Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

Title: Protocol for the Management of Community Services Health Records

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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**
- **Inclusion of recording of Communication Needs from the Accessible Information standard**
- **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
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Policy to be uploaded to the Trust's External Website? Yes

Review: 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 COMMUNITY SERVICES HEALTH RECORDS

1. Introduction

This document supports the Records Management Policy and focuses on Community 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 Data Protection Act 1998 defines a health record as:

"Any electronic or paper information recorded about a person for the purpose of managing their healthcare" section 68 (1) (a)

This guidance relates to all health records created by staff within Community 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 mechanisms 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 Process for creating a health record

For those Community Services which have already adopted an electronic patient record e.g. PARIS, EMIS the new referral will be created electronically. 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*)

In services which are not fully electronic, a paper health record is created when a referral or transfer form is received into a service and a service user is accepted into service. Information should be stored in an appropriate folder with the name of the Trust, the type of record or service, the surname, forename, date of birth, NHS number and any local identifier on the front cover. The folder should be marked up as Confidential and information should be stored in an agreed filing structure for that service.

[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 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 (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.

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

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

(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 1.

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.

6.1 Objectives of good record keeping

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

- 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 enabling early detection of complications;
- Supporting clinical audit, research, allocation of resources and performance planning;
- Help to address complaints or legal processes.

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

6.2 Information which should be recorded:

- **Reason for the referral to the service**[5]
- **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 regardless of medium. For example, 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, immunisations, vaccines;
- 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 and effectiveness of care i.e. that demonstrates that care is regularly reviewed;
- Discharge summary / report that includes any arrangement for discharge or transfer of care;

[5] Screening services deliver universal services and are not based on a referral and do not contain all the information listed above

- 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)[6].

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' which should be filed at the front of the health record. The passport can be found in the Accessible Information Policy.

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.

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

6.5 Record keeping standards (see appendix 2)

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 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 complaints (see section 6.12).

6.7 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 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 record. Additional audits will also take place as identified in section 15 (Records Audit and Monitoring).

6.8 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. The unregistered practitioner is then accountable for both the care provided and its documentation. If an unregistered practitioner is deemed competent this should be documented in their supervision records. 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).

6.9 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 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.

6.10 Logging Queries in Health Records

If staff recognise that an error has occurred or there is an anomaly within the paper 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 an error has been identified in the electronic patient record this should be logged with the ICT Service Desk. A system is in place to merge any duplicate records in the PARIS EPR system.

6.11 In Community Services paper health records are usually kept in episodes of care; however the following volumising procedure may be applicable in some services (i.e. splitting and cross-referencing oversize paper health records).

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 health records should be split on a chronological basis with the most recent documentation in the latest volume.
2. The 'old' volume of health records should be checked for loose filing and all documentation secured to the body of the folder in the appropriate location.
3. 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 health record.
4. Older volumes should be crossed through and "Volume Closed" written clearly on the front cover. No further documentation should be inserted into closed volumes.
5. If the health records are electronically tracked this should be updated to indicate that there are multiple volumes of health records.

6. The most recent volume should always be used and tracked electronically, where appropriate in the normal way.
7. If older volumes are requested these must also be tracked electronically, where appropriate.
8. If a service is in transition from paper to electronic please see CO95 Procedure for the transition from paper to electronic records and how to volumise.

6.12 Filing of 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.

7. Record Maintenance including tracking and record movements

Accurate recording and knowledge of the whereabouts of all health records is essential if the information they contain is to be located quickly and efficiently. One of the main reasons why records get misplaced or lost is because their next destination is not recorded anywhere.

7.1 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.

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

Any 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

7.2 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 health 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). It is acknowledged that some client held records may be destroyed by family members especially if a person is deceased even though they are the property of Pennine Care and should be returned. Lost / destroyed client held records should also be reported as an incident via the Incident Reporting mechanism – 87 handheld records destroyed.

Any 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 Owner's (IAO's) and IAA's who would agree the action plans on a quarterly basis. Local service quality groups will be responsible for the implementation of these action plans.

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

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 health records must not be sent outside of the Trust.

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 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 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. Services may take a copy of the notes but the originals should be sent to the requestor within one working day which would either be Corporate Governance or the legal team. The 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). This may differ within child health systems where the records follow the child if they change address and the child health system retains an electronic record of interventions. In addition the child health system is used as a tracking medium for records.

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 6).

- 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 5 – 8.
- 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 the contents, name of service and destruction date.
- 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 8)

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

10.3 Taking paper health records off site

- 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 9 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.
- The procedures for bulk transferring[7]/moving Patient/Person identifiable information can be found in the Records Moving Protocol CO62.

