Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Health and social care records policy

Board library reference	Document author	Assured by	Review cycle
P046	Head of Compliance	Quality & Safety Committee	3 Years

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Contents

1. Introduction

The Trust is required by law to maintain accurate and up to date formal records of all of its activities relating to the provision of Health and Social Care.

Accurate Health & Social Care Records are a tool of professional practise that should improve the care process for all patients.

Good record keeping can determine accountability, facilitate clinical decision making, improve patient care through clear communication of the treatment rational; provide a consistent approach to team working; and help defend complaints or legal proceedings.

2. Policy statement

2.1 High quality health and social record keeping

The Trust expects that information contained within the Health & Social Care Records are correctly recorded, regularly updated, legible, factual and easily accessible.

These principles with the addition of the documentation of clinical findings, decision making, medication prescribed, investigations, treatments and information given to patients and carers assists in the safe care and treatment of patients

High quality records support effective clinical judgements, allow easier continuity of care, identify risk and enable early detection of complications, provide documentary evidence of service delivered, promote better communication and sharing of information between members of the multi-professional healthcare team, support patient care and communications and support the delivery of services.

3. Purpose or aim

The purpose of this Policy is to ensure that the Trust conducts its business in compliance with the legal and regulatory framework and to ensure the highest possible standards of safety of its service users, carers and staff.

Records created by the NHS are public records and under the provisions of the Public Records Act of 1958, all NHS employees are responsible for any records that they create or use in the course of their duties.

The Data Protection Act of 1998 requires the Trust to have both organisational and technical measures in place to ensure that “personal data ” and “sensitive personal data ” is fit for purpose (data quality), and is protected from accidental or deliberate loss or damage (data security).

In addition, the management of Health and Social Care Records is regulated by national standards defined by the Department of Health in “Records Management: NHS Code of Practice and the NHS Confidentiality Code of Practice” (the “Codes”).

The guidelines contained in the Codes apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held.

Professionally qualified staff must also adhere to their professional bodies code of conduct on record keeping.

The Trust provides standardised record keeping systems and procedures in order to be compliant with the legal and regulatory framework within which the NHS operates.

This Policy describes the Trust’s approved processes and standards for the creation, use, maintenance, management, storage and destruction of Health and Social Care Records.

4. Scope

This Policy applies to all Health and Social Care Records in either paper or electronic format.

This is a Trust-wide Policy and applies to all staff and personnel operating under the auspices of the Trust, including employees, locums, contractors, temporary staff, students, service user representatives, volunteers and partner agency staff.

Due to the integration in Health & Social Care Teams of staff from partner organisations there may be additional "data controllers" interested in the content of the Health & Social Care Record which is 'owned' and administrated by the Trust.

Where a third party has an organisational policy that differs from this Policy, a formal agreement as to which policy statement applies shall be outlined and agreed in an appropriate protocol if necessary. In the absence of such an agreement, this Policy shall be deemed to have precedence.

5. Content

5.1 RiO electronic patient record

RiO is the approved electronic patient record.

Access to RiO is only provided for authorised staff members via the Registration Authority once they have met certain conditions and supplied identification to the satisfaction (eGIF Level 3) security requirements,

Access is then provided via a smartcard in accordance with the Position Based Access Control which is assigned to job roles.

Each member of staff has their own unique smartcard and in accordance with the issuing terms of the smartcard that staff agree to, it is expressly forbidden to share the use and log on details of smartcards with colleagues. Each staff member is accountable for the activity recorded against their smartcard.

Access is then available 24 hours a day, 7 days a weeks across all Trust sites.

5.2 Creating a RiO record

A RiO record is created upon receipt of a referral into the Trust and the procedures for registering a referral in RiO Clinical Manual Wiki Pages, RiO Registration.

