HEALTH RECORDS POLICIES & PROCEDURES POLICES & PROCEDURES

Summary of Health records policies/ procedures

There is a policy for the retention, destruction or archiving of health records in accordance with national guidelines. The method of destruction must ensure that confidentiality is maintained at all times.	001	PRIMAP Standard 4 (Point 4.9)	
There is a policy on confidentiality and the release and management of information that complies with the relevant legislation and national guidance. The policy sets out how the organisation ensures that information held about patients, their families and staff is managed confidentially.	002	PRIMAP Standard 4 (Point 4.17)	IG Standard 6.005
There is a policy for ensuring the physical security of areas where health records may be accessed e.g. locking doors; filing cabinets etc.	003	PRIMAP Standard 4 (Point 4.21)	

There is a policy in respect of safe and secure transportation of health records within and without the organisation's boundaries.	004	PRIMAP Standard 4 (Point 4.28)	IG Standard 5.001
There is a policy in respect of receipt and transmission of faxes and electronic data flows containing confidential patient identifiable information.	005	PRIMAP Standard 4 (Point 4.31)	
There is a policy for the creation and subsequent incorporation of temporary records.	006	PRIMAP Standard 4 (Point 4.38)	
There is a protocol for safe manual and object handling practices that all staff are fully aware of.		PRIMAP Standard 2 (Point 2.11)	Refer to NHS Boards' Moving and Handling Procedures
There is a mechanism to ensure that all equipment used in the department conforms to the appropriate legislation.		PRIMAP Standard 2 (Point 2.14)	Refer to NHS Boards' Estates Procedure for Equipment checks
There are procedures for the safe storage and retrieval of health records both manual and electronic	007	PRIMAP Standard 2 (Point 2.27)	

There are procedures for booking records out from the normal filing system, which enables rapid retrieval of records and prevents misfiling.	008 009	PRIMAP Standard 2 (Point 2.28)	
There is a method for indicating alert to risk factors, which is used consistently in all patient records, with the case note containing a designated place for healthcare professionals to record actual allergies/risks; to be signed and dated.	010	PRIMAP Standard 3 (Point 3.4) Please note policy 010 has not been drafted as it was felt this would be best developed at local hospital or NHS Board level.	
There is a procedure for splitting fat folders, including cross-referencing of the volumes, such that clinical staff may efficiently use them.	011	PRIMAP Standard 3 (Point 3.10)	
There is a procedure relating to the return of patient-held records to the health records department when the episode of care for an individual patient is complete.	012	PRIMAP Standard 3 (Point 3.11) Please note policy 010 has not been drafted as it was felt this would be best developed at local hospital or NHS Board level.	

There is a procedure for issuing local patient identifiers. The relevant staff are aware of the procedure and there is evidence of implementation.	013	PRIMAP Standard 4 (Point 4.10)	
There is a procedure for updating patient demographic details (e.g. change of address) when these are notified to a member of the organisation's staff.	013	PRIMAP Standard 4 (Point 4.12)	
There is a procedure for handling subject access requests, with clear responsibility for responding by fully trained and resourced staff who process such requests efficiently and in accordance with the law.	014	PRIMAP Standard 4 (Point 4.18) Please note policy has not been drafted as it was felt this would be best developed at local hospital or NHS Board level.	
There is a procedure in place which identifies the responsibility for filing of loose documentation within case records. This makes reference to the responsibility of all stakeholders.	015	PRIMAP Standard 3 (Point 3.15)	

001. Retention, Destruction and Archiving Of Health Records

1. Opening Statement

The data protection act 1998 sets out a series of standards which NHS Boards and other NHS Bodies must meet in order to comply with the law. One of these is that they must comply with the Fifth Data Protection Principle which is that "Personal Data processed for any purposes shall not be kept for longer than is necessary for that purpose or those purposes".

2. Retention Periods

Legal requirement is (x) years but local policies may differ. List local retention periods for deceased, current, non current health records etc.

3. Exceptions

List categories that must not be destroyed e.g. pre 1948 etc.

