Health Records Management Policy

Policy information

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Summary of document:
This policy sets out best practice for the creation, utilisation, retention and destruction of health records within Hywel Dda University Health Board (HDUHB).

Scope:
This policy has been written to provide advice and guidance for all Hywel Dda University Health Board staff dealing with operational records management issues on a daily basis. The Policy highlights the standards that should be attained by all staff when utilising records from creation until final disposal. This policy applies to all permanent, temporary or contracted staff employed by Hywel Dda University Health Board (including Executive and Non – Executive Directors).

To be read in conjunction with:
[192] – Health Records Management Policy – opens in a new tab
[193] – Retention and Destruction of Records Policy – opens in a new tab
[249] – Access to Health Records Policy – opens in a new tab
[172] – Confidentiality Policy – opens in a new tab
[836] – All Wales Information Governance Policy – opens in a new tab

[837] – All Wales Information Security Policy – opens in a new tab
[347] – Corporate Records Management Policy – opens in a new tab

Patient information:

Owning group:
IGSC

Executive Director job title:
Director of Operations

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1 New policy September 2012
2 Full review 23.2.2016
3 DPA update 26.6.2018
4 Full review 27.6.2023

Keywords
Health Records, Records Management

Glossary of terms
Records management - is that “field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and disposal of records, including processes for capturing and maintaining evidence of and information about business activities and transactions in the form of records”.

A record - A health record is “one which relates to the physical or mental health of an individual which has been made by or on behalf of a health professional in connection with the care of that individual”. Anything that contains information that has been created or gathered as a result of any aspect of the work of NHS employees.

Data Protection Act 2018 - The Data Protection Act 2018 is a United Kingdom Act of Parliament which updates data protection laws in the UK. It is a national law which complements the European Union's General Data Protection Regulation and replaces the Data Protection Act 1998.

Public Records Act 1958 - The Public Records Act 1958 is an Act of the Parliament of the United Kingdom forming the main legislation governing public records in the United Kingdom.

Subject Access Request – Individuals have the right to access and receive a copy of their personal data, and other supplementary information. This is commonly referred to as a subject access request or 'SAR'. Individuals can make SARs verbally or in writing, including via social media.

Data Protection Impact Assessment – Describes a process designed to identify risks arising out of the processing of personal data and to minimise these risks as far and as early as possible. DPIAs are important tools for negating risk, and for demonstrating compliance with the GDPR.

Contents

Introduction

Hywel Dda University Health Board (HDUHB) will conduct its responsibilities for records management in accordance with relevant legislative requirements of the European Parliament, the United Kingdom and Welsh Government. HDUHB will also comply with any decisions or guidance issued by Welsh Government.

Health Records form an integral part of the clinical recollection of HDUHB, providing evidence of decisions, the rationale for decisions and supporting the HDDUB daily functions and operations. As contemporaneous records they form the basis for the organisations accountability for clinical care. Health records are also essential to protect the rights of patients, staff and members of the public who have dealings with the HDUHB. Health Records support consistency, continuity and efficiency and help the Board to deliver services to our patients in a consistent and equitable way.

Health Records management is about the proper content, control, security, storage and ultimate destruction of records. Records created and held by HDUHB as part of its functions, are public records under the Public Records Act 1958. The Public Records Act 1958 requires that there is a systematic and planned approach to the management of records within an organisation. Moving forward, the effectiveness, safety, care and efficient management of healthcare services, depends on the right information being available to the right people, at the right time. This can only be achieved if there are effective health records management policies and processes in place.

The Board, Executive Team, senior management and all who work for the organisation have responsibilities to ensure that information is handled appropriately and is not retained unnecessarily beyond its life cycle. We also have a responsibility to ensure the accuracy of records and to be able to identify and locate information that is critical for current decision making and available when required for patient care.

This document should be read in conjunction with other HDUHB policies e.g. HDUHB 191 Health Records Management Strategy, 193 - Retention and Destruction Policy, 249 - Access to Health Records Policy – all open in a new tab - etc and also the Data Protection Act.

