group policies and procedures

# Records management policy

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**Related policies and guidance**

1. Data Protection & Information Sharing Policy
2. Subject Access & Fair Processing Notice
3. Data Quality Policy
4. Information Governance Policy

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# Purpose

Records Management is the process by which an organisation manages all the aspects of records whether internally or externally generated and in any format or media type, from their creation, all the way through to their lifecycle to their eventual disposal.

The Records Management: NHS Code of Practice© has been published by the Department of Health as a guide to the required standards of practice in the management of records for those who work within or under contract to NHS organisations in England. It is based on current legal requirements and professional best practice.

Castleman Healthcare Ltd records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of Castleman Healthcare Ltd and the rights of patients, staff and members of the public. They support consistency, continuity, efficiency and productivity and help deliver services in consistent and equitable ways.

The Castleman Healthcare Ltd Management Board has adopted this records management policy and is committed to ongoing improvement of its records management functions, as it believes that it will gain a number of organisational benefits from so doing. These include:

1. better use of physical and server space
2. better use of staff time
3. improved control of valuable information resources
4. compliance with legislation and standards
5. reduced costs

The organisation also believes that its internal management processes will be improved by the greater availability of information that will accrue by the recognition of records management as a designated corporate function.

This document sets out a framework within which the staff responsible for managing Castleman Healthcare Ltd’s records can develop specific policies and procedures to ensure that records are managed and controlled effectively, and at best value, commensurate with legal, operational and information needs.

This policy needs to be read in conjunction with Castleman Healthcare’s Data Protection & Information Sharing Policy 2016.

# Scope and Definitions

**Scope**

This policy relates to all clinical and non-clinical operational records held in any format by Castleman Healthcare Ltd. These include:

1. All administrative records (e.g.: personnel, estates, financial and accounting records, notes associated with complaints); and
2. All patient health records (for all specialties and including private patients, including x-ray and imaging reports, registers, etc.)

**Definitions**

Records Management is a discipline which utilises an administrative system to direct and control the creation, version control, distribution, filing, retention, storage and disposal of records, in a way that is administratively and legally sound, whilst at the same time serving the operational needs of Castleman Healthcare Ltd. and preserving an appropriate historical record. The key components of records management are:

1. Record creation
2. Record keeping
3. Record maintenance (including tracking of record movements)
4. Access and disclosure
5. Closure and transfer
6. Appraisal
7. Archiving and
8. Disposal.

The term Records Life Cycle describes the life of a record from its creation/receipt through the period of its ‘active’ use, then into a period of ‘inactive’ retention (such as closed files which may still be referred to occasionally) and finally either confidential disposal or archival preservation.

In this policy, Records are defined as ‘recorded information, in any form, created or received and maintained by the Castleman Healthcare Ltd in the transaction of its business or conduct of affairs and kept as evidence of such activity’.

Information is a corporate asset. Castleman Healthcare Ltd’s records are important sources of administrative, evidential and historical information. They are vital to Castleman Healthcare Ltd to support its current and future operations (including meeting the requirements of Freedom of Information legislation), for the purpose of accountability, and for an awareness and understanding of its history and procedures.

# Aims of our Records Management System

The aims of our Records Management System are to ensure that:

1. Records are available when needed - from which Castleman Healthcare Ltd is able to form a reconstruction of activities or events that have taken place.
2. Records can be accessed - records and the information within them can be located and displayed in a way consistent with its initial use, and that the current version is identified where multiple versions exist.
3. Records can be interpreted - the context of the record can be interpreted: who created or added to the record and when, during which business process, and how the record is related to other records.
4. Records can be trusted - the record reliably represents the information that was actually used in, or created by, the business process, and its integrity and authenticity can be demonstrated.
5. Records can be maintained through time – the qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the record is needed, perhaps permanently, despite changes of format.
6. Records are secure - from unauthorised or inadvertent alteration or erasure, that access and disclosure are properly controlled and audit trails will track all use and changes. To ensure that records are held in a robust format, which remains readable for as long as records are required.
7. Records are retained and disposed of appropriately - using consistent and documented retention and disposal procedures, which include provision for appraisal and the permanent preservation of records with archival value; and
8. Staff are trained - so that all staff are made aware of their responsibilities for record-keeping and record management.

