Health Records Policy

Classification :	Policy
Authors Name:	
Authors Job Title:	Patient Services Manager
Authors Division:	**Core Clinical & Support Services**
Departments/ Group this Document applies to:	All Clinical Staff Patient Pathway Administrators Ward Clerks Medical Records Staff
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Policy to be followed by (target staff): All staff using Health Records		

To be read in conjunction with the following documents:

- Department of Health: Records Management Code of Practice
- Health Records Keeping Standards Document
- MKHFT Data Protection Policy
- MKHFT Code of Confidentiality
- MKHFT Information Governance Policy
- Agreement between MKH and Thames Valley Police
- EPR Business Continuity Plan
- EDM Business Continuity Plan
- MKHFT Being Open Policy (Duty of Candour)
- MKHFT Corporate Records Management Policy
- MKHFT Data Quality Policy
- MKHFT Hospital Post Mortem Consent Policy
- MKHFT Information Governance Strategy
- MKHFT Information Sharing Protocol
- MKHFT Patient Information Sharing Opt Out Procedure
- MKHFT Policy & Guidelines for Consent to Examination or Treatment
- MKHFT Third Party Policy and Agreement

CQC Fundamental standards:
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 17 – Good governance

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Policy Statement

This policy will be used to ensure that all staff within Milton Keynes University Hospital NHS Foundation Trust are aware of their responsibilities relating to the management of patient health records.

Health records will be managed in accordance with the Data Protection Act 1998, Freedom of Information Act 2000, Records management code of practice for health and social care 2016, Care Quality Commission (CQC) standards, NHS Litigation Authority (NHSLA) Standards, other current legislation and the Trust's overarching Corporate Records Management Policy.

Health Records must be managed appropriately to support the day to day activities of the Trust including patient care and continuity of care, meeting legal requirements, supporting decision making, and assisting clinical and other audits.

Misuse of health records or breaches of this policy will be reported to the ICT Security Manager, which may result in disciplinary action being taken.

Purpose and scope

This policy covers those staff and services that access health records. The policy identifies:

- The roles and responsibilities of users in relation to health records.
- The processes and procedures for the management of health records.
- The Trust's requirement for clinical staff to demonstrate an understating of, and compliance with, records keeping standards.

Abbreviations used

EDM - Electronic Documentation Management
EPR – Electronic Patient Record

1.0 Roles and Responsibilities:

The Medical Records Department is part of the Core Clinical and Support Services Division.

The Patient' Services Manager is responsible for the Medical Records Department and reports to the Head of Patients' Services.

1.1 Chief Executive

The Chief Executive has overall accountability for ensuring that health records management operates correctly and legally within Milton Keynes University Hospital NHS Foundation Trust.

1.2 Chief Operating Officer

The Chief Operating Officer will report any issues pertaining to Health Records to the Trust Board.

1.3 General Manager – Core Clinical

The General Manager will be advised of the Health Records Service performance and issues via the Head of Patients' Services, if required any issues will be escalated to the Chief Operating Officer.

1.4 Patient' Services Manger

The Patient's Services Manager will receive monthly Governance reports and Key Performance Indicator (KPI) reports pertaining to the Health Records Service.

1.5 Deputy Health Records Manager

The Deputy Health Records Manager will manage the Medical Records Department and will be responsible for enforcing the Health Records Policy. They will also monitor the management of health records throughout the Trust and report any issues to the appropriate department manager, Head of Patients' Services and Medical Director.

1.6 Department Managers

It is the responsibility of department managers to ensure:

- All staff in their remit are aware of and adhere to the Health Records Policy and procedures
- Where appropriate, staff in their remit are trained to use the Electronic Document Management (EDM) System.
- Within clinical areas, staff that will be completing documentation relating to the patient's treatment are trained to complete the document to the required standard and complete the Health Records Keeping Standards Mandatory Training document (Appendix 1).
- Health records are appropriately managed whilst in the department in accordance with the Health Records Policy. This includes maintenance, filing of information, tracking (where applicable) and storage.
- Remedial action is taken to resolve non compliance issues, informing the Patient' Services Manager of action taken.

1.7 Trust Documentation Committee

The Trust Documentation Committee shall approve the format and content of documents that are intended to be used during patient care and form part of the patient's electronic health record.

1.8 Medical Director

The Medical Director will lead on the Trust's annual clinical documentation and consent audit, with support from the Clinical Governance Department. This involves agreeing a Trust action plan and ensuring that CSU action plans are developed and monitored within each Division.

1.9 Clinical Governance Department

Provides support to the Medical Director for the Trust annual medical documentation and consent audit and the Ward Managers for ongoing ward nursing documentation audits.

1.10 Matrons & Midwifery

Responsible for ensuring that as part of nursing metrics, senior ward sisters and charge nurses audit five sets of nursing documentation every week on their ward. This information is then part of the ward scorecard which is RAG rated, over 90% accurate completion being the indicator for green status.

1.11 Allied Health Professionals

Responsible for ensuring that documentation audits are undertaken, findings reviewed and actions taken to address issues.