Scope

This policy has been written to provide advice and guidance for all Hywel Dda University Health Board staff dealing with operational records management issues on a daily basis. The policy highlights the standards that should be attained by all staff when utilising records from creation until final disposal. This policy applies to all permanent, temporary or contracted staff employed by HDUHB (including Executive and Non – Executive Directors).

Aim

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

The Health Records Management policy applies to all health records and personal information collated in relation to clinical activities and patient care. As the HDUHB utilises a hybrid of both paper and electronic records to support clinical processes this policy and the agreed standards of records

management will fully apply to both formats. The policy sets out best practice for the creation, utilisation, retention and disposal of health records. It applies to all health records regardless of format, of all types and in all locations where they are used to:

- to support patient care and the continuity of care
- to support evidence based clinical practice
- to assist clinical and other types of audits
- to support improvements in clinical effectiveness through research and support archival functions by taking account of the historical importance of material and the needs of future research
- to support the day-to-day business which underpins the delivery of care
- to support sound administrative and managerial decision making as part of the knowledge base for the NHS services
- to support patient choice and control over treatment and services designed around patients
- to meet legal requirements including requests from patients under subject access provisions of the Data Protection Act

Objectives

The objective of this policy is to ensure that health records management is applied consistently across the HDUHB and draws on best practice, as well as ensuring that our services meet the legal, professional and individual responsibilities associated with record keeping. It is designed to provide the staff who create, hold and utilise the health record in the course of their duties with their obligations and expectations and help to increase the confidentiality, integrity and availability of the health record.

The policy relates to all health records which are created carrying out the HDUHB business and captured in any readable form, providing evidence of the patient care delivered. The policy provides all HDUHB staff with clear guidance and standards to attain on a daily basis and robust assurance that health records management systems are able to ensure that:

- **health records are available when needed** – from which the HDUHB is able to form a reconstruction of activities or events that have taken place
- **health records can be accessed** – health records and the information contained within them can be located and displayed in a way which is consistent with the records initial use and that the current version is identified where multiple volumes exist;
- **health records can be interpreted** – the context of the record can be interpreted; who created or added to the health record and when, during which business process, and how the health record is related to other health records
- **health records can be trusted** – the health record reliably represents the information that was actually used in or created by the business process, and the record integrity and authenticity can be demonstrated;
- **health records can be maintained through time** – the qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the health record is needed, perhaps permanently despite changes of format;
- **health records are secure** – from unauthorised and inadvertent alteration and erasure. Access and disclosure are properly controlled and audit trails will track all use and changes to ensure that health records are held in a robust format;

- **health records are retained and disposed of appropriately** – using consistent documented retention and disposal procedures which include provision of appraisal and permanent preservation for health records with archival value;
- **staff are trained** – all staff within the organisation are made aware of their responsibilities for health record keeping and management.

Health Records Resource

Records are a valuable resource because of the information they contain. Information is only useful if it is correctly recorded in the first place, is regularly updated and is easily accessible when it is needed. Information is essential to the delivery of high quality healthcare and effective records management. The records and formats will include (but is not limited to):

- Records of patients treated by HDUHB including health and care records
- Records of private patients treated on NHS premises
- Records of patients treated on behalf of the NHS in the private healthcare sector
- Adult Service user records where there is integration with health services e.g. jointly held records

This list is not exhaustive.

A health record is everything (paper or electronic) that contains information which has been created or gathered as a result of any aspect of the delivery of patient care, including (but not limited to):

- Personal health records (electronic, microfilmed, scanned images & paper based)
- Theatre Registers and all other registers that may be kept
- X-ray and imaging reports, output and images
- Photographs, slides and any digital images
- Audio and video tapes, cassettes
- Digitised images/Digital Records (scanned)
- Emails
- Text messages (SMS)

This list is not exhaustive.