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

[7] Trafford protocols for this are available on this link:
http://portal/traffordcs/integrated-gov/Pages/Bulk-Transfer.aspx

12. Archiving

12.1 Storage of Archived paper health records

When 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 records easily accessible. This period of time will be determined by the service depending on availability of storage space within the services. The period varies typically from 1 month to 3 years. When health records are no longer required to be retained within the service, the records are archived and thus become 'archive records. For Community Services archive health records are sent to off-site storage. The archiving procedure is outlined in Appendix 4 for HMR, Bury & Oldham and Appendix 10 for Trafford division.

12.2 Retrieval of Records

Staff should ascertain the surname, first name, date of birth and the NHS number or local identifier**.**

Health records should be tracked on every occasion by the person who received the request and who physically locates the health records and physically sends them to the requestor. The requestor on receipt of the health records should then track the health records in. This should happen whether the tracking system is electronic or manual so that the location of the health records is known at all times.

12.3 Patient/Client Held Records

Where it is necessary to leave records with the individual who is the subject of care, it must be indicated on the records that they remain the property of the issuing organisation and include a return address if they are lost. Pennine Care must be able to produce a record of their work which includes services delivered in the home where the individual holds the record.

Where client held records are used clients should be informed that the record remains the property of the organisation. Clients should be advised of the purpose and importance of the record and their responsibility for keeping it safe. Clients should be advised that the record will be retrieved when the health / social need has been addressed. Upon the termination of treatment where the records are the sole evidence of the course of treatment or care, they must be recovered and given back to the issuing organisation. These same principles apply equally to parent held records, the retrieval of these records when the child legally becomes an adult

A copy can be provided if the individual wishes to retain a copy of the records. Where the individual retains the actual record after care, the organisation must be satisfied it has a record of the contents. An example is a child's red book where the parent retains the record but the contents are also recorded in the health visiting file.

13. Disposal

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

a. 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. The template can be accessed via the http://portal/ig/recordsmgt/Pages/default.aspx on the intranet.

It is important that confidentiality is safeguarded at every stage and that the method used to destroy 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.

b. 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 the IAA's, IAM's & IAO's at IGAG