4. Process

List your local procedure for:
Identification of records suitable for destruction
Recording date of destruction
Confidential destruction/ disposal of health record

Definition of Terms & Acronyms

Reference **(National/local guidelines, standards and legislation)**

Links **(related policies and guidance)** can also include web links if applicable:

NHS MEL (2000)17 : Data Protection Act 1998
www.sehd.scot.nhs.uk/mels/200017.doc

Records Management Code of Practice (NHS Scotland)

Policy 007 : Medical Records Filing System

002. Confidentiality/Security and the Release and Management of Information

1. Opening Statement

Everyone working in the NHS has a legal obligation to keep all patient related information confidential.

Security and Confidentiality of data applies not only to manual health records but also computer systems both administrative and clinical, e.g. PAS, Laboratory, Radiology systems etc.

2. Your Responsibility

Staff should read and be aware of the content of the NHS Code of Practice on protecting patient confidentiality (yellow booklet). This should be provided with letter of appointment. All staff must sign a confidentiality statement on commencement of duty. Any breach of confidentiality will attract disciplinary action, which may lead to dismissal.

3. What Constitutes Confidential Data

All information held about a patient is regarded as confidential. This includes: demographic/administrative data as well as clinical data, e.g. name, address, postcode, telephone number, clinic attended, appointment details. Give examples of what constitutes confidential data and how confidentiality may be breached.

4. Security

Describe physical controls e.g. ID badges, restricted access, key pads etc

5. Security of Computerised Data

Describe system controls e.g. Passwords/unique user name, level of access, private and unintelligible to others, audit trails ,follow up action, termination of employment, secure areas, logging off etc.

6. Staff Members with a Legitimate Right to Access Confidential Data

Medical, Nursing, Research, Health Records, Medico/legal, clinical effectiveness, Allied Health Care Professionals etc.

7. Data Protection Act/Access to Health Records Act

Refer to Data Protection Act 1998 and Access to Health Records Act 1990. Describe on a step by step basis the process for receipt of data subject access requests, processing and release. Timescale, Mandates. List all forms of access.

8. Information Sharing

This process usually requires the consent of the patient. This may be implicit i.e. implied when the patient seeks medical care or explicit i.e. the patient makes an informed decision to consent to the release/sharing of their data. Examples of information which may be divulged under statutory obligation include:

List : Notification of Infectious Diseases

Notification under child protection arrangements, DSS BR409 etc.

Definition of Terms & Acronyms

Reference **(National/local guidelines, standards and legislation)**

Links **(related policies and guidance)** can also include web links if applicable

Data Protection Act 1998 www.sehd.scot.nhs.uk/mels/2000_17.doc

Access to Health Records Act 1990

Caldicott Principles www.confidentiality.scot.nhs.uk/caldicott.htm

www.elib.scot.nhs.uk

"Protecting Personal Health Information" – Information Guide for Patients (NHS- National Service Scotland)

Health Right Information Scotland.

“Confidentiality – It’s Your Right” http://www.hris.org.uk

“Confidentiality – A guide for young people under 16” http://www.hris.org.uk

“How to see Your Health Records” http://www.hris.org.uk

Policy: Local IT Security

003. Security of Health Records Storage Areas

1. Opening Statement

Storage has a huge impact on the effectiveness of the service we provide. Areas must be secure to protect records against loss, damage or access by unauthorised persons.

2. Health Records Libraries

List local controls procedures i.e. security – key pad, swipe card etc.

3. Peripheral Office Accommodation and Storage Areas

List local physical controls and procedure for access (including out of hours access).

4. Off-site Storage

Include details: off-site storage location and supplier and out of hours access.

5. Electronic Storage

Levels of access e.g. electronic document management system.

6. Access

List staff groups who are allowed to access the various storage areas.

Definition of Terms & Acronyms

Reference **(National/local guidelines, standards and legislation)**

Links **(related policies and guidance)** can also include web links if applicable

Policy 002 : Confidentiality/Security and the Release and Management of Information Local Moving and Handling, Health & Safety, Security and Lone Working policies

004. Transportation of Health Records Within and Outwith Organisation Boundaries

1. Opening Statement

Patients' Health Records contain personal and sensitive information and are highly confidential documents. Care must be taken when transporting them within or outwith the hospital.

2. Transportation of Health Records within Hospital

Local procedure for transporting to clinics/secretarial staff and wards. Use of trolleys. Local procedure for porter delivery.

3. Transportation of Health Records to other Hospitals within the Health Board Area

Physical controls e.g. Sealed boxes. Dedicated portering service if applicable.