# Roles and Responsibilities

**Corporate Governance Director**

The Corporate Governance Director has overall responsibility for records management within Castleman Healthcare Ltd. As accountable officer, he/she is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity. Records management is key to this, as it will ensure appropriate, accurate information is available as required.

Castleman Healthcare Ltd has a particular responsibility for ensuring that it corporately meets its legal responsibilities, and for the adoption of internal and external governance requirements.

**Caldicott Guardian**

Castleman Healthcare Ltd’s Caldicott Guardian has a particular responsibility for reflecting patients’ interests regarding the use of patient identifiable information. They are responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.

**Roles and Responsibilities**

All Castleman Healthcare Ltd staff, whether clinical or administrative, who create, receive and use records have records management responsibilities. In particular, all staff must ensure that they keep appropriate records of their work within Castleman Healthcare Ltd and manage those records in keeping with this policy and with any guidance subsequently produced.

# Legal and Professional Obligations

All NHS records are Public Records under the Public Records Acts. Castleman Healthcare Ltd will take actions as necessary to comply with the legal and professional obligations set out in the Records Management: NHS Code of Practice, in particular:

1. The Public Records Act 1958
2. The Data Protection Act 1998
3. The Freedom of Information Act 2000
4. The Common Law Duty of Confidentiality
5. The NHS Confidentiality Code of Practice

and any new legislation affecting records management as it arises.

# Retention and Disposal Schedules

It is a fundamental requirement that all of the Castleman Healthcare Ltd’s records are retained for a minimum period of time 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 Castleman Healthcare Ltd’s business functions.

Castleman Healthcare Ltd has adopted the retention periods set out in the Records Management: NHS Code of Practice. The retention schedule will be reviewed annually.

# Records Management Systems Audit

Castleman Healthcare Ltd will regularly audit its records management practices for compliance with this framework. The audit will:

1. Identify areas of operation that are covered by Castleman Healthcare Ltd’s policies and identify which procedures and/or guidance should comply to the policy;
2. Follow a mechanism for adapting the policy to cover missing areas if these are critical to the creation and use of records, and use a subsidiary development plan if there are major changes to be made;
3. Set and maintain standards by implementing new procedures, including obtaining feedback where the procedures do not match the desired levels of performance; and
4. Highlight where non-conformance to the procedures is occurring and suggest a tightening of controls and adjustment to related procedures.

The results of audits will be reported to Castleman Healthcare Ltd Board.

# Lifecycle of policies

Lifecycle management of records is the process by which an organisation manages all aspects of records. It applies whether records are internally or externally generated and, in any format, or media type, from their creation, all the way through their lifecycle to their eventual disposal.

The ‘Documents and Records Management Policy’ published by NHS England is a guide to the required standards in the management of records for those who work within, or under contract to, NHS organisations in England. It is based on current legal requirements and professional best practice. As Castleman Healthcare Ltd works under contract to the NHS, Department of Health recommendations and guidelines are adhered to and represented throughout this policy.

# Registration of Record Collections

Castleman Healthcare Ltd will establish and maintain mechanisms through which staff can register the records they are maintaining.

The inventory of record collections will facilitate: -

1. The classification of records into series; and
2. The recording of the responsibility of individuals creating records.

This inventory will form a record register and the register will be reviewed annually.

# Training

All Castleman Healthcare Ltd staff will be made aware of their responsibilities for record-keeping and record management through generic and specific training programmes and guidance.

# Review

This policy will be reviewed every year (or sooner if new legislation, codes of practice or national standards are to be introduced).

# Appendix 1 - References

1. The Public Records Act 1958 http://www.legislation.gov.uk/ukpga/Eliz2/6-7/51
2. The Data Protection Act 1998 http://www.legislation.gov.uk/ukpga/1998/29/contents
3. The Freedom of Information Act 2000 http://www.legislation.gov.uk/ukpga/2000/36/contents
4. The Common Law Duty of Confidentiality http://www.dhsspsni.gov.uk/gmgr-annexe-c8
5. The NHS Confidentiality Code of Practice <https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice>

# Annex 1

**RECORDS TO BE MAINTAINED FOR INSPECTION**

**1. A register of patients, including -**

(a) The name, address, telephone number, date of birth and marital status of each patient.