Roles and Responsibilities

All health and care employees are responsible for managing records appropriately. Health records management must provide a focus for all types of records, in any format to be managed from their creation to ultimate disposal. The health record management function must have clear responsibilities and accountability throughout the HDUHB.

Chief Executive

The Chief Executive has overall accountability and responsibility for ensuring that health record management operates correctly and legally within the HDUHB. The CEO may delegate responsibility for management and organisation of the health records services to the Caldicott Guardian or another Director who will be responsible for ensuring that appropriate mechanisms are in place to support service delivery and continuity.

Caldicott Guardian/SIRO

The Caldicott Guardian/SIRO are responsible for protecting the confidentiality of service user information. The Caldicott Guardian/SIRO have strategic roles which involve representing and championing

information governance requirements and particular responsibility for reflecting patients' interest regarding the use of patient identifiable information.
The Caldicott Guardian has responsibility for:

- Ensuring the HDUHB is fulfilling all legal obligations in managing patients' health records
- Agreeing and reviewing internal protocols governing the protection and use of patient identifiable information by HDUHB staff
- Agreeing and reviewing protocols governing the disclosure of patient information across organisational boundaries e.g. with social services and other partner organisations, contributing to the local provision of care (WASPI)
- Developing the HDUHB security and confidentiality policies through the clinical and information governance frameworks
- Representing confidentiality requirements and issues to the HDUHB, advising on annual improvement plans and agreeing and presenting outcome reports

The SIRO is responsible for:

- Fostering a culture for protecting and using data
- Provides a focal point for managing information, risk and incidents
- Is concerned with the management of all information assets
- Acts as an advocate for information risk on the Board and provides written advice to the Accounting Officer on the content of their annual governance statement in regard to information risk

Executive Directors
All Executive Directors are responsible for implementing records management arrangements at Directorate level through the relevant committees and meeting forums and overseeing a programme of record management activities, in accordance with this policy.

Digital Director
The Digital Director is responsible for ensuring that regulations are in place to maintain the security of all electronically stored information, outlining the security responsibilities of management and staff. The Director is also responsible for the management of electronic/digital systems.

Information Governance Sub Committee
The Information Governance Sub Committee is responsible for ensuring that the Health Records Management Policy is implemented through its endorsement and approval and will take a lead role in its obligation to ensure robust records management arrangements are implemented across the HDUHB.

Head of Information Governance
The Head of Information Governance is the designated management advisor for the HDUHB and has responsibility for ensuring that the HDUHB complies with the developments in national guidance relating to information governance. They will have a responsibility to provide any specialised advice or guidance to other service areas as required and maintain an Information Asset register, which can be utilised for records management arrangements.

Health Records Manager
The Health Records Manager has professional responsibility and accountability for the overall development and maintenance of health records management practices within the organisation and for ensuring that related policies and procedures conform to the latest legislation and standards on data protection, UK GDPR, confidentiality and health records practice. They will have a responsibility to

provide specialised leadership, guidance, advice and support in regards records management arrangements and processes within the HDUHB. They have responsibility for overseeing, directing and coordinating the day to day management of operational matters within the Health Records Service including the provision of patient records for inpatient, outpatient and day case attendances. They are responsible for ensuring that the release of all patient clinical information for data Subject Access Requests (SARs) and provision of records for medico-legal purposes is in accordance with the legislation.

Information Asset Owners & Information Asset Administrators
Information Asset Owners (IAO's) will delegate responsibility to Information Asset Administrators (IAA's), whose remit will also include responsibility for health record management arrangements within their service. The IAO's will ensure that the policy is implemented within their service areas and robust records management arrangements are in operation.

Professional Staff Groups
Professional staff groups must ensure that they maintain factual, clear, concise and unambiguous records to provide credible and authoritative evidence of services delivered. They must ensure that all contact with service users, carers or other relevant individuals is systematically recorded in keeping with agreed standards. Ensure that no action or omission on their part or within their sphere of responsibility is detrimental to the interests, condition or safety of service users, staff or the HDUHB and that records are always documented with a view that they can potentially be disclosed and read by the service user/patient.