1.12 All Staff

Responsible for adhering to the requirements within this policy.

The Patient' Services Manager will be responsible for reviewing and implementing the Health Records Policy.

2.0 Implementation and dissemination of document

The Health Records Policy will be available on the intranet. Supporting Standard Operating Procedures (SOPs) will be available in the Medical Records Department.

All ward clerks must be aware of their responsibilities relating to the Health Records Policy; Ward Managers will be responsible for ensuring this and can request an induction to the Health Records Department via the Deputy Health Records Manager, which will include an introduction to the Health Records Policy.

Department Managers will be responsible for ensuring their staff adhere to the Health Records Policy.

Processes and procedures

3.0 The Health Record

The patient health record is held on an Electronic Document Management (EDM) system. During a patient's attendance any documents generated, including handwritten notes, are filed within a 'paper lite' folder, which is then transferred to the Medical Records Department for scanning onto EDM.

3.1 Folders

A Trust health record will be maintained for each patient and will be held electronically, however whilst the patient is being seen during a consultation or inpatient stay a 'paper lite' folder will be available which will contain the documentation for the current episode, after which it will be scanned onto EDM.

Four types of paper lites exist:

- Outpatient clinics – Red opaque PVC folder.
- Pre Assessment Clinics – Green opaque PVC folder which will contain section dividers.
- Inpatient Admissions – Red hard back ring binder which will contain section dividers.
- Emergency Department – Red PVC folder with a transparent front cover to contain the patient front sheet from EPR.

Paper lite folders must not be removed from the clinic venue or ward and must be returned directly to the Medical Records Department upon completion of the visit. Within the Medical Records Department the documents will be removed from the folder, scanned onto EDM and then after a period of one month the paper document will be securely destroyed. This process will adhere to standards and guidance regarding legal admissibility.

The *Records management code of practice for health and social care 2016* has a section on Scanned Records which says:

"This section applies to health and care records as much as it does to corporate records. Where scanning is used, the main consideration is that the information can perform the same function as the paper counterpart did and like any evidence, scanned records can be challenged in a court. This is unlikely to be a problem provided it can be demonstrated that the scan is an authentic record and there are technical and organisational means to ensure the scanned records maintain their integrity, authenticity and usability as records, for the duration of the relevant retention period…
"..The legal admissibility of scanned records, as with any digital information, is determined by how it can be shown that it is an authentic record. An indication of how the courts will interpret evidence can be found in the civil procedure rules and the court will decide if a record, either paper of electronic, can be admissible as evidence[78].

The standard, 'BS 10008 Electronic Information Management - Ensuring the authenticity and integrity of electronic information', specifies the method of ensuring that electronic information remains authentic[79]. The standard deals with both 'born digital' and scanned records. The best way to ensure that records are scanned to the appropriate standard is to use a supplier or service that meets the standard." (p.39)

[78] https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part31
[79] BS 10008 Electronic Information Management - Ensuring the authenticity and integrity of electronic information (subscription required) http://www.bsigroup.com/en-GB/bs-10008-electronic-information-management/

As the code of practice refers to the Civil Procedure Rules Part 31 and the British Standard BS 10008 Electronic Information Management.

3.2 Order of documentation displayed within the Electronic Document Management (EDM) System

The order in which documents are displayed on the EDM system reflects the order of the prior paper based record. There are twelve tabs:

1 Front sheets / Alerts
2 Correspondence
3 Multidisciplinary notes
4 Operation sheets
5 Nursing Records and Pams
6 Results
7 Prescription charts
8 ED (Emergency Department)
9 Maternity
10 Clinical Trials
11 Loose Filing
12 Appointment Letters

3.3 Filing paper documents

All documents and patient identification labels must be securely affixed within the paper lite folder. Placing a document loose inside the folder is not permitted. Documents must be secured by the clip. Within ward/maternity/loose filing folders, the documents much be filed behind the correct section divider.

Inpatients

While the patient remains on the ward it is the responsibility of the ward manager to nominate the ward clerk or another member of the ward staff to file reports etc into the patient's paper lite record behind the appropriate divider. Any documentation e.g. result received after the discharge should be referred to the Pathway Co-ordinator for the appropriate clinician.

Outpatients

Each paperlite file contains one sheet of address labels and one multidisciplinary sheet. Attached to the front of each file is an clinical outcome form pertaining to the relevant clinic. At the end of each clinic the files are collected and returned to Medical Records for scanning.

Off site facilities

The CSU co-ordinator or appropriate administration staff shall be responsible for filing all documents in the paper lite file, where documents are received on an ad hoc basis these must be

sent to Medical Records Department within the CSU loose filing folder with the patient details clearly identified on each page.

Loose Filing
Folders are supplied to the CSU, each folder contains a set of dividers which allows all staff to file all loose filing under the correct sections. The folders are collected on a daily basis and scanned onto the Electronic Document Management system (EDM) within 48 hour of collection.

