Lindsey Lodge Hospice & Healthcare

RECORDS MANAGEMENT POLICY

Contents

1 Introduction

This policy sets out our commitment to achieving high standards in records management.

Records management is vital to the delivery of our services in an orderly, efficient, and accountable manner. Effective records management will help ensure that we have the right information at the right time to make the right decisions. It will provide evidence of what we do and why. All records are valuable owing to the information they contain and they form a legal document.

We will create and manage records efficiently, make them accessible where possible, protect and store them securely and dispose of them safely at the right time.

By adopting this policy we aim to ensure that the record, whatever form it takes, is accurate, reliable, ordered, complete, useful, up to date and accessible whenever it is needed to:

- help us provide outstanding Patient care and continuity of Care
- helps us to carry out our business;
- help us to make informed decisions and shows good practice
- make sure we comply with relevant legislation and meet data quality standards;
- provide an audit trail to meet business, regulatory and legal requirements;
- make sure we are open, transparent and responsive;
- a reduction in clinical risk
- a reduction in patient complaints
- clear and concise understanding for all staff using the confidential records

Information should always be accurately recorded, should be regularly updated as necessary and easily accessible when requested. This policy applies to all staff and Volunteers working for Lindsey Lodge Hospice & Healthcare. Everyone should ensure:-

- Both the quality and quantity of information that it generated is controlled and maintained
- Information is maintained in an effective manner
- Information is disposed of efficiently when it is no longer required, in accordance with national guidelines

The Caldicott Guardian or Data Protection Officer is responsible for advising in respect of any patient records containing person identifiable information. They are responsible for ensuring patient identifiable information is only shared in an appropriate and secure manner.

2 Standards for Record Keeping

All departments within LLH should keep clear and accurate records relevant to their individual roles and this is not only limited to patient records.

To achieve this, you must:

- Complete all records at the time or as soon as possible after an event, ensuring that you do record in the notes if they are written sometime after the event by entering “Written Late” and then the entry.
- Attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed if applicable and do not use unnecessary jargon.
- Complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these standards.

- Any paper copies which are scanned onto the system i.e. Systm one can be destroyed once you are confident that they are filed electronically.
- Take all steps to make sure that all records are kept securely including passwords to systems and your Systm One smartcard.
- Record keeping is a tool of professional practice and one which should assist the care process so rules by the GMC, NMC, Royal Marsden Online clinical procedures chapter 2.7 and Health and Care Profession Council (HCPC) regarding record keeping should be followed at all times.
- On admission to LLH a new patient record should be created for all new patients attending and the record opened on Systm One. In the paper record pre-printed patient labels must be maintained throughout the record to prevent the omission of NHS number/name and date of birth on the records.
- All new staff and volunteers should have a personnel file created electronically and on paper.
- New donors are created on Donor flex.

3 Records Confidentiality, Security & Storage

The patient record should not be removed from LLH without prior approval from the Manager for the clinical area and recorded on the patient location file document on the L drive. Information Governance rules should be followed when the file is in your possession.

All patient record movements should be recorded on L\Misc\General\Patient location file, so we can locate patient files at all times

Following Discharge or Death for clinical areas the notes should be updated accordingly and discharged from Systm one. Any other databases containing this information should be updated and made inactive. Once the notes have been updated these should be filed in the archive room, by the therapy rooms, downstairs. These are filed in alphabetical order in locked filing cabinets.

If medical records are needed from Northern Lincolnshire & Goole Hospitals NHS Trust, a request should be sent via email to

nlg-tr.CorporateHealthRecordsEnquiries@nhs.net

Log the request on L:\General\misc\patient file location then tab to “hospital records” page.
On receipt of the medical records the log sheet should be updated.

When the patient leaves the care of LLH the medical records should be returned to the hospital as soon as possible. This needs to be updated on the log on the L drive.

The medical records, correctly packaged, should be taken to reception for collection by the hospital transport. Please note that these should **not** be kept in reception overnight. The collection is usually daily at 11am. If the transport has left for the day these should be kept in the bottom drawer of the filing cabinet in the IPU nurses office.