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

CO60- Protocol for the Securing and De-securing of Clinical Case Notes

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

HR46 - Clinical Supervision Policy

Appendix 1

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 2

RECORD KEEPING STANDARDS

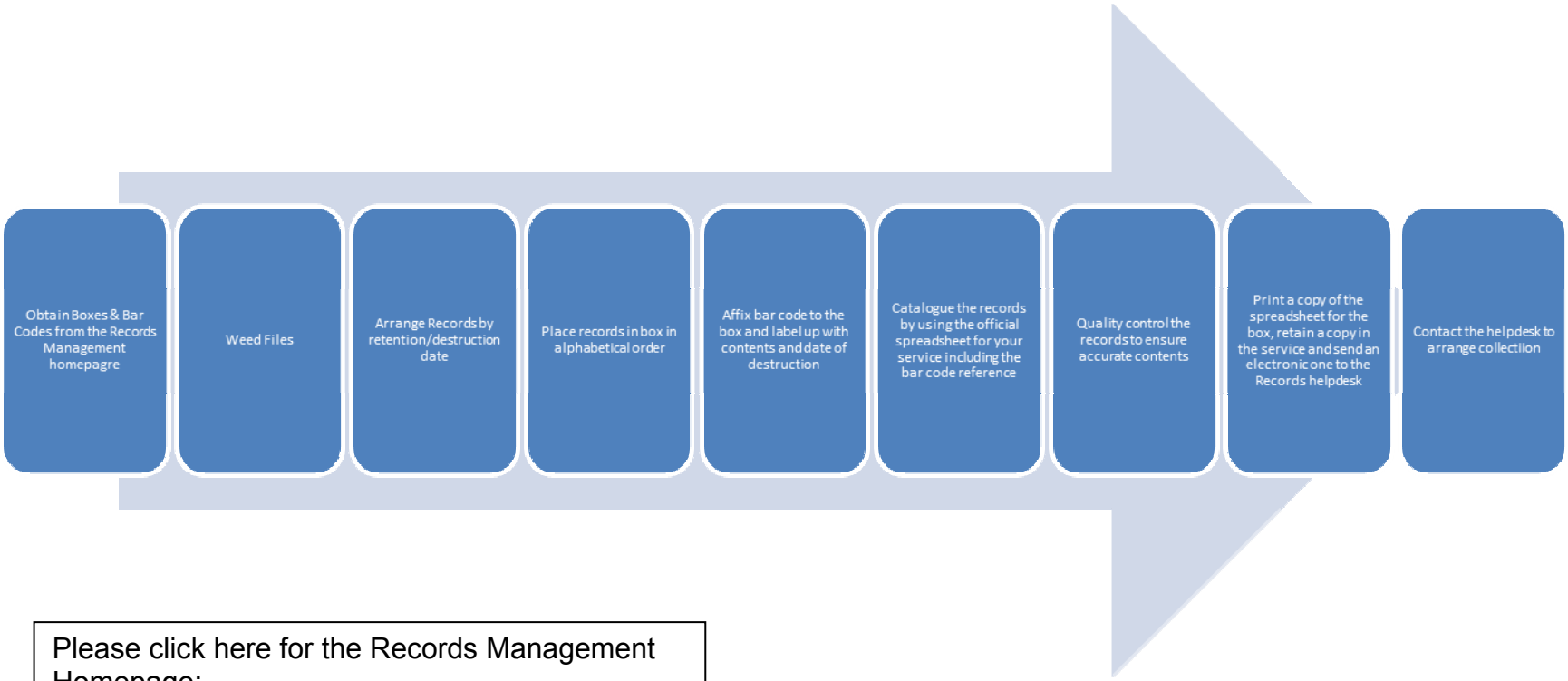
Pennine Care NHS
NHS Foundation Trust

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 **local identifier** is on all 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 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)

Appendix 3

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

Pennine Care NHS
NHS Foundation Trust

Archiving Procedure for Community Services paper health records (excluding Trafford division– please see Appendix 10)

When 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 records easily accessible. This period of time will be determined by the service depending on availability of storage space within the services. The period varies typically from 1 month to 3 years. When health records are no longer required to be retained within the service, the records are archived and thus become 'archive records'.

Ideally two years of inactive paper health records should be kept at service/departmental bases. Older inactive records should be sent for external archiving according to the guidance provided in this procedure.

1. Procedure for archiving paper health records

1.1 Preparation of health records for archiving

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

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

Health records for an individual patient should be fastened together as a single record 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.

1.2 Archive Year

Adult health records
Health records should be archived throughout the year as they become inactive; and reviewed on an annual basis. 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 record with the last entry during April 2013 and an 8 year retention period will be due for review for destruction in January 2022. **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 destruction.

Children 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.

1.3 How and when to archive

Community Child Health Records

Health Visiting - Health Visiting records should be transferred to the appropriate Health Visiting. If a Health Visitor is unable to trace a child and has completed all necessary checks to trace the child, the records should be sent into Child Health or retained at the Health Visitor's base to be filed in the untraceable drawers. These records should be checked approximately every 6 weeks to determine if the child has re-registered in another area or with another GP/address in the borough. These are then either sent to the new Health Visiting informing Child Health of the new details or sent out of area. All pre-school untraceables reaching school age are once again checked to see if they are attending a school within the borough, if the child is not attending school, the records should be passed on to the School Nursing Team as these are still active records and should be kept in house until school leaving age. However if confirmation is received that the child has emigrated those records can be archived off site.

Family records or Social Circumstances records should be archived with the records of the youngest child

School Nursing - These records have come from Health Visitors and now belong to School Nurse Teams (Community Child Health Record). These are not to be archived by the School Nursing team but letters sent to parents asking which school their child is attending. Children with no school/missing education are sent to a designated nurse for further follow up. If there is still no confirmation of the child's whereabouts these are stored in the bases until a request is received with checks throughout the year for new information.

School Health and Child Health - Records should be archived when the child leaves year 11 or the area/service. Paper records should be placed in alphabetical order in boxes by year of birth. It is appropriate to archive School Health records at the end of the school year, giving a 1st September review date. A school academic year may include more than one year of birth within the same box (records of children born prior and after January).If this is the case identify the youngest child in the box and retain the box until the youngest child reached 25 years of age. Boxes should be marked with the calendar year of birth with a 1st January review date 25 years after the latest birth date.

Looked after and adopted children – These records should be retained until the child 26th birthday. If the records are required by Ofsted when a child reaches the age of 21 then they should be retained in service and sent for off site storage beyond this date. When they become inactive School Nursing and Health Visiting records must be amalgamated with Looked after Children's records so that they can be archived together.

District Nursing - Patient-held records will be retrieved for archiving on conclusion of treatment and archived by year of last entry. Duplicate records must not be kept by the teams and must not under any circumstances be sent for off site storage.

