Standard Operating Procedures

Salisbury NHS Foundation Trust

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SOP Title	**Healthcare Records – Creation, Use and Management**
Version	1.0
Related SOPs	• Casenote Management (Lorenzo SFT 07) • Duplicate Records Management (Lorenzo SFT17) • Retention and disposal of healthcare records • Access to person and health information
Purpose	The purpose of this Standard Operating Procedure (SOP) is to document and standardise the processes for the creation, usage and ultimate destruction of Health Care Records
Policies and Guidance	Information Governance Policy and Strategic Management Framework
Roles responsible for carrying out this procedure	All clinical and administrative NHS staff employed at Salisbury NHS Foundation Trust
Accountabilities	
Sponsor	Director of Corporate Development
Post Holder Responsible for SOP	Health Records Manager
Directorate Responsible for SOP	Chief Executive's
Collaboration	Information Governance Manager Business Change Manager, Informatics
Approvers	Information Governance/Registration Authority Manager and Data Protection Officer

Contents

Introduction

Salisbury NHS Foundation Trust (SFT) provides a Health Records Service for all patients and, although there are a wide variety of records, including electronic records, all documents and other media containing patient information should comply with the practices and processes of this SOP.

SFT is committed to ensuring that all health records are available in the right place at the right time and are written or electronically documented to an appropriate standard to assist in the provision of safe patient care.

The purpose of the health record

The purpose of Health Records that are created and maintained for the Trust is to:

- Provide accurate, current, comprehensive and concise information concerning the condition and care of the patient
- Provide a record of any problems that arise and the action taken in response to them
- Include a record of any factors (physical, psychological or social) that appear to affect the patient
- Record the chronology of events and the reasons for any decisions made
- Support standard setting, quality assessment and audit
- Provide a baseline record against which improvement or deterioration may be judged

Legal obligation

All NHS records are classified as public records under the terms of the Public Records Act 1958. The Trust has a clear duty to make arrangements for the safe keeping of those records.

The General Data Protection Regulations (GDPR) have significant implications for the management of Health Records in order to safeguard the data subject's rights.

Ethical obligations

Those who create, access and use records should understand the ethical concepts of professional practice, including the need to protect confidentiality, to ensure true consent and to assist patients to make informed decisions.

- The record should demonstrate that the practitioner's duty of care has been fulfilled.
- The originator, regardless of profession or grade, will ensure that the entry in a record is totally accurate and based on respect for truth and integrity**.**

Scope

This SOP relates to all health records in whatever format they are created:

- Patient health records – paper, electronic and microfiche etc.
- Notes held by individual professionals e.g. physiotherapy, OT
- Special case files e.g. child protection notes
- Records of private patients seen on NHS premises
- Accident and emergency, birth and all other registers
- Theatre and minor operation registers
- X-rays and imaging reports, output and images
- Photographs, slides and other images

- Audio and video tapes, cassettes, CD-ROM
- Patient held records

Standards of record keeping

The records folder

Records folders used in the Trust contain clear instructions regarding the filing of documents.

Clinical risk to the patient is minimised by:

- Ensuring that records are bound and stored so that loss of documents is minimised
- Ensuring that every piece of paper is secured within the record folder
- Ensuring that every piece of paper is identified with at least 3 of the following:
  - Patient's full name
  - Patient's date of birth
  - Patient's Hospital registration number
  - Patient's NHS number
  - Consultant in charge of patient at that time

The clinical notes

Patient records should be clear, accurate, legible and contemporaneous. They should report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed.

Any member of staff recording within a clinical record has a responsibility to comply with the standards set within this policy in order to maintain the quality of the records and to reduce risk.

The minimum Trust standards for record keeping (adapted from the Royal College of Physician's standards) are:

Every entry made in patient's records should:

- Be made as soon as possible after the event
- Be in chronological order
- Be readable on any photocopies
- Be dated
- Be timed – using the 24 hour clock
- Be signed
- Have the name of the person making the entry legibly printed against the signature
- Have the status of the person making the entry (e.g. House Officer) and contact number
- Be legible
- Be understandable

The quality of documentation within the Medical Record across all specialties is audited annually.

Electronic records – including patient records on Lorenzo

Entries into electronic records should follow the same principles as the paper records.

NHS Digital's Professional Record Standards Body has published a guide to the structure and content of the health record: PRSB Structure and Content of Health and Care Records

Examples of other nationally available guidance can be accessed in the following link: Academy of Medical Royal Colleges - A Clinicians Guide.

All staff should follow the Lorenzo standard operating procedures for the creation, use and management of electronic Lorenzo records:

Lorenzo standard operating procedures

Further guidance:

Royal College of Physicians 'Generic Medical Record Standards' - RCP Standards

Nursing and Midwifery Council - NMC Code of Practice

Confidentiality

The NHS, and all persons working within the NHS, have a common law duty of confidence to patients and a duty to maintain professional ethical standards of confidentiality. Salisbury NHS Foundation Trust is committed to:

- NHS Code of Confidentiality
- General Data Protection Regulation (GDPR)

The Health Record is the property of the Salisbury NHS Foundation Trust. The contents (and even the fact that a patient attends the hospital) are CONFIDENTIAL information.

Access

All persons engaged in the treatment of the patient and who need to read their records to enable them to carry out their work are given access.

Staff members, including senior officers (nursing, administrative and occupational health staff) have no special right to access the health records of a member of their staff. Written permission must be obtained from the patient (i.e. staff member) for information to be released.