Allied Health Professionals and Specialist Nurses
AHP's and Specialist Nurses are responsible for ensuring that the patient record is kept up to date with relevant information. Paper lite records are supplied for patients' outpatient clinic visits and are available on the ward while the patient is an inpatient.

CTG's (Cardiotocographs)
CTG's will be scanned onto EDM as a continuous trace, then the original hard copy CTG will be filed into a sealed envelope and will be stored within the Medical Records Department in numerical order.

3.4 Forms/Documents

All new types of documentation to be contained within the health record must first be approved by the Trust Documentation Committee and will be issued with an approved reference number.

All new types of documents intended to be filed into the patient's record must include:

- Trust Logo
- Space on top right side of the document for a patient addressograph label
- Author
- Version
- Original date of approval
- Version date of approval
- Hospital code – issued once documents is approved
- Instruction regarding the location in the electronic record for the form to be scanned in to.

Documents will be scanned in black and white, with the exception of some key documents that have been identified for colour scanning, these are:

- Adult Admission Assessment Booklet
- Anaesthetic Charts
- Ante-Natal Booklet
- Consent Forms
- CTG's
- Early Warning Systems
- ECG's
- Operation Sheet
- Paediatric Growth Charts
- Photographs
- X-Ray's
- Prescription Booklets

Colour scanning for any further documents must be approved by the Trust Documentation Committee.

3.5 Creating/Completing Documentation

The Trust requires all clinical staff to ensure that they complete documentation correctly. In order to confirm that they understand this requirement, clinical staff are required to read and sign a one page document outlining the principles for the expected standard of records keeping and completion of clinical documentation. This training document forms part of the Trust's Training Needs Analysis (TNA) as a mandatory training requirement and is monitored for compliance by the Learning and Development Team.

All clinical documentation must adhere to the following requirements:

- Patient ID label must be affixed to each document, if a label is not available the Patient NHS number, MRN and Full Name (First and Surname) must be written in the top right corner.
- All entries must be signed, have the staff member's name and designation printed alongside, dated and timed (using 24 hour format)
- Stamps with Name and Designation are permitted provided a signature, date and time are also entered.
- All entries must be legible
- The entry within the record must accurately reflect the communication and information given to the patient.
- If an error is made, this must have a single black line through it with a signature and be noted in a second entry which must be signed and dated. The incorrect entry must never be deleted or covered using correction fluid.
- Allergies and Hypersensitivities must be recorded on the Alert Sheet.
- Any written entries within the record must be completed in black ink with the following exceptions, previously approved by the Health Records Committee (subsequently Trust Documentation Committee):
    - Pharmacy may use green ink
    - Pharmacy Technicians may use red ink to distinguish their entries from the Pharmacist.
    - DoCC may use red ink for the purpose of recording central venous pressure

3.6 Reports from other hospitals

Appropriate information about a patient obtained from another source will be scanned in to the patient's health record within the correspondence section. The name of the source will appear on the document. This document is in Appendix 1.

3.7 Alerts/Sensitivities

Alerts and sensitivities will be recorded on the green Alert sheet.

The sheet will be scanned into the first tab on EDM 'Front sheets / Alerts'

All entries must be dated.

MRSA status will also be recorded on this document and will be dated. Any alteration of MRSA status must also be recorded.

The Only Alerts added by Medical Records staff are "Red Box" and "Promoting Wallfare" these are requested via email.

Any alerts recorded on EPR will be transferred to EDM where possible this is via an HL7 message and will therefore be displayed as part of the patient's electronic record. Where the alert cannot be transferred electronically a manual system of inputting the alert onto EDM will be put into operation.

4.0 Identification/Tracking of records that exist for a patient

All current records exist on EDM.

Historical records exist on microfilm or document imaging, or on a combination of these.

The case note tracking information is found on the HIM Tracking module of the EPR system and will indicate the location of these records:

- Location 'OSDI' (Off Site Document Imaging) indicates that the patient has an archived record on the CDView7 system.
- Location 'Archive' indicates that the patient has a record on microfilm, held in the Medical Records Department
- Location 'Offsite EDM' indicates that the patient had an active record within the Medical Records library at the time of EDM implementation, their record was scanned onto the EDM system and will display within EDM with the associated date of 01.01.1000

Media types for records on the EPR system are:

- RD8GEN – Indicates a general record prior to EDM implementation.
- RD8MAT – Indicates a maternity record prior to EDM implementation.
- RD8TEMP – Indicates a temporary file existed for the patient prior to EDM implementation.
- RD8EDM – Indicates a paperlite file is in current use.
- RD8EDMMAT – Indicates an obstetric paperlite file is in current use.

Paperlite files required for ward admissions will be tracked to the ward whilst the patient is an inpatient. Upon discharge the file will be tracked to destination library and once it has been received into the medical records department and scanned onto the EDM system will be purged from the EPR system And a note added indicating it has been prepared for scanning.

Outpatient and Emergency Department paperlite files are not tracked as they are used only on the day of attendance within one location and are returned at the end of each day to the Medical Records Department for scanning onto EDM.

