g. deceased records, borough or department and a destruction date.
- For health & safety reasons all archived boxes should be of a size and weight which can be moved and carried by a member of staff
- All health records other than hospital records should be manually tracked to Deceased Filing Room.
- All hospital health records should be tracked, where possible using PARIS:
- **Process for tracking on NCRS**

  The physical health records should be tracked on NCRS.
  The storage location and Storage Service Point should be tracked to:
  - ***Storage Location – Archiving Records Team***
  - ***Storage Service Point – Deceased Filing Room***

- For safe transportation of records please liaise with helpdesk.art@nhs.net

Appendix 14

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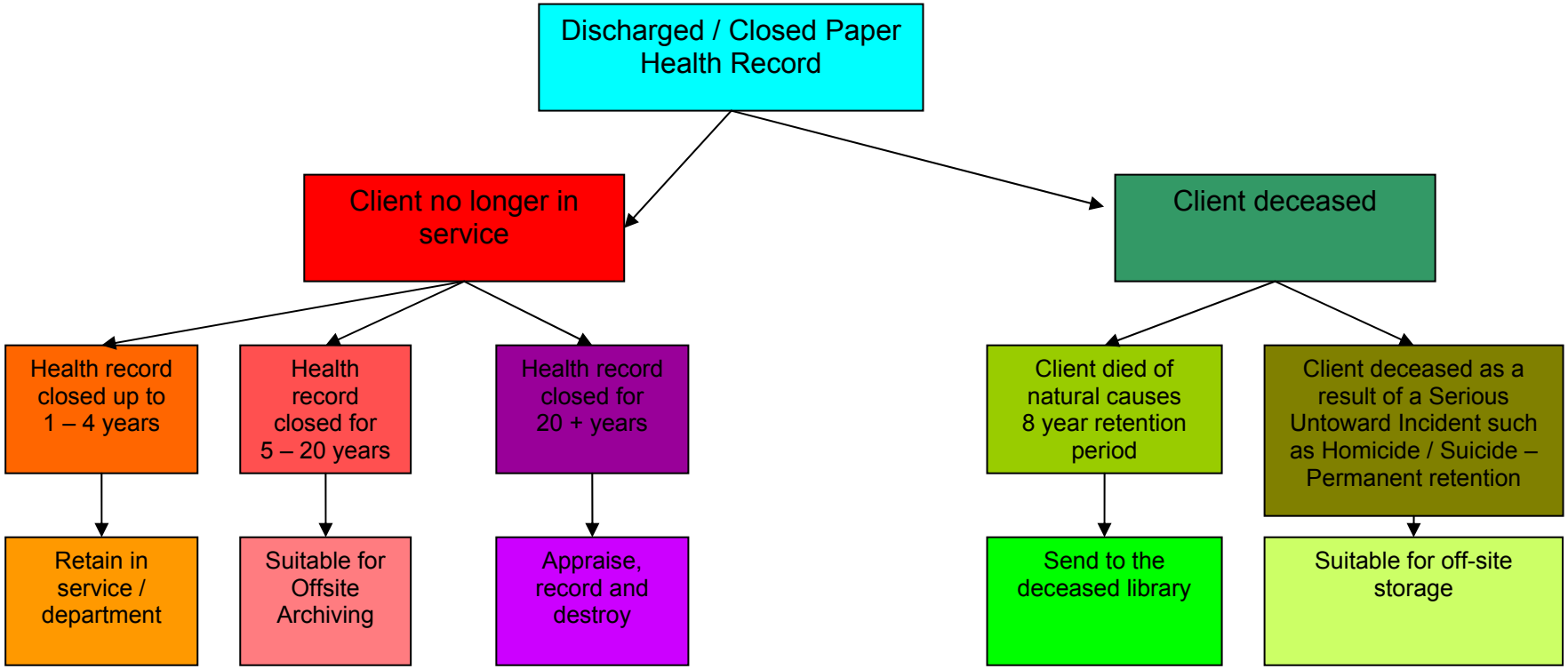
Mental Health & Specialist Services Health Records Archiving

Flowchart 2016 (NB Currently retaining all records through the Inquiry into historical child sexual abuse)



Appendix 15

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Healthy Young Minds (CAMHS) Health Records Paper Archiving Storage
Flowchart 2016 (NB Currently retaining all records through the Inquiry into historical child sexual abuse)