4 Access to Records

Under the Data Protection Act 2018, the right of access, commonly referred to as subject access, gives individuals the right to obtain a copy of their personal data as well as other supplementary information. It helps individuals to understand how and why you are using their data, and check you are doing it lawfully.

They are only entitled to their own personal data and not information relating to other people, unless the patient has died. An individual can make a subject access request verbally or in writing and can be made to any part of LLH. It may be received from a third party acting on behalf of the client. You need to be satisfied that the third party making the request is entitled to act on behalf of the individual.

The subject access request is processed by the Data Protection Officer who needs informing of the request immediately. We do not charge for actioning the request and we must act on the subject access request without undue delay and at the latest within one month of receipt. The response is normally sent out in writing to the requestor but if an individual makes a request electronically it will be provided in a commonly used electronic format, unless the individual requests otherwise.

All requests are logged on the L drive, Information Governance, Subject Access Requests, Subject Access Requests Log as evidence of what information has been provided.

5 Retention & Destruction Management

Destruction of confidential information will be normally actioned after the minimum retention period specified, unless LLH identifies the record for retention for an extended period. Here at LLH we follow the "Records Management Code of Practice for Health & Social Care 2021" from NHS digital. Please see Appendix 1 for full retention periods that we follow.

The retention period will be calculated from the end of the calendar year following the last entry. Detailed below is a brief summary of our different types of records:

i) Patient records

- These are stored in the respective areas when patients are at LLH i.e. Wellbeing, Inpatients and Lymphoedema
- Once patients have been discharged or died, these are stored in the archive room opposite therapy room 2 in locked cabinets for the current and previous year. After this time they are then stored in the archives upstairs.
- They should be kept for a minimum of 8 years
- Destruction is the responsibility of the Data Protection Officer or Caldicott Guardian

ii) Financial Records

- These are stored in the Financial archive which is the storage room attached to the Finance office
- They should be kept for 6 years
- Destruction must be the responsibility of the Finance Manager
- The procedure for destruction is as for Patient records

iii) Staff & Volunteer Records

- These are stored in the locked filing cabinets in the server room or in the upstairs document store in Well-Being
- They should be kept for 6 years
- Destruction is the responsibility of the Workforce Manager
- The procedure for destruction is as for Patient records

iv) Donor records

- These are stored electronically on the Donorflex database
- Once we have been notified of a death we will ensure that if they have a record on Donorflex the status is changed to deceased and an inactive flag is activated.
- If a donor requests removal from the database the status is changed to inactive and we ensure they are made not contactable
- If a donor requests no further contact the record will be flagged as inactive
- Superdraw tickets will only be kept for 3 months following the draw
- Registration forms for events will be inputted onto Donorflex and then destroyed
- Sponsorship forms will be kept for 6 years in line with gift aid

v) Destruction

The destruction of confidential waste is now managed by Restore (Datashred).
All confidential information is put into the white bags in offices and once full are sealed and kept in the upstairs archive room, which are locked ready for collection by Restore.
When Retail shops are sending a full confidential waste bag to the hospice, please email Kay Fowler the Data Protection Officer, so she can track the waste bag and ensure that this is received safely and stored in the correct location.

As part of our contract with Restore we are contracted to a regular service every 8 weeks and if an extra collection is needed please call them on 03300 538 541 or via email at: customerhub@restore.co.uk

After collection and when our confidential waste has been successfully destroyed they provide us with a certificate and a copy is held on the L drive/Facilities/Maintenance and Service/Restore/Destruction certificates

6 Consultation

Quality Assurance and Clinical Leads

7 Dissemination

Via Lindsey Lodge `L` drive policies/guidelines of this form.

8 Equality Act

In accordance with the Equality Act (2010), the Hospice will make reasonable adjustments in the workplace so that an employee with a disability, as covered under the Act, should not be at any substantial disadvantage. The Hospice will endeavour to develop an environment within which individuals feel able to disclose any disability or concern which may have a long term ad substantial effect on their ability to carry out their normal day to day activities.