5.0 Transportation of Medical Records

The secure transportation of all types of records is a requirement of the NHS Information Governance Standards and the Data Protection Act 1998. The NHS Information Governance Standards are available online through the NHS Information Governance Toolkit (https://www.igt.hscic.gov.uk/).

Approved transport / couriers must be used to transport records; records must be secure at all times and must not be left unattended.

The appropriate storage for records held within a department / ward will be the responsibility of the person in charge of that area. If a record needs to be transferred to another ward / department it must be recorded on the case note tracking system.

Special controls should be adopted, where necessary, to protect sensitive information from unauthorised disclosure or modification. Examples include:

- Use of locked containers
- Delivery by hand

- Tamper evident packaging (which reveals any attempt to gain access) which can include signing over the seal of an envelope and putting sellotape over the top.
- Encryption and password protection

Records must be transported securely in accordance with the following requirements:

5.1 Around the hospital site

Health records in a paper lite format shall be transported by the Medical Records Department runner service.

Staff preparing records for transport must ensure:

- The pile of records is no larger than 6 inches.
- The records are secured for transport using 2 large elastic bands to ensure that they cannot fall out of the pile.
- The records are clearly labeled indicating the delivery destination.

The Medical Records runners will use trolleys for the transportation of records which will not be left unattended and will not be left in unsecured areas.

All areas throughout the Trust will receive a scheduled regular collection / delivery, apart from Physiotherapy and selected other areas which receive collections when requested. The Medical Records Clinics team leader will monitor this.

If a patient is being transferred to theatres or another ward on a trolley an appropriate member of staff will accompany the patient on their trolley journey and will be responsible for the transfer of the patient's record.

Health records are not to be given to patients or their relatives to take to another department. If it is absolutely necessary, the record must be placed in an envelope, sealed and marked to ensure tampering can be detected

Any record being transported must be clearly addressed.

5.2 Clinics/Treatment being provided off site

Records will only be sent off site if absolutely necessary and consent has been obtained from the Medical Director or ICT Security Manager.

For clinics / treatment being provided off site a service level agreement must be agreed.

Where appropriate, the clinician providing treatment offsite will log into EDM via VPN access. If this is not achievable the records relating to the patient's attending the clinic will be downloaded onto an encrypted and password protected laptop which will be handed directly to the clinician. Paper lite folders will be generated and will be sent to the off site facility via a secure courier.

In some circumstances an encrypted, password protected, CD will be generated and securely transported to the treating location.

A driver service is provided by primary care and is deemed to be a secure method of transporting records. Any record sent via this service must be secured and sealed within an envelope and clearly marked with the destination address. The driver collects / delivers twice daily from the Medical Records Department reception.

Records must be securely transported within any vehicle and should not be left visible.

All records being sent off site must be in a sealed container and kept in a secure area of the vehicle.

Records must be returned as soon as they are no longer required.

5.3 Couriers

In emergency situations approved couriers may be used to transport health records. The Procurement Department will advise on which couriers can be used.

All records sent by courier will be secured and sealed in an envelope and clearly marked with the destination address.

The Medical Records Department or hospital switchboard arranges for courier collections.

5.4 Copies of records to solicitors and government agencies

When patient identifiable information is being transported, these will be sent by the 'Special Delivery' service operated by Royal Mail or courier.

5.5 Patient records required by Consultants for non NHS work

The use of patient records in this way may cause problems in relation to the individual's rights to privacy under the Human Rights Act 1998, the Data Protection Act 1998 and the Caldicott Principles – re: fair obtaining and consent issues. In most cases this should only occur with the consent of the patient and the management of the employing organisation.

- Human Rights Act 1998
- National Data Guardian (2013) *Information: to share or not to share? The information governance review.*
  This is the 2013 Caldicott Review that updated the Caldicott Principles
- National Data Guardian for Health and Care (2016) *Review of data security, consent and opt-outs.*
  This is the new Caldicott Review of data security published in July 2016.

5.6 Patient information used for training junior doctors in a classroom environment

It is common for consultants/senior medical staff to use 'live' patient records for teaching junior doctors. Sometimes the only way certain conditions can be discussed is by using 'live' records. Patient records can only be used for this purpose with the consent of the patient or their representative. The patient identifiers MUST be removed from all information before being used for training purposes, prior to any records being used, even if anonymised, advice should be sought from the ICT Security Manager and/or the Caldicott Guardian before this occurs.

6.0 Provision of records

6.1 Staff records

Staff should not have access to their medical records unless they go through the appropriate channels via the Access to Health office ext 6645. This also includes staff attending clinic appointments or in hospital.

Any suspected inappropriate access to a member of staff's record will be investigated and audited on the EDM system to identify who has accessed the record, in order for appropriate action to be taken.

If any inappropriate access is identified this will be managed in accordance with the Trust's Disciplinary Policy.

6.2 High Profile Patient's Records

Records for high profile patients will be restricted and access will only be granted upon permission being given from the Duty Manager.

6.3 Paper lite folders required for clinic visits

Clinic lists are generated at 8.30am the day prior to the clinic.