4. Transportation of Original or Copy Health Records to Hospitals or Authorised Agencies outwith the Internal Mail Delivery Service

Physical controls e.g. Recorded Delivery, Taxi, sealed boxes, double envelopes etc. Photocopy sent to reduce risk of losing original etc.

5. Lifting and Handling of Health Records

Proper use of trolleys, keep bundles manageable, See manual handling policy

6. Staff Transportation of Health Records

Staff awareness of procedures for safe and confidential physical transportation of health records throughout the organisation.

Definition of Terms & Acronyms

Reference **(National/local guidelines, standards and legislation)**

Links **(related policies and guidance)** can also include web links if applicable

Policy 002 : Confidentiality/Security and the Release and Management of Information

Policy 008 : Case record Tracking / Tracering

005. Electronic Transmission of Patient Identifiable Data

1. Opening Statement

The protocol should conform with the guidance contained within NHS MEL (1997) 45 "*Guidance on the use of facsimile transmissions for the transfer of personal health information"* and local policy on e-mailing patient identifiable data. For the safe transmission of electronic patient data no information identifying the patient should be faxed.

2. Safe Haven

Record location of safe haven fax.

3. Removal of Demographic Details

List steps followed before faxing information i.e. photocopy original, blank out patient identifiable information etc.

4. Receipt of faxes

Acknowledge receipt, date stamp etc.

5. Receipt of Electronic Referrals

Detail local procedure on receipt of electronic referrals etc.

Definition of Terms & Acronyms

Reference **(National/local guidelines, standards and legislation)**

Links (related policies and guidance) can also include web links if applicable

NHS MEL (1997)45 "Guidance on the use of facsimile transmissions for the transfer of personal health information"

Policy 002 : Confidentiality/Security and the Release and Management of Information

Policy 009 : Missing Case records

006. Temporary And Duplicate Case records

1. Opening Statement

A temporary case record folder may only be issued on the instruction of a member of the management team when she/he is satisfied that an exhaustive search has been carried out and original case record cannot be found. When duplicate registrations are identified action must be taken to amalgamate both physical case record and computerised system.

2. Procedure for Issuing Temporary Case record Folder

List your local procedure which explains step by step guide i.e. inform clinician, obtain copies of documentation, creating a temporary folder etc.

3. Amalgamation of Documentation

Actions taken when original case record found i.e. shredding of copy documents etc.

4. Tracking of Temporary Case records

Local policy i.e. recording electronically and manually.

5. Amalgamation of Duplicate Registrations/Case records

Local procedure i.e. merge patient index record and contents of both case records physically amalgamated into correct folder etc.

Definition of Terms & Acronyms

Reference **(National/local guidelines, standards and legislation)**

Links **(related policies and guidance)** can also include web links if applicable

Policy 009: Missing Case records

007. Medical Records Filing Systems

1. Opening Statement

The prime purpose of a Health Records Department is to bring together 3 key players – the patient, the doctor / healthcare professional and the case record i.e. have the right case records in the right place at the right time. Whichever filing system is used, it is imperative that case records are filed accurately as a great deal of time can be wasted searching for mis-filed records. Failure to produce the case record can result in:

- past medical history being unavailable;
- refusal/delay by Consultant to see patient;
- cancellation of procedure;
- distress to patient/relative;
- increase in clinical risk.

2. Filing System

Describe local filing procedure for each records collection, e.g. terminal digit, alphabetical etc.

3. Case records Storage Systems

Describe the various storage systems in use throughout the Board including secondary storage/off- site storage and other media.

4. Electronic Patient Records

Describe local procedures for accessing /indexing documentation and retrieval of records.

Definition of Terms & Acronyms

Reference **(National/local guidelines, standards and legislation)**

Links **(related policies and guidance)** can also include web links if applicable

Policy 008: Case record Tracking / Tracering

Policy 002: Confidentiality/Security and the Release and Management of Information

Policy 001: Retention, Destruction and Archiving of Health Records

Local Moving & Handling policy

008. Case record Tracking / Tracering

1. Opening Statement

When case records are removed from the filing system or given from one person to another the chart tracking system is updated. Failure to update the chart tracking system as case records are removed from file or change location may result in case records not being available when required.

2. General Principle

Describe general principle for updating the chart tracking system including the accountability for each staff group in the patient process. E.g. Health records, ward clerks, medical secretaries etc.