The Hospice will wherever practical make adjustments as deemed reasonable in light of an employee's specific circumstances and the Hospice's available resources paying particular attention to the Disability Discrimination requirements and the Equality Act (2010)

References: Records Management Code of Practice 2021, ICO website AUTHOR: Kay Fowler RATIFIED BY THE QUALITY ASSURANCE COMMITTEE OF THE BOARD OF TRUSTEES ON 24 January 2019				
ISSUE DATE January 2019, review 2 yearly				
To Be reviewed	Review completed	By	Approved By	Circulation
Sept 19	Kay Fowler	KF	IT/IG Committee	Yes
Sept 21		KF	IT/IG Committee	L: Policies, guidelines & Protocols
Sept 2023				

RECORD TYPE	Department	Retention Start	Retention period	Action at end of retention period	Notes
Patient records not covered by any other section in this schedule	Clinical Records	Discharge or patient last seen	8 years	Review and destroy	Basic health and social care retention period - check for any other involvements that could extend the retention. (i.e. Clinical trials/CJD) All must be reviewed prior to destruction taking into account any serious incident retentions.
Controlled drugs requests. Lloyds Drug Sheets - stock request forms. Patient drug request forms	Clinical Records	Creation	See Notes	Review and destroy	NHS England and NHS BSA guidance for controlled drugs can be found at: http://www.nhsbsa.nhs.uk/PrescriptionServices/1120.aspx and https://www.england.nhs.uk/wp-content/uploads/2013/11/som-cont-drugs.pdf The Medicines, Ethics and Practice (MEP) guide can be found at the link (subscription required): http://www.rpharms.com/support/mep.asp Guidance from NHS England is that locally held controlled drugs information should be retained for 7 years. NHS BSA will hold primary data for 20 years and then review. NHS East and South East Specialist Pharmacy Services have prepared pharmacy records guidance including a specialised retention schedule for pharmacy. Please see: http://www.medicinesresources.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Reports-Bulletins/Retention-of-pharmacy-records/ Pharmacy prescription
Clinical Audit	Clinical Records	Creation	5 years Review and if no longer needed destroy	Review and destroy	
Referrals not accepted	Clinical Records	Date of rejection	2 years as an ephemeral record	Review and destroy	The rejected referral to the service should also be kept on the originating service file. (these are kept on Systm1)

Ward handover sheets Death certificate book & counterfoil	Clinical Records Clinical Records	Date of handover Creation	2 years 2 years	Review and destroy Review and consider transfer to a Place of Deposit	This retention relates to the ward The individual sheets held by staff must be destroyed confidentially at the end of the shift.
Board Meetings	Corporate Records	Creation	Before 20 years but as soon as practically possible	Review and consider transfer to a Place of Deposit	This includes all meetings (i.e. Health & Safety, QA, HR, Finance and Business development & Board Meetings). Local decision can be made but must not exceed 20 years
Chief Executive records	Corporate Records	Creation	May retain for 20 years	Transfer to a Place of Deposit	The may include emails and correspondence where they are not already included in the board papers and they are considered to be of archival interest.
Incidents (non-serious) Incidents (serious) requiring investigation	Corporate Records	Date of incident	10 Years 20 years	Review and consider transfer to a Place of Deposit	These are all recorded on L:\ drive incidents database
Non-Clinical Quality Assurance Records	Corporate Records	End of year to which the assurance relates	12 Years	Review and destroy	
Policies, strategies and operating procedures including business plans	Corporate Records	Creation	Life of organisation plus 6 years	Review and consider transfer to a Place of Deposit	
Patient information leaflets	Clinical Records	End of use	6 Years	Review and consider transfer to a Place of Deposit	
Press releases and important internal communications	Corporate Records	Release Date	6 Years	Review and consider transfer to a Place of Deposit	Press releases may form a significant part of the public record of an organisation which may need to be retained