A red opaque paper lite folder is created for each patient attending the clinic and will contain a history sheet, clinic outcome form and patient identification labels. For paediatric clinics the original paediatric growth chart will be made available.

Records will be delivered to the clinic venue by 3.45pm the day prior to the clinic.

Paper lite folders will be collected and prepared for scanning within 1 working day of the clinic and will be scanned and available to view on EDM 2 working days after the clinic.

If the information from the clinic visit is required prior to this, the scanning team leader must be informed and will then arrange for priority scanning of those documents.

6.4 Pre Assessment Paper Lite folders

Patients attending a pre assessment will have a green opaque pre assessment paper lite folder created containing the appropriate pre assessment paperwork and care pathway for the admission. This folder will be stored within the Treatment Centre records room if the patient is attending for their admission within 2 weeks of the pre assessment. The folder will be tracked on EPR.

6.5 Records required for elective admission

A red opaque ward paper lite folder containing section dividers and patient labels will be provided for each patient's elective admission. A consent form will be included where it exists.

If the patient has previously attended a pre assessment clinic, the pre assessment paper lite file must be collected by the admitting ward and the pre assessment documents must be amalgamated into the ward paper lite, with the exception of ACU who will use the pre assessment paper lite in place of the ward paper lite. These will then be scanned within 2 working days of receipt into the Medical Records Department.

6.6 Paperlite folders for inpatients

All wards will retain stocks of empty paperlite files. Upon a patient's admission a folder will be created by the ward staff, which will contain patient labels and all documentation pertaining to the patient's admission. The folder will be tracked to the ward on EPR by the ward staff.

Once the patient is discharged, the file will be tracked to destination library on EPR by the ward staff and returned to the Medical Records Department for scanning.

The Medical Records Department will purge the paperlite from the EPR system once it has been scanned onto the EDM system.

6.7 Emergency Department Paper Lite Folders

A red paper lite file will be generated for every patient attending the Emergency Department. These will be prepared for scanning by the Emergency Department Receptionists and will then be scanned into EDM by the Medical Records Department within 2 working days of receipt.

6.8 Patient Held Records

Ante-natal patients are issued with a set of patient held records for the duration of the pregnancy. Upon admittance to the Maternity Unit, the patient held record will form part of the record for that admittance and will be filed into the paper lite folder on the ward, which will be tracked on EPR to the Maternity Ward.

Once the patient is discharged, the paper lite file will be tracked to destination library on EPR by the ward staff and returned to the Medical Records Department for scanning.

The Medical Records Department will purge the paperlite from the EPR system once it has been scanned onto the EDM system.

6.9 Gender Reassignment

The Gender Recognition Act 2004 provides for transsexual people to apply to the Gender Recognition Panel to receive a Gender Recognition Certificate. Successful candidates, who are granted a full Gender Recognition Certificate, will from the date of issue be considered in the eyes of the law to be of their acquired gender.

The Act also provides transsexual people with special protection of their privacy and it is therefore an offence to disclose to any other person the transsexual history of the patient without their explicit consent.

Patients who wish to become known by a name and gender other than that of their birth should initially advise their GP. The GP should arrange for a new registration of the patient in order for a new NHS number to be issued.

The patient has the right to have a new health record created which should not contain any reference to their previous gender. To ensure continuity of care and avoidance of clinical risk previous clinical information from the previous record should be transferred to the new record, however this must not include any reference to the patient's previous gender, name or reference to gender specific treatments / tests / lifestyle factors.

The previous health record becomes protected information and must not be shared or disclosed, unless an exemption applies. Example exemptions are:

- The patient has consented.
- Information is needed for the prevention and investigation of crime
- Information is needed to comply with a court order

If the patient does not consent to having previous clinical information included in their new health record, the trust will meet with the patient to advised of the potential risks of this decision and to explain the process for creating a new record. Input for the meeting should be sought from the Medical Director, Head of Risk & Governance and the Trust's Legal Team.

6.10 Records for deceased patients

The Bereavement Officer will collect the paper lite file of the deceased from the ward and will deliver it to the Mortuary. Once per week the Coding Department collect all paper lite files from the

Mortuary and complete the coding for that episode, once this is done the Coding Department return the paper lite file to the Medical Records who scan the information onto the EDM system within 2 working days of receipt.

7.0 Missing/Misplaced paper notes

This relates to any paper based notes which are in active use and have not yet been scanned onto EDM.

In the event that it is identified that a paperlite file is missing the following process must be adhered to:

- Check the immediate vicinity, i.e. nurses station, note trolley, patient bedside etc
- Check all other locations in the Trust that the patient has visited during the active episode covered by the missing notes e.g. Theatres, Imaging etc
- EPR Tracking information must be checked to ensure that the file has not been taken elsewhere
- Check the responsible clinician's office

If the file is still not located then:

- A DATIX incident report must be immediately submitted
- The Patient' Services Manager or Deputy Health Records Manager must be notified via ext 2170, who will organise for a search of all returned files for that day to be undertaken.
- The Matron for the area must be notified
- The Clinician responsible for the patient must be notified
- The Risk Manager must be notified
- If the patient has been off-site for treatment, contact the off-site facility to ensure they have not received the file and inform the ICT Security Manager.
- Create a second volume of paperlite notes for the patient in order to file any documents whilst the search is being undertaken. This must be created on the EPR system as RD8EDM – Volume 2 and a note added explaining that the volume has been created whilst a search for volume 1 is undertaken. .
- The responsible clinician must ensure a summary is added to the new paperlite file detailing plan of care and any alerts such as DNAR.