(b) The name, address and telephone number of the patient's next of kin or any person authorised by the patient to act on the patient's behalf.

(c) The name, address and telephone number of the patient's general practitioner.

(d) Where the patient is a child, the name and address of the school that the child attends or attended before admission to an establishment.

(e) Where a patient has been received into guardianship under the Mental Health Act 1983, the name, address and telephone number of the guardian.

(f) The name and address of anybody that arranged the patient's admission or treatment.

(g) The date on which the patient was admitted to an establishment or first received treatment provided for the purposes of an establishment.

(h) The nature of the treatment received by the patient or for which the patient was admitted.

(i) Where the patient has been an in-patient in an independent hospital, the date of the patient's discharge.

(j) If the patient has been transferred to a hospital (including a health service hospital), the date of the transfer, the reasons for it and the name of the hospital to which the patient was transferred.

(k) If the patient dies whilst in an establishment or during treatment provided for the purposes of an establishment, the date, time and cause of death.

**2. A register of all surgical operations performed in an establishment, including -**

(a) The name of the patient on whom the operation was performed

(b) The nature of the surgical procedure and the date on which it took place.

(c) The name of the medical practitioner or dentist by whom the operation was performed.

(d) The name of the anaesthetist in attendance.

 (e) The name and signature of the person responsible for checking that all needles, swabs and equipment used during the operation have been recovered from the patient.

(f) Details of all implanted medical devices, except where this would entail the disclosure of information contrary to the provisions of section 33(5) of the Human Fertilisation and Embryology Act 1990 (restrictions on disclosure of information).

**3. A register of each occasion on which a technique or technology to which regulation 411 applies has been used, including -**

(a) The name of the patient in connection with whose treatment the technique or technology was used.

(b) The nature of the technique or technology in question and the date on which it was used.

(c) The name of the person using it; and

(d) Where the person using the technique or technology is not a medical practitioner, dentist or other competent person, the name of the medical practitioner, dentist or other competent person on whose direction the technique or technology was used.

**4. A register of all mechanical and technical equipment used for the purposes of treatment provided by the establishment, including -**

(a) The date of purchase of the equipment;

(b) The date of installation of the equipment;

(c) Details of maintenance of the equipment and the dates on which maintenance work was carried out.

**5. A register of all events which must be notified to the Assembly in accordance with regulation 271.**

**6. A record of the rostered shifts for each employee and a record of the hours actually worked by each person.**

**7. A record of each person employed in or for the purposes of the establishment, which shall include in respect of an individual described in regulation 181 the following matters –**

(a) The person's name and date of birth;

(b) Details of the person's position in the establishment;

 (c) Dates of employment; and

(d) In respect of a health care professional, details of relevant professional qualifications and registration with the relevant professional regulatory body

1 The Private and Voluntary Health Care (England) Regulations 2001

# Annex 2

**PERIOD FOR WHICH HEALTH RECORDS MUST BE RETAINED**

**Type of patient Minimum period of retention**

(a) Patient who was under the age of 17 at the date on which the treatment to which the records refer was concluded.

Until the patient's 25th birthday.

(b) Patient who was aged 17 at the date on which the treatment to which the records refer was concluded.

Until the patient's 26th birthday.

(c) Patient who died before attaining the age of 18.

A period of 8 years beginning on the date of patient's death.

(d) Patient who was treated for mental disorder during the period to which the records refer.

A period of 20 years beginning on the date of the last entry in the record.

(e) Patient who was treated for mental disorder during the period to which the records refer and who died whilst receiving that treatment.

A period of 8 years beginning on the date of the patient's death.

(f) Patient whose records relate to treatment by a general practitioner.

A period of 10 years beginning on the date of the last entry in the record.

(g) Patient who has received an organ transplant. A period of 11 years beginning on the date of the patient's death or discharge whichever is the earlier.