5.3 RiO down time

There will be times when RiO is not available to record patient care. To view a backup of the service users record go to the Clinical Viewer, accessible through Ourspace

In the highly unlikely event that neither RiO nor the Clinical Viewer are accessible then clinicians should make clinical decisions based on the information they are able to obtain. This may include:

- An assessment of how the service user is presenting there and then
- Information available from service users friends and family
- Speaking to G.P. and asking for them to provide information electronically
- Gathering information from partner agencies involved in the service user care
- Gathering information from other AWP staff members involved in the service users care

During both planned and unplanned downtime, all clinical information must be recorded on 'downtime' forms in the absence of any other local documented process. Localities may choose

not to use downtime forms and to use their own solution though this must be documented clearly.

When RiO is restored staff are responsible for entering any data for the period when RiO was not available. All records recorded on downtime forms during the upgrade must be shredded once access to RiO has been restored and must not be filed.

Guidance on the management of specific documents can be found within the RiO Clinical Support (Wiki) pages.

5.4 Historic records

Where a paper record already exists, (buff folder), in most cases this is termed as the historic part of the record in its entirety i.e. RiO (electronic part) and Historic (paper part). Where a record is closed to a service, the dormant /closed historic record must be safely and securely stored in the Health and Social Care record archives. If the historic record is required then it can be requested from the Health & Social Care Records archive and tracked and traced as detailed in the Tracking and Tracing Paper Records in RiO available on the Health & Social Care Records pages of Ourspace..

5.5 Standards for record keeping

Clinical recording standards ensure that the health and social care records should inform any health professional involved with the service user of those responsible for providing care, what that care is or has been and any key features or risks. This must be in line with the Trust's Care Programme Approach Policy.

The Health and Social Care Record will detail the service users' current assessment, the care plan, the care coordinator and the review cycle.

Where available a diagnosis should be recorded.

A risk assessment must be undertaken and any risk identified should be recorded.

Health and Social Care Record entries must be clear, legible and follow a logical and methodical sequence where practical.

All clinically pertinent communications regarding the service user must be recorded within RiO, this includes telephone conversations, emails, faxes and letters. If paper diaries are also used for making notes on a service user or detailing comments, these must also be placed on the record.

All documents created within RiO will include the service users NHS number as the unique identifier.

Rio Clinical Support gives guidance on basic record keeping standards .

5.6 Information that is not part of the health and social care record

The following information is not part of the Health & Social Care Record and must not be uploaded into RiO:

- medico-legal documents
- complaints and related correspondence
- PALS information
- Adverse Incident Forms
- Serious Untoward Incident Reports
- Subject Access and Access to Health Records requests

5.7 Non registered staff

Non Registered Clinical staff will be able to validate their RiO entries after completing an assessment of competency which can be found in the RiO Wiki Clinical Manual.

5.8 Incidents

The following must all be reported on an Adverse Incident and reported to both the Health and Social Care Records Manager and Information Governance Manager:

- Any breaches or potential breaches of confidentiality
- wrongly addressed/delivered historic record
- insecurely delivered historic record
- historic record lost in transit
- historic record found in an inappropriate location

5.9 Retention and disposal of records

Records are to be retained for a minimum period of time as defined in the Retention and Disposal Schedules contained in the Records Management: NHS Code of Practice

The process is overseen by the Health & Social Care Records Department and the standing operating procedures can be found here.

5.10 Permanent preservation

If a health professional considers that a service users Health & Social Care Record to be worthy of permanent preservation once the relevant retention period has been exceeded they must request this stating the reasons in writing to the Trust's Caldicott Guardian. A copy of this letter must be scanned into the RiO document section.

The Caldicott Guardian will inform the Health & Social Care Records Department of their decision, for them to action.

When dealing with the historic part of the record, a standard operational procedure is in place 'Permanent Preservation' which will be followed by Health and Social Care Records Staff but can also be found on the Health and Social Care Records web page.

5.11 Informing Service Users

Service users should be informed about the ways the Trust will use and share personal information both internally and with external agencies in accordance with the Care Record Guarantee. The Trust maintains a Fair Processing Notice on the Trust's public website.

These purposes are documented in the Trust's Data Protection Notification maintained by the Data Protection Officer.