3. Process for Confirming Case records Back into Current File

Local procedure i.e. medical records staff only re filing into current filing area

4. Computer System Downtime

Describe local procedures which are put into place i.e. manual tracers, registers etc

Definition of Terms & Acronyms

Reference **(National/local guidelines, standards and legislation)**

Links **(related policies and guidance)** can also include web links if applicable

Policy 007 : Medical Records Filing Systems

Policy 004 : Transportation of Health Records within and outwith Organisation Boundaries

009. Missing Case records

1. Opening Statement

Health Records staff are responsible for ensuring that all patients' case records are available for any attendance or admission the patient may have at hospital. In addition to this, case records require to be obtained timeously for a number of administrative processes.

2. Chart Tracking History

Describe steps taken to obtain history, e.g. checking last and previous locations chart tracking system.

3. Procedure for Obtaining Missing Case records

List steps i.e. search shelves, clinic bundles (not tracked), secretaries offices etc.

4. Escalating Problem if Case records Cannot be Found

Local procedure e.g.. passed to Supervisor, Issue of Temporary Folder.

5. Case record Located

Local procedure i.e. original documentation amalgamated, copies shredded, update tracking system.

Definition of Terms & Acronyms

Reference **(National/local guidelines, standards and legislation)**

Links **(related policies and guidance)** can also include web links if applicable

POLICY 006: Temporary and Duplicate Case records

011. Splitting of Voluminous Case record Folders

1. Opening Statement

When the documentation relating to a patient can no longer be securely filed in one volume, a second volume is created to hold the overflow. Some patients may require a third or fourth volume in order to keep the notes manageable.

2. Numbering

Outline your local procedure for numbering each volume.

3. Procedure for Splitting Case records

List contents of each volume.

- Culling and Retention Procedure.
- Outline your local Tracking procedure.
- Describe process for labelling closed records.

Definition of Terms & Acronyms

Reference **(National/local guidelines, standards and legislation)**

Links **(related policies and guidance)** can also include web links if applicable

Policy 007 : Medical Records Filing Systems

Policy 008: Case record Tracking / Tracering

Policy 001: Retention, Destruction and archiving of Health Records

013. Searching and Updating Patient Demographic Data In The Master Patient Index

1. Opening Statement

The Master Patient Index is an alphabetical key to records which are filed numerically. It allows patient search, amendment to patient demographics and registration of new patients creating a departmental patient identification number which is linked to the Community Health Index number as the unique patient identifier. It can be kept on a computerised patient administration system or on a manual card system.

2. Information Held on Master Patient Index

List demographic data held on MPI, e.g. date of birth, name, post code, CHI number, GP etc.

3. Search and Registration Techniques

Describe local search procedures e.g.:

- full patient demographics, surname, forename, date of birth, name, sex, CHI etc;
- DOB only;
- homonyms / alias;
- combination of patient demographics, e.g. surname and postcode or name and CHI etc.

4. Maintenance of Master Patient Index

Describe procedures for updating the Master Patient Index, e.g. change of patient demographic details, recording deaths etc.

5. Unknown Patients

Describe procedures for registration of unknown patients.

6. Data Quality

List mandatory fields

- Process for duplicate checking
- Process for notification of duplicates

- Accountable officer

Definition of Terms & Acronyms

Reference **(National/local guidelines, standards and legislation)**

Links **(related policies and guidance)** can also include web links if applicable

7. 015. Filing of Loose Documentation

8. Opening Statement

During the course of a patients' treatment within the hospital, many documents and reports are produced by the various clinical and laboratory departments concerned with the patients' care. These documents and reports arrive at a variety of destinations within the hospital. Health Records, ward clerks and medical secretarial staff are responsible for ensuring loose documentation is timeously and correctly filed within the Health Record folder.

9. Health Records Department

Describe procedures and accountability for loose documentation

10. Medical Secretarial Level

Describe procedures and accountability for loose documentation

11. Ward Level

Describe procedures and accountability for loose documentation

12. Accident and Emergency

Describe procedures and accountability for loose documentation

Definition of Terms & Acronyms

Reference **(National/local guidelines, standards and legislation)**

Links (related policies and guidance) can also include web links if applicable

 ISBN 978 0 7559 9316 1 (web only publication)