Duplicate information should be securely and confidentially disposed of. Documentation received in the office pertaining to a patient needs to be filled in relevant patient held record under the correct section of the folder. Loose filing is not acceptable. For teams that need to archive in off site storage on a monthly basis due to limited storage, records should be stored alphabetically detailing month and year of discharge.

Health Improvement Services – In some of the boroughs the Health Trainers team use the electronic national system, NCRS which has been modified in to capture record keeping for other health improvement programs with the exception of Smoking Cessation who use their own electronic record system, Quit Manager.

Duplicate information that is available electronically should not be retained nor sent for archiving to the off site storage company. Duplicate information should be securely and confidentially disposed of. Smoking cessation records should be retained for 2 years from date of discharge and other health Improvement records for a retention period of 3 years.

Dental Services – Child and adult records must be separated. Records pertaining to adults should be retained for 10 years from last date of discharge and for children until the 25th birthday. Records should be stored alphabetically and then by treatment year. Duplicated information available electronically or that has been scanned in the Dental system must not be sent for off site storage.

Community Nursing, Community Rehabilitation, Enhanced Intermediate Care, Rapid Response, Speech and Language Therapy, Occupational Health, Podiatry,
Physiotherapy, Continence and Stoma, Tissue Viability etc – Records should be stored in alphabetical order by calendar year of discharge, death or last treatment. There is no requirement to separate adult discharges from deceased patients (RIP), however, if they have been separated this should be indicated on the box label/index. Records should be sent to locality administrative bases for preparation and collation for storage.

All services that see a combination of adult and children must ensure that adult and child records are always stored separately when preparing and archiving inactive records. Boxes must be identified clearly as adult or child attendances. For adults the destruction date is calculated from the date of the last record and for children the year in which the child turns 26 years of age.

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).

2. 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 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.

2.1 Preparing and packing the records

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. Ensure all the papers contained within the health record relate to the patient whose name is on the front of the record. If documents are misfiled this may make retrieval impossible and result in the wrong records being destroyed or preserved for longer that 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 records already held elsewhere should not be archived.

Arrange health records by retention /destroy date
Ensure records placed in the box have the same retention period (destroy date). Common sense should be applied if there are not enough records to fill a box then these should be retained and put in the next year and the retention period amended. If in doubt, please contact the helpdesk.

Place records into the boxes in alphabetical order
Do not over pack the boxes or place too many records within it – the lid must fit securely

2.2 Cataloguing contents of the boxes to be archived in off site storage Adults, Children and Deceased Health records

A detailed inventory is required of the contents of each box, one copy retained in the box, a second electronic version kept by the department/service and an electronic version sent to the art.helpdesk@nhs.net . The templates can be accessed via the Records Management page on the intranet: http://portal/ig/recordsmgt/Pages/default.aspx.

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

▼

Names should be formatted with Surname and then First name e.g. Bloggs Joe.

▼

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 records from the boxes.

2.3 Referencing Archive Boxes

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

2.4 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.

3. Sending records to the off-site storage

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

4. 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.

5. Retrieval of archived records from off site storage

Records stored in the off-site storage company archive may be retrieved by completing the retrieval form and contacting the Helpdesk function at art.helpdesk@nhs.net . The individual health record or box containing the record will be delivered to the site.

Retrieval Request Template can be accessed via the Records Management page on the intranet: http://portal/ig/recordsmgt/Pages/default.aspx

In most circumstances 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.

6. 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.)

7. Returning boxes to the off site storage

The records management function will liaise with the off-site storage company to organise the return of the boxes to the off site storage.

8. 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:
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.