Under the GDPR and Data Protection Act 2018, patients have the right to:

- Access their health records, subject to certain safeguards
- Have copies of their records
- Have these records explained if they are illegible or unintelligible

Roles & responsibilities

Creation paper records

New records
In order to reduce the risk of duplicate patient records the creation of casenotes is limited to the following groups of staff:

- Records Library
- Maternity Department
- Plastics

Any other area wishing to create notes should contact the Records Library.

Subsequent volumes
If a volume is full a request should be sent to the Records Library for a new volume.

Access to records

It is essential that paper records can be accessed 24 hours per day, 7 days per week.

The Library is staffed from 8am -11pm and provides records from within the Library and those

stored around the hospital site.

Notes for emergency use are accessed from the Library, by reception staff, in the Emergency Department, or by members of the Site Care Team, from 11pm – 8.00am. Reception staff during these hours are trained in Library procedures and are given access to the department during these hours, in order to carry out this function.

All areas in the Trust where records are held have an obligation to ensure 24/7 access to the paper records. *Under no circumstances* should paper records be stored in a locked office or filing cabinet unless the Records Library staff have been provided with a key.

Filing in paper records

In order to prevent potential clinical risks to the patient from lost information ALL users are required to file ALL documents securely in the correct section of the file. It is the responsibility of the staff member creating a document to ensure that it is securely filed.

Instructions for filing in the casenotes are printed on the inside of the front cover and on the dividers.

Notes should not leave the ward or outpatient area unless all filing has been correctly secured.

Maintenance

Notes require maintenance when they become over full or if the folder becomes damaged.

It is the responsibility of ALL staff, whatever discipline, to maintain the casenotes and to request a replacement if the existing folder is damaged, or an additional volume once the notes are full (notes are deemed to be full when they are greater than 2 inches thick).

Tracking

The patient's complete health record should be available at all times. Therefore recording ***ALL*** movements of casenotes is essential to maintaining the effectiveness of Patient Document Tracking (PDT) on Lorenzo.

Effective use of PDT will save considerable staff time within the Trust and reduce the risk to patients from missing records.

ALL users must ensure that notes are:

- Dispatched on PDT when sent to another location
- Received on PDT when they arrive in a location

For details of how to track records on Lorenzo please see the following Lorenzo quick user guides (available on the intranet):

- How to dispatch and receive individual casenotes
- How to dispatch and receive casenotes with a barcode scanner
- How to find the location of patient casenotes

In the event of a system failure all areas are expected to record movements of casenotes on paper and then update Lorenzo as soon as it becomes available.

Storage

The main storage areas for Health Records are:

- Medical Records Library
- On Site Archive Store
- On site overflow filing rooms

- Maternity Department
- Spinal Unit
- Children's Unit

Records that are in use are also stored in secretaries' and consultant's offices, outpatient areas and other departments within the Trust. Records are returned to the main storage areas as soon as practicable after use.

All areas storing records must ensure that the notes stored securely but are accessible at all times. Records must not be taken home or to onsite accommodation by staff as this makes them inaccessible.

Sending notes offsite

It is important to ensure that a patient's records are available at all times in order to reduce:

- Clinical risk to the patient whilst an inpatient or outpatient
- Data protection risk through loss of information
- Risk of financial loss to the Trust

For this reason original notes are NOT sent out of the hospital unless it is for:

- Inpatients/outpatients at:
  - WMH
  - Fordingbridge Hospital
  - Warminster Hospital
  - Blandford Hospital
- Peripheral clinics at other sites

In all other cases copies of relevant notes can be provided as follows:

In hours:

All requests from other hospitals or health care organisations should be passed to the health records administrators who will log and action the request.

Out of hours:

The ward area to copy any records that have been requested (patients being transferred out of hours to another hospital).

Under no circumstances should notes be taken offsite for administrative purposes.

Destruction

The Trust follows the national guidelines for the destruction of records which can be found in the NHS Records Management Code of Practice.

Medical Records are retained as per the timescales set down in the Records Management NHS Code of Practice. The Trust's policy includes the facility to mark notes for retention with a 'Do not destroy' sticker. Exceptions to the destruction timescale, and full details of the destruction process, are documented in the Retention and Destruction SOP.

Monitoring

Annual audit

The Clinical Audit Department facilitate an annual Healthcare Records audit to ensure that paper record keeping standards set by Salisbury NHS Foundation Trust comply with processes set for Trusts.

Departments across the Trust participate in the audit including high risk areas such as ED, ITU,

Anaesthetics and Maternity. Standard data collection forms are provided by the Directorate for Clinical Effectiveness.

The overall Trust results of the audit are presented to:

- The Clinical Governance Committee
- The Clinical Management Board (CMB)

Results for individual directorates and departments are distributed to the Directorate Management teams who are set targets for improvement and are asked to provide action plans to demonstrate how these will be met. This is monitored by the Clinical Audit department.

Notes retrieval

The retrieval standard set for outpatients is 99%. This is monitored on a daily basis using information supplied by the Records Library Supervisor.

Records are considered to be missing if:

- The folder is not available
- The folder is found after the appointment time
- Only a temporary folder is available

A log of missing records is maintained by the Health Records Manager.

A regular report on the availability of records is produced for the Information Governance Steering Group.

Amendment record

Document Version Control (to be updated during the development of this version until final version is published)

Version No	Changes	Author/s	Date
0.1	First Draft	Sandy Higdon	26/09/2018
1.0	FINAL VERSION	Diane Gravett	23/10/2018
1.3	Post Access Policy review		

Review and Amendments Log (will only be completed for subsequent published versions of this procedure)

Version No	Reason for Development/Review	Description of Changes	Date

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