(h) All other cases. A period of 8 years beginning on the date of the last entry in the record

# Annex 3

**STANDARDS FOR CONTENTS OF PERSONNEL FILES**

**1.** All personnel files shall be contained within an opaque folder with the name of the individual on the front cover.

**2.** All personnel files shall be marked confidential on the outside of the folder.

**3.** Application form (including: a full employment history, together with a satisfactory written explanation of any gaps in employment).

**4.** Authentication of identity which includes a photograph (passport or driving licence).

**5.** Two written references (one being from the applicant’s most recent employer).

**6.** Where a person has previously worked in a position which involved work with children or vulnerable adults, verification, so far as reasonably practicable, of the reason why he ceased to work in that position.

**7.** Documentary evidence of any qualifications required for the post.

**8.** Work visa (if applicable).

**9.** Where the individual is a health care professional, confirmation of their registration with their professional body is evidenced.

**10.** Details of any criminal offences or cautions are documented.

**11.** Copy of the Offer letter of employment.

**12.** Copy of signed contract of employment.

**13.** Job description.

**14.** Confirmation of CRB declaration.

**15.** Interview notes.

**16.** Induction checklist.

**17.** Copies of training certificates.

**18**. Copies of performance appraisal documentation.

# annex 4 STANDARDS FOR HEALTH RECORDS

Minimum standards for all paper-based Health records will be audited to ensure best practice and regulatory requirements are being adhered to.

**Standard Rationale**

1. Each patient shall have a health record created which shall be contained within an opaque folder. To ensure information is held in a confidential manner
2. Patient’s name is readily identifiable on the front of the folder
* Black ink only
* Upper & Lower case letters
* First name and surname printed

**Facilitates accurate patient identification**

1. A unique patient number is recorded on the front of the health record folder enables ease of filing
2. The address, telephone number, date of birth and marital status of each patient is recorded in each record to comply with regulatory standards
3. All health care professionals working on a patient’s case will record all treatment given and recommendations in the patient’s health record to comply with regulatory standards
4. All entries in patients’ health records are legible Enables all involved in patient care can readily identify medical history of patient
5. All entries in patients’ health records by health care professionals are dated, timed and signed, with the signature accompanied by the name and designation of the signatory. Individuals involved in patient care are readily identifiable
6. Any alterations or additions are dated, timed and signed, and made in such a way that the original entry can still be read. Changes made to patient records are identifiable
7. Health Record folder is marked ‘Confidential’ A visible reminder for all users that the information contained within is to handled confidentially
8. A notice will be placed on the front of the folder if the patient is known to have allergies. Patient susceptibility to adverse reactions is readily identifiable
9. No loose sheets of paper are within the Health Record to prevent loss of clinical information resulting in an incomplete Health Record
10. Folder condition is satisfactory
* Folder is not torn or damaged
* Spine is in good working order to ensure that documentation inside is secure
1. Other than the patient name, no other confidential or personal information is on the front of the Health Record folder. Displaying such information is a breach of confidentiality
2. Patient name is on all pages within the Health Record. Should information be separated from the main folder this enables re-filing to be carried out accurately.
3. The discharge summary or imaging report is available Shows completion of the care episode.
4. If the patient is undergoing an imaging or invasive procedure\* a consent form shall be completed and signed Informed consent can be demonstrated
5. A summary of the patient’s treatment/care is sent to the patient’s GP within a locally agreed timescale, but which is no more than four weeks’ Timely information exchange to facilitate patient care
6. When the referral is not from the patient’s GP or dentist, the patient is asked to formally sign a form to give or refuse consent for sending details of the treatment provided (the consultant’s discharge letter) to his/her GP. Patients privacy is protected
7. If the patient does not give consent for details to be sent to his/her GP, a summary of the treatment provided is given direct to the patient so that he/she has it for future reference, and this shall be documented in the patient record Patients privacy is protected and information available to inform patient care choices

\*An invasive medical procedure involves either making a surgical cut in the skin or inserting an instrument, such as a needle or a tube, into the body. The procedure may be a form of treatment or investigation.