Employees
All NHS employees and staff are responsible for any health records which they create or use. This responsibility is established and defined by the law and any records created by an employee are public records. All HDUHB staff, whether clinical or administrative, have an individual responsibility for records management and for the correct creation, use and retention of records in line with their job roles. Staff must ensure that they keep appropriate records of their work and manage those records in keeping with this policy and with any supporting policies or guidance subsequently produced.

Everyone working for or within the NHS who records, handles, stores or otherwise comes across patient information has a personal common law duty of confidence to patients and to his or her employer. The duty of confidence continues even after the death of the patient of after the employee or contractor has left the NHS. All staff must ensure that all confidential, patient identifiable information is retained in the appropriate records management system. Staff have a duty to read and understand the content of this policy and a Breach of this policy will mean that the HDUHB is not safeguarding information entrusted to it, which could render the HDUHB liable to prosecution. It is therefore essential that staff within the organisation with responsibility for record management comply with the policy or they may be subject to disciplinary procedures.

Legal and Professional Obligations

All health and care employees are responsible for managing records appropriately. Records must be managed in accordance with the law. All NHS Health Records are public records under the Public Records Act. The HDUHB will take actions as necessary to comply with legal and professional obligations such as:

- Public Records Act 1958 and Local Government Act 1972
- Freedom of Information Act 2000
- Records Management Code of Practice for Health and Social Care 2022
- UK GDPR and Data Protection Act 2018
- Access to Health Records Act 1990
- The Common Law Duty of Confidentiality
- Health and Social Act 2008
- Limitation Act 1980 and Consumer Protection Act 1987
- Caldicott: Principles into Practice
- Any new legislation affecting health records management as it arises

Health and care professionals also have professional responsibilities for example complying with the **record keeping standards** as set out by registrant bodies.

Health Records Lifecycle

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

Creation

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

- Patient demographic data for each registration should be recorded on the master patient index of the patient administration or departmental system
- The minimum patient demographic data should include: surname, forename, sex, date of birth, home address, postcode, NHS and or PAS/departmental number
- The organisation should use the NHS number as the main patient identifier and a partial validation tool
- Where there is more than one local identifier or case record per patient, a system is in place to ensure that the existence of all other health records is known
- The paper health record has a standard case record folder constructed of robust material which can withstand handling and transport and has secure anchorage points to protect against loss or damage to documentation
- There is a designated area within the health record for health professionals to record actual or suspected clinical alerts or risk factors
- There is a locally agreed format for the filing of the information in the health record which facilitates ease of access to all clinical information. Clear instructions regarding the order of filing is contained within the folder
- Machine generated reports and recordings such as CTG, ECG and laboratory reports are stored securely within the case note folder
- All electronic systems are password protected and passwords are changed at regular intervals. An audit trail of access, amendments or updates is available and reports can be taken from the system

Storage

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

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

Management of Records (onsite & offsite)

Maintaining the health record is vital to patient care. The health records service has well defined procedures and systems in operation for the ongoing management of the health record from initiation to final disposal in accordance with legislation.

- Whenever possible, separate areas are maintained for current and non-current health records in use within the organisation;
- There are documented procedures for the safe storage and retrieval of health records;
- There are documented procedures for the tracking of records within the organisation and audit is used to highlight any issues that arise as a result of non compliance
- There is a documented procedure for the splitting of fat folders and cross referencing of the volumes. Closed volumes are suitably labelled.
- There is a documented procedure relating to the return of the patient held record when an episode of care is complete.
- The responsibility for the filing of loose documentation rests with the staff who generate the information.
- There are agreed processes and identified staff responsible for the filing of loose documentation.
- Each person who uses and adds to the record has the responsibility to maintain the record and file any information into the appropriate section and format. This is part of the overall record keeping standards of the organisation.
- Health records staff will routinely split large folders or provide a new folder if the outer cover is not of a good standard.
- There are documented procedures for the transportation of health records both within and outside of the HDUHB.