Any new processing of personal information must be reported to the Data Protection Officer in order for this to be registered.

Where it is necessary to share information with parties not directly involved with the care of the service user, whether this a legal duty or a legal power exists, it may be appropriate to first seek the consent of the service user. This must be documented in RiO Progress Notes section.

Further guidance on sharing information can be found in the Department of Health's, Confidentiality Code of Practice and the General Medical Council's Confidentiality Guide for Doctors.

Health Care Professionals must record any patient's consent for the disclosure or non-disclosure to relatives, carers and friends on the Information Sharing Consent form. The form must be uploaded into RiO. It is good practice to also make a note of this in the progress notes as this will alert a reader where the form is and the fact it has been completed. This must be revisited on a regular basis.

5.12 Security and confidentiality of personal and sensitive data

All "personal and sensitive data" processed by the Trust is subject to the Data Protection Act of 1998, and must therefore be processed in accordance with the Trust's Data Protection Policy.

Personal and sensitive data is collected in confidence; it must remain confidential, and may only be used for the purpose for which it was originally collected unless there is a legitimate legal reason for disclosure.

Staff may only access confidential information on a need-to- know basis, and only for the legitimate purpose of doing their jobs.

It is the responsibility of SBU Directors to ensure that: adequate control measures are in place for the security of records whilst in use or transit and that records are not accessible to unauthorised parties; and

Staff or other parties working on behalf of the Trust understand and carry out their individual responsibilities for information security as described in the Trust's Information Security Policy, Data Protection Policy and Acceptable Use Policy.

Local managers are required to conduct formal risk assessments to identify areas that may present a security or business continuity risk for paper records.

Appropriate physical security measures must be in place to control access to work areas where records are stored or are in use. The risk assessment must be reviewed following any security incident or when circumstances change. The risk assessment can be found on the Health and Social Care Records Service web pages via Ourspace.

It is the responsibility of ward managers to ensure that records are secured at all times. This is the responsibility of the clinic manager for out-patient clinics.

Records in transit must not be left unattended in vehicles unless the vehicle has suitable security arrangements to prevent the theft of the vehicle and/or the records it is transporting.

5.13 Tracking and tracing of historic record

The Tracking and Tracing of historic paper records must be completed in the Comments Field of the Patient Demographic Screen in order to allow for efficient retrieval as necessary. The procedure can be found on the Health and Social Care Records Service web pages via Ourspace.

5.14 Service User access to records

Service users and their representatives are entitled to request access to the Health and Social Care Records the Trust processes about them.

This is known as a "Subject Access Request" and is to be processed in accordance with the Trust's Data Protection Policy and associated procedure by the (SAR Team), Subject Access Request Team, C/O Health & Social Care Records Service.

Additionally representatives of deceased service users are able to request access to the Health and Social Care Records the Trust processed about them and again this must be dealt with by the (SAR Team), Subject Access Request Team, C/O Health and Social Care Records Service.

5.15 Transferring records to another Trust/Provider

All requests for copies or the original record received by another trust/provider must be dealt with by the Health and Social Care Records Service.

5.16 Movement and transportation of paper records

Users of Health and Social Care Records are personally responsible for the security of the Health and Social Care Record they hold. The procedure can be found in the Health and Social Care Records Service web pages via Ourspace.

6. Roles and responsibilities

6.1 The Chief Executive

The Chief Executive has strategic responsibility for the management and quality of records in accordance with the Department of Health publication - Records Management: NHS Code of Practice, and delegates this responsibility to officers of the Trust as described below.

6.2 The senior information risk owner (SIRO)

The Resources Director shall be the Senior Information Risk Owner (SIRO) and shall represent any relevant information risk to the Board of Directors.

6.3 LDU Directors

Service and Clinical Directors of LDUs are accountable to the Director of Operations for the implementation of this policy within their LDU. The LDU Directors are responsible for the risks associated with the quality of records via the Trust's records auditing processes via the Trust Quality Information System (IQ).