If the paperlite file is located:

- All staff who have been involved in the search must be informed.
- The DATIX incident record must be updated to reflect where they were located.
- The paperlite files, volume 1 and volume 2, must be amalgamated.
- The tracking information on EPR must be updated, by purging volume 2 and adding a note indicating that volume 1 has been located.

If the paperlite file cannot be located:

- Update DATIX incident record to reflect this
- A written entry within the patient notes must be made indicating that notes from xx/xx/xx date to xx/xx/xx date are missing

8.0 Disclosure of Information

The health record is the property of Milton Keynes University Hospital NHS Foundation Trust. The content of the patient record in paper and electronic format is confidential. The fact the patient is

attending the hospital is also confidential. Information shall be issued with caution and in accordance with current legislation.

All staff that have access to patient records, both in paper and electronic format have an obligation to ensure that the confidentiality of the information is maintained. Failure to do so is regarded as a serious breach of conduct and will result in disciplinary action, which may lead to dismissal. All staff are required to abide by the Staff Code of Practice, sign a confidentiality agreement and to attend mandatory training sessions, including Information Governance.

8.1 Maintaining patient confidentiality

Staff must ensure:

- That they abide by the staff code of confidentiality and the data protection policy.
- Patients are not discussed by name or other identifying information in public places.
- Patient paperlite records, the EDM system and the EPR system screens are not left unattended.
- Information gained during the course of their work is not discussed with persons inside or outside the hospital.
- Health records, letters etc are reviewed in private, not public areas.
- Health records in a paper lite format are stored appropriately within departments; advice will be given on suitable storage by the Health Records Manager or ICT Security Manager.

8.2 Access to information contained within a patient health record

This relates to all persons employed in the assessment or treatment of the patient who needs access to information to carry out their role. However access should not be assumed automatic. Before allowing access to records or information contained within them it may be necessary to obtain patient or consultant consent. Proof of identity from the requestor and consent to disclose may need to be sought.

9.0 Requests for Information

9.1 In-Patient access to their medical records

Patients and relatives requiring access to their medical records whilst in hospital can be given as long as the following conditions are met:

- The records have been checked to ensure that there is nothing in there which is going to cause substantial harm or damage to the patient. This should be a clinical decision.
- There is no third party information within the record i.e. Social Services, Relatives, police etc.
- Access by a third party i.e. relative would need patient consent, or the consent of the Clinical lead if the patient is not capable of giving consent.
- Parents of Children under the age of 16 may have access.
- Access which is required by all other bodies should be referred to the Information Governance Team.

Please familiarise yourself with the Access to Health Records Policy

9.2 Patients

Patients can apply for access to their health record under the Data Protection Act 1998. Relatives can apply for access to the records of a deceased patient under the Access to Health Records Act 1990. The Policy relating to Subject Access to Data in accordance with the Data Protection Act 1998 provides further information.

Deadlines and fees for this service are applicable.

Requests must be made via the Information Governance team.

9.3 Government Departments

The Department of Department for Work and Pensions(claims for disablement or war disabilities pensions, vaccine damage compensation) shall be dealt with by the Information Governance team.

9.4 Solicitors

There is an agreed procedure laid down under the Data Protection Act 1998. The Access to Health Records team will deal with these requests (with the exception of claims against the Trust). Patient written consent followed by consultant permission to disclose information will be obtained. Either an electronic copy or photocopies of records will be provided.

"The Data Protection Act 1998 (DPA) governs access to the health records of living people." (p.3)

This guide also has a copy of the standard consent form issued by the BMA and the Law Society for patients to allow solicitors to access their health records, which are headed "Releasing health records under the Data Protection Act 1998". (p.11)

The Law Society's website has the same form entitled "Consent form to be used for the release of Health Records under the Data Protection Act 1998." See http://www.lawsociety.org.uk/support-services/advice/articles/consent-form--access-to-client-health-records/

9.5 Insurance Claim Forms

Patients with private health insurance will require verification of attendance, diagnoses or operation code entered on their form. The Information Governance team will deal with these requests. A fee is required for completion of these forms.

9.6 Media

All media enquiries should be transferred to the Trust's Press / Communications Manager.

9.7 Police

The police have no automatic right of access to any information relating to a patient.

All requests for information from the police will be dealt with in accordance with the 'Agreement between MKH NHS Trust and Thames Valley Police' available on the intranet.

The Emergency Department staff will deal with any enquiries regarding the attendance or treatment of a patient within the Emergency Department.