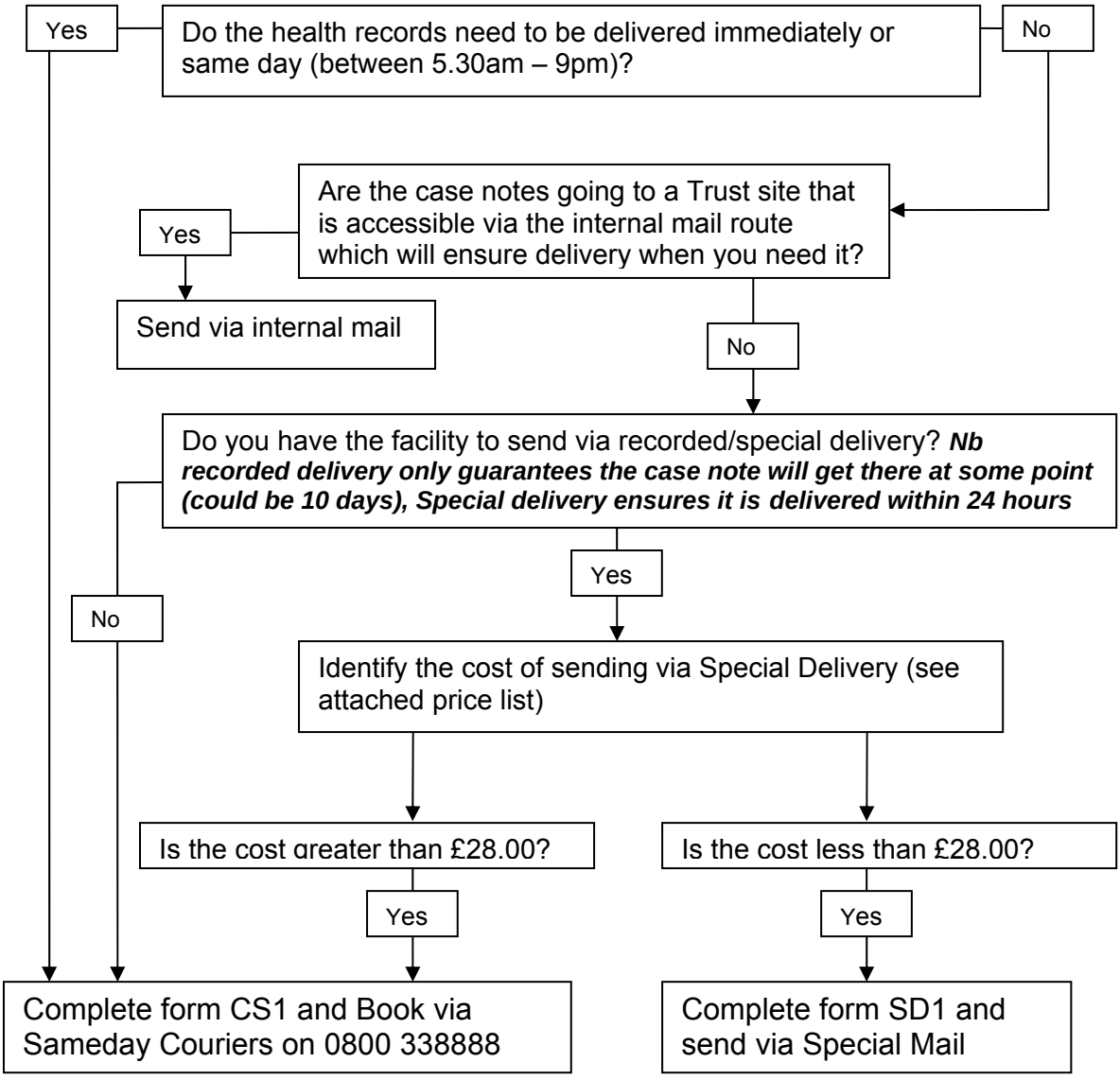
The following should be recorded: a list of the health records destroyed, when this took place, the name of the person who authorised destruction, who carried out the process and the reason for destruction.

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.

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 in the Greater Manchester area to transport health records 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 6

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 7

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 8

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 : ☐ Bury ☐ Oldham ☐ HMR ☐ 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

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 the Management of Community Services Health Records on taking records off-site (section).

Signed: ……..

Name: Job Title:

Location: Date:

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

Record type:
E.g. District Nursing 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:

Appendix 10

Pennine Care NHS
NHS Foundation Trust
Trafford Community Services

Trafford Division

Standard Operating Procedure for preparing & sending boxes of Records ready for Off-Site Storage (Restore)

Updated December 2016

Clinical & Corporate Records

1) Ensure Appropriate Indexing of Each Box: (Every file needs to be traceable)

- Each box of Records should be in alphabetical and date order (unless valid reasons can be given to the contrary)
- Four index's showing the details of each file within the box should be created and maintained
    - One should be **left inside the box** (stuck to the inside of the lid)
    - One should be stored in an **manual index register** left in an appropriate place within each department
    - One should be stored on **computer** on an excel spreadsheet and kept in a logical electronic folder – with access allowed only to those with the appropriate authority
    - One should be sent to the **Records & Information Manager** over email: Tom Walker: tomwalker@nhs.net (tel 0161 975 4754)

The spreadsheet should show information shown on the external reference template (as detailed in section 2) and also specific data relevant to each file and include headings such as:

- Patient Name
- Date of Birth

Additional information can also be included at each individual department's discretion if deemed appropriate (for example NHS Number or national insurance number if relating to personnel records)
See below for Example: *(*all names listed are fictious)*

Microsoft Excel
97-2003 Worksheet

Standard Archiving spreadsheet Template:

Microsoft Excel
97-2003 Worksheet

N.B: There is some flexibility in how departments index their records, though each individual file within a box needs to be traceable and the template above should be used for all archived material.