Off Duty Rota	Staff Records	Close of financial year	6 Years	Review and destroy	
Staff/Volunteer Record	Staff Records	Staff/volunteer leaves	6 years	Create Staff Record Summary then review or destroy the main file	This includes (but is not limited to) evidence of right to work, security checks and recruitment documentation for the successful candidate including job adverts and application forms. May be destroyed 6 years after the staff member/volunteer leaves
Timesheets (original record)	Staff Records	Creation	2 Years	Review and destroy	
Staff Training records	Staff Records	Creation	See Notes	Review and consider transfer to a Place of Deposit	Records of significant training must be kept until 75th birthday or 6 years after the staff member leaves. It can be difficult to categorise staff training records as significant as this can depend upon the staff member's role. The IGA recommends: · Clinical training records - to be retained until 75th birthday or six years after the staff member leaves, whichever is the longer Statutory and mandatory training records - to be kept for ten years after training completed Other training records - keep for six years after training completed.
Building plans and records of major building work	Corporate Records	Completion of work	Lifetime of the building or disposal of asset plus 6 years	Review and consider transfer to a Place of Deposit	Building plans and records of works are potentially of historical interest and where possible be kept and transferred to a place of deposit.

CCTV	Corporate Records		See ICO Code of Practice/ automatic erasure takes place after approx. 2 months	Review and destroy	ICO Code of Practice: https://ico.org.uk/media/for-organisations/documents/1542/cctv-code-of-practice.pdf The length of retention must be determined by the purpose for which the CCTV has been deployed. The recorded images will only be retained long enough for any incident to come to light (e.g. for a theft to be noticed) and the incident to be investigated.
Equipment monitoring and testing and maintenance work	Building	Completion of monitoring or test.	11years	Review and destroy	
Inspection reports	Building	End of lifetime of installation	Lifetime installation	Review	
Leases	Building	Termination of lease	12 years	Review and destroy	
Minor building Works	Building	Completion of work	6 years	Review and destroy	
Photographic collections of service locations and events and activities	Building	Close of collection	Retain for not more than 20 years	Consider transfer to a place of deposit	The main reason for maintaining photographic collections is for historical legacy of the running and operation of an organisation. However, photographs may have subsidiary uses for legal enquiries.
Accounts	Finance	Close of financial year	6 Years	Review and destroy	Includes all associated documentation and records for the purpose of audit as agreed by auditors.
Donations	Finance	Close of financial year	6 years	Review and destroy	Donations that have a complete gift aid declaration are kept indefinitely
Expenses	Finance	Close of financial year	6 years	Review and destroy	
Final annual accounts report	Finance	Creation	6 years	Transfer to a Place of Deposit	Should be transferred to a place of deposit as soon as practically possible.

Financial records of transactions	Finance	End of financial year	6 Years	Review and destroy	We keep all documents for 6 years. Records for assessment/new buildings/capital expenditure kept indefinitely
Petty Cash	Finance	End of financial year	6 Years	Review and destroy	
Pension records	Finance	Close of financial year	6 Years	Review and destroy	
Complaints case file	Clinical Records	Close of incident (see notes)	10 Years	Review and destroy	http://www.nationalarchives.gov.uk/documents/information-management/sched_complaints.pdf The incident is not closed until all subsequent processes have ceased including litigation. The file must not be kept on the patient file. A separate file must always be maintained.
Subject Access Requests (SAR) and disclosure correspondence	Clinical Records	Closure of SAR	3 Years	Review and destroy	
Ward Registers	Clinical Records	End of financial year	8 years	Review and destroy	This covers all clinical areas
Communication Books	All Departments	End of Calendar Year	8 years	Review and destroy	Clinical/Doctors etc.
Diaries	All Departments	End of Calendar Year	8 years	Review and destroy	Includes kitchen/IPU/Bereavement
Environmental Health Checks	Catering	6 months from date completed	6 months	Review and destroy	

Procurement	Contracts sealed or unsealed	End of contract	6 Years	Review and if no longer needed destroy	
Procurement	Contracts – financial approval files	End of Contract	15 years	Review and if no longer needed destroy	
Procurement	Contracts – financial approved suppliers documentation	When supplier finishes work	11 years	Review and if no longer needed destroy	
Procurement	Tenders (successful)	End of Contract	6 years	Review and if no longer needed destroy	
Procurement	Tenders (unsuccessful)	Award of tender	6 years	Review and if no longer needed destroy	