Executive Directors and LDU Directors are responsible for the implementation of the standards of compliance specified in this policy within their areas of responsibility.

6.4 Other Executive Directors

Executive Directors are accountable to the Chief Executive for the implementation of this policy where Health and Social Care Records are handled by staff in their Directorates.

6.5 The Caldicott Guardian

The Caldicott Guardian role is undertaken by the Director of Nursing who represents and champions information governance and has a fundamental role around confidentiality. The Caldicott Guardian is responsible for championing the principles of confidentiality across the Trust and ensuring that patient identifiable information is shared only for justified purposes and that only the minimum information is shared.

The Director of Nursing is the RiO Information Asset Owner.

6.6 The Health & Social Care Records Manager

The Health and Social Care Records Manager is responsible for historic paper and archived records

The Health & Social Care Records Manager is responsible for the maintenance and review of this policy and associated procedures.

The Health & Social Care Records Manager is responsible for overseeing subject access requests with regard to Health & Social Care Records.

6.7 The Head of Compliance

The Head of Compliance is responsible for supporting the Health & Social Care Records Manager and for providing specialist advice on compliance with this policy and the regulatory framework.

6.8 The Clinical Systems Manager

The Clinical Systems Manager is the responsible officer for RiO electronic records.

6.9 Information Governance Steering Group

The Information Steering Governance Group (IGSG) shall monitor and report on the implementation of the Trust's Information Governance Management System (IGMS) with respect to the management and quality of Health & Social Care Records.

The ISGG reports to the Integrated Governance Group.

The Health & Social Care Records Policy is presented to the Quality and Standards Committee for approval.

6.10 Line Managers

Line Managers are responsible for ensuring compliance with this policy through appropriate managerial arrangements including training, supervision, performance management and the use of disciplinary procedures where necessary.

It is the responsibility of Line Managers to arrange for the provision of suitable Records training for staff which can be found in the Managed Learning Environment and the Information Governance Training Tool.

6.11 All Users of Health and Social Care Records

All users of Health and Social Care Records are responsible for ensuring that their use of Health and Social Care Records is conducted in compliance with this policy and any relevant professional code of conduct to ensure the highest quality records.

Additionally staff have a personal duty and responsibility to keep up to date with and adhere to, relevant legislation, case law and national and local policies relating to information and record keeping.

7. Standards

This policy provides for compliance with the following standards:

- Public Records Act 1958
- Data Protection Act 1998
- Freedom of Information Act 2000
- NHS Confidentiality Code of Practice
- Records Management : NHS Code of Practice 2006
- National Archives Guidance
- National Health Service Litigation Authority Clinical Negligence Scheme for Trusts

- Care Quality Commission
- The Information Governance Toolkit
- The Care Record Guarantee

8. Training

The Trust's overarching policy for training is the Learning and Development Policy and this should be read in conjunction with this policy. Attached as appendices to that policy are the Trust's learning and development matrices. These matrices describe the minimum statutory, mandatory and required training for all staff groups in respect of Health & Social Care Records Management.

The Learning and Development Policy also describes the Trust's arrangements for training, in particular how there are processes in place to ensure staff receive the training they require and how non- attendance is followed up. These arrangements are further supported by management supervision and appraisal processes.

9. Monitoring or audit

The Health & Social Care Records Manager and Head of Information Management are responsible for monitoring that the requirements of this policy have been met.

Compliance with this policy will be monitored and measured by IQ metrics and the Information Governance Toolkit requirements,

10. Definitions

Health & Social Care Record – the Data Protection Act 1998 describes a health records as consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual". In some situations the Trust also provides social care relating to the provision of care that enables individuals to retain their independence, control and dignity.

11. Associated and related procedural documents

- Data Protection Policy
- Information Security Policy
- Registration Authority Policy

12. References

A full list of the applicable legislation referenced in the compilation of this policy can be viewed in the NHS Information Governance Guidance on Legal and Professional Obligations at the following link: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079616

Version History

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