- There are documented procedures for the handling of subject access and Access to Health Records requests with clear responsibility for responding by fully trained, dedicated staff who process requests in accordance with the law;
- There are documented procedures for the retention, archiving and destruction of health records in accordance with national guidelines. The method of destruction ensures that confidentiality is maintained at all times.
- There is a set of performance indicators which demonstrate the efficiency of the health records service which include health record availability, incorrectly tracked records, SAR's compliance etc
- Offsite records requires that there is a full inventory of the records that are held offsite
- Retention periods require to be assigned to each record held offsite
- Evidence is obtained of secure disposal of records and information
- A Data Protection Impact Assessment (DPIA) must be conducted if moving records to an offsite storage contractor and the Health Records service contacted for advice and guidance on the factors to be taken into consideration prior to removal of records to an offsite store.

Creation and Maintenance of Patient Healthcare Records

The HDUHB uses the Welsh Patient Administration system (WPAS) to create a patient record. HDUHB policies and procedures specify clear standards that should used by all staff involved in maintaining the patient record.

Wherever possible all patient information should be centrally held as part of the main patient record. However the HDUHB acknowledges that in some circumstances it may be practical to generate or hold local patient records, for example emergency attendances. Where there are locally held patient records, all staff involved in the creation, use and/or management of these records should also ensure they meet the required standards and ensure that the record types are recorded on the Information Asset Register.

The Health Records Department are responsible for identifying main clinical records for retention or destruction and will apply the retention schedules as stipulated in the HDUHB 193 - Retention and Destruction Policy – opens in a new tab - and supported by the Record Management Code of Practice.

Tracking and Retrieval of Records

The movement and location of records should be controlled to ensure that a record can be easily retrieved at any time, that any outstanding issues can be dealt with and that there is an auditable trail of record transactions.

The HDUHB utilises the Welsh Patient Admin System **Intelligent Tracking** facility to monitor and records the movement of the main patient healthcare record within the organisation (paper). The objectives of this policy are to:

- Ensure all health records are tracked on WPAS
- Ensure the location of all health records are known at all times
- Establish and maintain standards for the use of health records
- Reduce the risk of health records not being available for patient consultations, subject access requests and legal requirements

Archiving and Disposal of Health Records

There is a detailed and agreed policy on the retention, destruction and/or archiving of health records, which operates in accordance with the Welsh Records Management Code of Practice. It is particularly important that the disposal of records, which is defined as the point in their lifecycle when they are either transferred to an archive or destroyed, is undertaken in accordance with clearly established policies.

It is a fundamental requirement that all the HDUHB records are retained for a minimum period for legal, operational, research and safety reasons. The length of time for retaining records will depend on the type of record and its importance to the HDUHB business and clinical functions. The HDUHB has a retention schedule which is set out in the HDUHB 193 - Retention and Destruction Policy – opens in a new tab. Records destroyed shall be recorded on WPAS. Destruction of eligible records shall be completed annually with archived records indicating the year for destruction, which will enable those pending destruction to be identified. Any decision to retain/destroy records outside of the periods specified will be approved and fully documented.

The Health Records Manager and Health Records Management team can offer advice on the requirements and procedure for dealing with the disposal of all records at this stage in the lifecycle.

Training

While some aspects of Information Governance is covered in the HDUHB Corporate Induction for all staff, it is expected that local induction arrangements will cover the specific roles and responsibilities of staff in relation to the lifecycle of records. All staff employed by the NHS in Wales will receive information on their personal responsibilities for record keeping in contracts of employment. This includes the creation, use, storage, security and confidentiality of health records. The mandatory training on Information Governance also includes elements of records management standards.

Appropriate training will be given to all health records staff on the systems used to maintain records and these will meet local and national standards. The Health Records service is able to support awareness sessions or bespoke sessions as and when required to increase the awareness of individual staff responsibilities in regards records management. Self-learning modules are available to all staff through the HDUHB's intranet and ESR application.