All other requests will be dealt with by the Information Governance team.

9.8 Coroner

All requests for copies of health records from the Coroner's office must be referred to the Trust's Litigation Administrator.

The Litigation Administrator will liaise with the Coroner's office and provide copies of the patient's health record.

10.0 Authorised Disclosure of Information

10.1 Copies of records printed from EDM

This shall require authorisation of the Consultant(s) involved in the patient's care or a Senior Sister in Charge of the Department or Ward, e.g. where a patient is being transferred to another hospital.

10.2 Copies of Letters from EDM

The Duty of Candour requires all health and adult social care providers registered with CQC to be open with people when things go wrong. Providers should establish the duty throughout their organisations, ensuring that honesty and transparency are the norm in every organisation registered by the CQC.

From 1 October 2014 this also became legislative (under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).
and it is a criminal offence for any registered medical practitioner, or nurse or allied health professional or director of an authorised or registered healthcare organisation to knowingly obstruct another in the performance of these statutory duties, provide information to a patient or nearest relative with the intent to mislead them about such an incident or dishonestly make an untruthful statement to a commissioner or regulator, knowing or believing that they are likely to rely on the statement in the performance of their duties.

11.0 Medical Record Maintenance

11.1 Unit Numbering System

All inpatient, outpatient and Accident and Emergency care records for a patient will be combined into a single unit numbering system. The 'unit' adopted by the Trust is the patient medical record number (MRN) and consists of six digits. The unit number is assigned when the patient is registered on the EPR system.

The unit number will identify all patient documentation created within the Trust and will also be the patient identifier on the EDM system.

11.2 Unavailability of the EPR system

In the event of the unavailability of the system the Trust's business continuity plan will be in affect and manual records will be maintained until the system is restored.

11.3 Unavailability of the EDM system

In the event of unavailability of the system the Trust's business continuity plan will be in effect. Records for patient's attending the Trust at the time of the system being unavailable will be downloaded onto encrypted USB sticks directly from the EDM Server. This will be undertaken by the health records staff with assistance from the IT department and will be delivered to the appropriate clinic / ward venue.

11.4 Patient Master Index (PMI)

All staff

In order to maintain an accurate PMI Trust staff are required to follow the CRS procedures:

- Searching for a patient
- Registering a patient
- Reporting a duplicate registration
- Changing / updating PMI information
- Deceased patient's records

At any attendance the patient's data should be checked to ensure amendments are captured and updated.

Data Quality Team
The EPR Data Quality Team check new registrations for duplicate entries. They will inform the X-Ray department of any duplicates and will then undertake the electronic merge on EPR which will automatically merge the health record on EDM via an HL7 message.

11.5 Monitoring / audits
Monitoring will be undertaken by the Medical Records Department Team Leaders to record the scanning of documents in accordance with agreed timescales, scanning throughput and quality of scanning preparation / scanning.

The results of this monitoring will be recorded on a daily basis and will be monitored by the Health Records Manager. Any issues identified will be reported to the Head of Patients' Services.

12.0 Retention Periods for Health Records

Health Records will be retained in accordance with the Records Management Code of Practice for Health and Social Care 2016 (replaces Records Management: NHS Code of Practice, 2006, revised 2009).

The new *Records Management Code of Practice for Health and Social Care 2016* (http://webarchive.nationalarchives.gov.uk/20160729133355/http:/systems.hscic.gov.uk/infogov/iga/rmcop16718.pdf)

In the event that Milton Keynes University Foundation Trust Hospital were to cease operations, provision would be made for the continuation of safe and secure storage of Health Records. These would be kept for the legally required period or until the records can be passed on to the new provider of operations.

12.1 Destruction of paper documents
Once paper documents are scanned into the EDM system they are checked to ensure the quality and accuracy of the scanning process has maintained the integrity of the document, after a period of one month the paper documents will be securely destroyed. This process will adhere to standards and guidance regarding legal admissibility.

13.0 The Medical Records Department

The Medical Records Department is a safe haven and has secure swipe access which is granted on an individual basis.

The Patient' Services Manager is responsible for the Medical Records Department and reports to the Head of Patients Services.

13.1 Operating hours
The Medical Record's Department operating hours are Monday to Friday 7.00am to 5.00pm.

13.2 Services
The Medical Records Department shall provide the following services:

- Provide training on Health Records policies and procedures to Trust staff, upon demand. Please refer to the Trust's Training Needs Analysis.

- Approve procedures for the creation of new health records folders.
- Ensure prompt retrieval and distribution of health records in their paper lite format to authorised personnel.
- Provide paper lite folders for inpatient and outpatient attendances.
- Control the release of health records and medical information contained within them.
- Manage the processing of paper lite folders and documents for scanning
- Manage the destruction of paper based information once uploaded to the EDM system and quality checked.
- Support the Trust's Clinical Governance, Risk Management and other related systems.
- Work in accordance with the Trust's Data Protection Officer.

13.3 Induction

Department managers must arrange for all new Ward Clerks and Patient Pathway Co-ordinators to attend an induction to the Medical Records Department. This will include an overview of the Health Records Policy and explanation of records keeping practices and standards.