Boxes should be durable, secure and in a good state of repair. They shouldn't be over filled or under filled. Lids should be able to fit firmly over the boxes. Masking tape can be used if necessary though shouldn't be used excessively as this can damage boxes making them difficult to access. In addition it **isn't** compulsory to use Restore's own branded boxes, any standard archive box will suffice.

Destruction Dates
Some departments will set their destruction dates based on year of birth (usually for children's records) others will do it based on the discharge date.

- For adult records most community records carry an **8 year** retention period
- For Children's records the retention period is usually to the **25th or 26th** birthday.
- Retention periods should always be recorded as the **31st of December**.
- Records of deceased persons in most instances should be retained for **8 years after death**. (RIP records ordinarily should be archived separately)

The 2016 Information Governance Alliance (IGA) Records Management retention schedule is shown below: (it replaces the DoH 2009 version)
http://systems.hscic.gov.uk/infogov/iga/rmcop16718.pdf

2) Attach external reference template with agreed format of referencing to the same side of the box as the barcode:

- This is the External Referencing template:

BOX NUMBER	
DEPARTMENT/TYPE OF RECORD	
LOCATION	
YEAR OF BIRTH ***(if applicable)*** **(year field)**	
DISCHARGE DATE (or) R.I.P DATE ***(if applicable)*** **(year field)**	
DESTRUCTION DATE	

An example of a completed reference template is shown below:

BOX NUMBER	1 (A-C)
DEPARTMENT/TYPE OF RECORD	Podiatry
LOCATION	Broomfield Lane Clinic
YEAR OF BIRTH ***(if applicable)*** **(year field)**	N/A
DISCHARGE DATE (or) R.I.P DATE ***(if applicable)*** **(year field)**	31/12/2012
DESTRUCTION DATE	31/12/2020

The year fields and destruction date must be completed by inserting a full date. In most instances this should be set to 31st of December. For the destruction date field it must **always** be set to 31st of December followed by the appropriate year.
The completed reference template should be securely attached **width** ways on the box otherwise the year fields may not be picked up on filetrak making information harder to locate.

External Referencing Template:

Microsoft Word 97 - 2003 Document

3) Write the number for each box on the corresponding index registers: (detailed in section 1)

- 1) To be included on the paper print out of the spreadsheet index (in the register)
- 2) To be included on the electronic index (Excel spreadsheet)

4) Leave boxes for collection in appropriate place:

- Taking into account Health & Safety procedures

- Ensuring that at all times the boxes are kept secure with access to authorised personnel only
- Allowing adequate access for the Restore personnel to be able to collect the boxes to transport back to base.

5) Using Restore Filetrak tracking system request pick up:

- Training will be provided to Records Management Leads by the Records and Information manager. User guides will be given to every account holder.
- Archiving staff to alert Leads when boxes are ready to be uplifted to off-site storage
- Records Management leads to go through the filetrak system to submit orders.
- Usernames will be set up as and when required.
- When pick up's are requested a note should be made of the boxes that are collected in case of any discrepancies.

Filetrak userguide

FileTrak user manual
Trafford Provider Ser

https://www.filetrak.co.uk/office/Login.asp

6) Save print out correspondence in appropriate file:

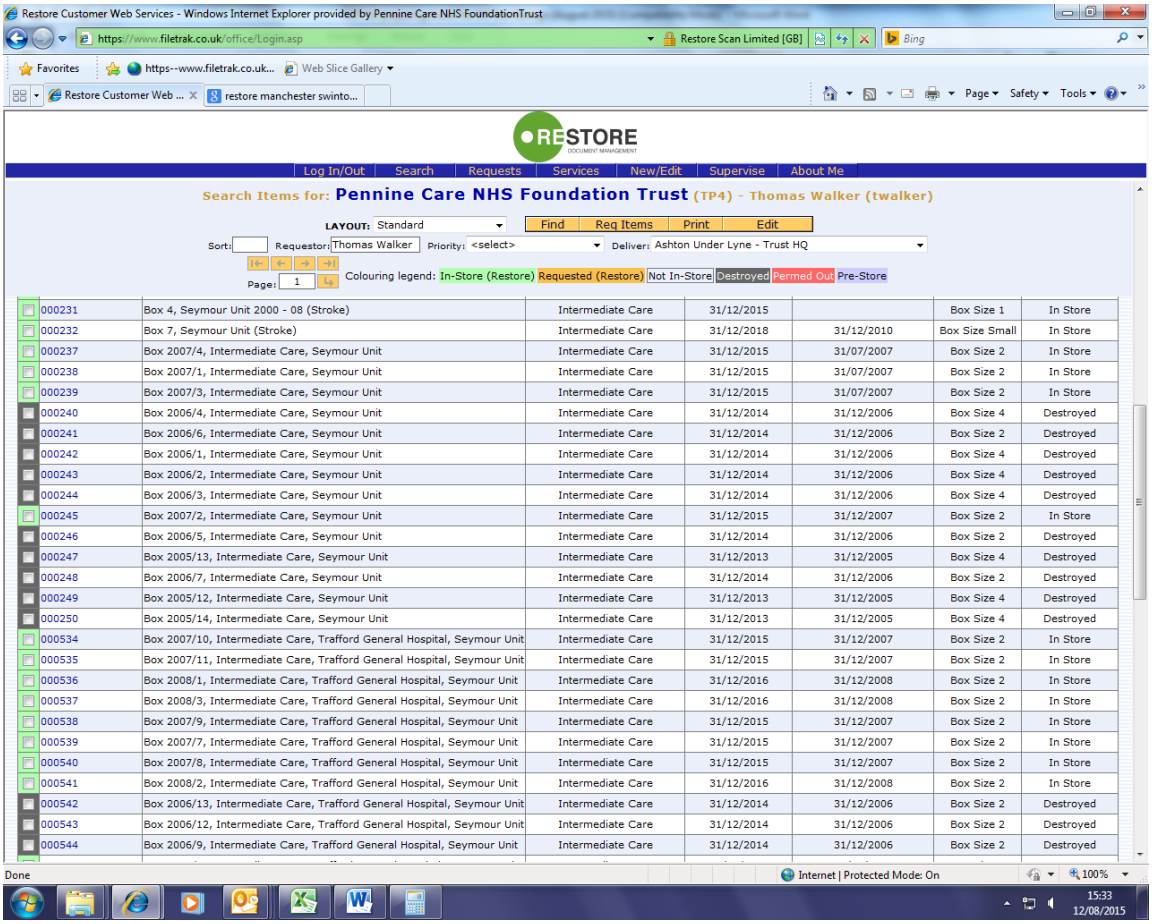
- All orders detailing retrievals, pick ups, stationery supplies or otherwise are to be stored logically and securely in a folder within each department

7) Restore will Barcode each box when they are dispatched to their warehouse *(Unless a department has specifically asked for barcodes so they can do their own barcoding):*

- The barcode stickers will be attached securely breadth-ways in the bottom left hand corner of the box
- Barcode numbers will be aligned to corresponding box numbers and will be available to view on Filetrak approximately 48 hours after they have been despatched to Restore.

8) Records Management Leads should access their Filetrak account to view box references and corresponding destruction dates:

- Checks should be done on filetrak to ensure that the details for department have been recorded correctly.
- All subsequent orders for pick up and retrievals are to be done using the filetrak system
- Corresponding barcode numbers should be recorded on matching spreadsheets (Barcode numbers are shown as the storage ID)
- Boxes that have been successfully uplifted to Restore will show as detailed on the screenshot below:



000231	Box 4, Seymour Unit 2000 - 08 (Stroke)	Intermediate Care	31/12/2015		Box Size 1	In Store
000232	Box 7, Seymour Unit (Stroke)	Intermediate Care	31/12/2018	31/12/2010	Box Size Small	In Store
000237	Box 2007/4, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2015	31/07/2007	Box Size 2	In Store
000238	Box 2007/1, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2015	31/07/2007	Box Size 2	In Store
000239	Box 2007/3, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2015	31/07/2007	Box Size 2	In Store
000240	Box 2006/4, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2014	31/12/2006	Box Size 4	Destroyed
000241	Box 2006/6, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2014	31/12/2006	Box Size 2	Destroyed
000242	Box 2006/1, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2014	31/12/2006	Box Size 4	Destroyed
000243	Box 2006/2, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2014	31/12/2006	Box Size 4	Destroyed
000244	Box 2006/3, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2014	31/12/2006	Box Size 4	Destroyed
000245	Box 2007/2, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2015	31/12/2007	Box Size 2	In Store
000246	Box 2006/5, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2014	31/12/2006	Box Size 2	Destroyed
000247	Box 2005/13, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2013	31/12/2005	Box Size 4	Destroyed
000248	Box 2006/7, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2014	31/12/2006	Box Size 2	Destroyed
000249	Box 2005/12, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2013	31/12/2005	Box Size 4	Destroyed
000250	Box 2005/14, Intermediate Care, Seymour Unit	Intermediate Care	31/12/2013	31/12/2005	Box Size 4	Destroyed
000534	Box 2007/10, Intermediate Care, Trafford General Hospital, Seymour Unit	Intermediate Care	31/12/2015	31/12/2007	Box Size 2	In Store
000535	Box 2007/11, Intermediate Care, Trafford General Hospital, Seymour Unit	Intermediate Care	31/12/2015	31/12/2007	Box Size 2	In Store
000536	Box 2008/1, Intermediate Care, Trafford General Hospital, Seymour Unit	Intermediate Care	31/12/2016	31/12/2008	Box Size 2	In Store
000537	Box 2008/3, Intermediate Care, Trafford General Hospital, Seymour Unit	Intermediate Care	31/12/2016	31/12/2008	Box Size 2	In Store
000538	Box 2007/9, Intermediate Care, Trafford General Hospital, Seymour Unit	Intermediate Care	31/12/2015	31/12/2007	Box Size 2	In Store
000539	Box 2007/7, Intermediate Care, Trafford General Hospital, Seymour Unit	Intermediate Care	31/12/2015	31/12/2007	Box Size 2	In Store
000540	Box 2007/8, Intermediate Care, Trafford General Hospital, Seymour Unit	Intermediate Care	31/12/2015	31/12/2007	Box Size 2	In Store
000541	Box 2008/2, Intermediate Care, Trafford General Hospital, Seymour Unit	Intermediate Care	31/12/2016	31/12/2008	Box Size 2	In Store
000542	Box 2006/13, Intermediate Care, Trafford General Hospital, Seymour Unit	Intermediate Care	31/12/2014	31/12/2006	Box Size 2	Destroyed
000543	Box 2006/12, Intermediate Care, Trafford General Hospital, Seymour Unit	Intermediate Care	31/12/2014	31/12/2006	Box Size 2	Destroyed
000544	Box 2006/9, Intermediate Care, Trafford General Hospital, Seymour Unit	Intermediate Care	31/12/2014	31/12/2006	Box Size 2	Destroyed

9) Inactive Records to be sent off-site on an ongoing and continual basis

- Its not permitted to allow a build up of inactive records. On at least an annual basis boxes of archived records should be sent to Restore.
- It's advised that once records are discharged (and hence become inactive) they should be stored on-site for 12 months and then sent to Restore this is because its more likely that a record will be called upon within the first 12 months of discharge rather than at any other time, subsequently its more convenient and cost effective to keep records instantly available for this period of time. (Tracking should be maintained with on-site records using the attached tracer card)

  Tracer Card

  Tracer Card.pdf

- Valid reasons need to be given to send records to off-site storage prior to 12 months after being inactive.
- Valid reasons needs to be given to keep records on-site after being 12 months inactive.

10) Changes to Electronic Records

- Staff should update electronic records (for example iPM Lorenzo or EMIS) in line with Records Management related activity as and when applicable

11) Cintas to Restore

As of 2015 Cintas became Restore: http://www.restore.co.uk/
Main Address:
Agecroft Commerce Park
7 Overman Way
Swinton
M27 8UJ

12) Contacts

Emma Liddle
Restore Account Manager
Mobile: 07703 974504
emma.liddle@restore.co.uk

Alexia Gregson/Louise Morgan
Restore Warehouse Manager's (Swinton Manchester)
alexia.gregson@restore.co.uk
Louise.Morgan@restore.co.uk

Restore General Telephone Numbers and Email Addresses
Switchboard: 0333 220 9689
General: 0333 220 5213
Business Support: 01293780055
helpdesk@restore.co.uk
manchesterretrievals@restore.co.uk
salessupport@restore.co.uk
businesssupport@restore.co.uk
accounts@restore.co.uk

Tom Walker
Records & Information Manager
Pennine Care NHS Foundation Trust
Trafford Division
Meadway Health Centre
Meadway
Sale
Greater Manchester
M33 4PS
Telephone: 0161 975 4754
Email: tomwalker@nhs.net
Fax: 0161 975 4757
Website: **www.penninecare.nhs.uk**