In clinical areas, the department manager must ensure that the clinical staff within their remit are aware of how to appropriately complete documentation; including junior doctors and that all clinical staff have read, understood and signed the Health Records Keeping Standards training document. See Appendix 1

15.0 Keeping patient demographic and contact details up to date

High quality, consistent, timely and comprehensive information is essential to the Trust to support patient care, management and planning, contracting and accountability. Staff must ensure that patient-related data is kept up-to-date and maintained in accordance with standards and procedures in place to comply with the Trust policy regarding Data Quality.

It is essential that patients' details are current, to enable accurate and rapid identification of the patient, and to permit contact with the patient when short notice situations arise.

When changes occur, the person receiving the change of details is responsible for ensuring that the EPR system is updated, this will also update the EDM system automatically via an HL7 message.

The EPR Data Quality Team take the overarching responsibility for monitoring accuracy of patient demographic details.

16.0 Security of health records

16.1 Health records throughout the Trust

Staff are individually responsible for records in their possession. Records must only be stored in approved and secure locations.
The Medical Records staff must have access to all areas which health records are being stored in.
The Emergency Department staff and Duty Manager must have access out of hours for emergency admissions.

Access to the EDM system will only be granted to a user if there is a legitimate business requirement for them to use the system. This will also be dependant on formal training and completion of an access request which must be authorised by the Head of Patients' Services.

16.2 The Medical Records Department

The Medical Records Department is a designated 'safe haven' and will be kept secure at all times.

Access to the department is restricted to staff who have a legitimate reason for entry.

The Medical Records Department is staffed from 7.00am to 5.00pm. The department will be secured and alarmed during unmanned periods.

Electronic locking devices secure all doors. Entry to the Department can be gained by using the Hospital ID card system upon the appropriate security being granted by the Patient' Services Manager. Staff without the access privileges and other callers can request entry via an intercom system on the Main Door, they must identify themselves and the purpose of their visit and upon entry to the Department they shall record their visit in the register provided.

The applicant's line manager shall endorse an application for access privileges (by e-mail). Authorisation for access to the Medical Records Department is granted at the discretion of the Patient' Services Manager. The Hospital ID card is not transferable, shall be reported immediately to the Security Department if lost, and returned to the Head of Department at the end of the cardholder's employment with the Trust.

Within the Medical Records Department, section team leaders/managers shall be held accountable for the physical security of the department, ensuring that all windows and doors within their designated area are secured and locked prior to leaving the area. The Medical Records Department Late Shift Team Leader shall be responsible for the final security check and for setting the security alarm.

Designated personnel, including Emergency Department Reception staff and the Duty Nurse Manager, shall be provided with alarm codes and appropriate security on their Hospital ID card to enable them to enter the building outside of these hours to retrieve records that are awaiting scanning if required. These staff shall be responsible for closing doors, including fire doors, setting the alarm system and securing the building when they leave.

17.0 Policies and Procedure notes

Written policies and procedure notes for the Medical Records Department shall be current, shall be enforced and shall relate to at least the following. Medical Records Department personnel will be briefed on department policy at induction or when a change occurs to the policy, and issued with the procedure notes (Standard Operating Procedures (SOPs) in hard copy at induction or as procedures change.

The available procedure notes for the medical records processes can be located within the Medical Records Department are:

- Scanning preparation
- Scanning protocol
- Release of medical records and information
- Security
- Quality Assurance procedures

Written policies and procedures for EPR users shall be current, shall be enforced and shall relate to the following:

- EPR - PMI: Creating and maintaining patient registration

Getting information back from the system on screen

- EPR - Case Records Tracking module: Tracking records
- Unavailability of the EPR system

18.0 Statement of evidence/references

References:

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- British Standards Institute (2014) *Electronic information management.* BS10008. Milton Keynes: BSI.See: http://www.bsigroup.com/en-GB/bs-10008-electronic-information-management/ (accessed 7 December 2016)
- Care Quality Commission (2015) *Regulation 11: Need for consent. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11. [Online].* Available from: http://www.cqc.org.uk/content/regulation-11-need-consent (accessed 6 December 2016)
- Care Quality Commission (2016) *Regulation 12: Safe care and treatment. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12. [Online].* Available from: http://www.cqc.org.uk/content/regulation-12-safe-care-and-treatment (accessed 6 December 2016)
- Care Quality Commission (2015) *Regulation 17: Good Governance. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17. [Online].* Available from: http://www.cqc.org.uk/content/regulation-17-good-governance (accessed 6 December 2016)
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- Department of Health. *Information Governance Toolkit.*Available from: https://www.igt.hscic.gov.uk/ (accessed 6 December 2016)
- Freedom of Information Act 2000Available from: http://www.legislation.gov.uk/ukpga/2000/36 (accessed 6 December 2016)
- Gender Recognition Act 2004 Available from: http://www.legislation.gov.uk/ukpga/2004/7 (accessed 7 December 2016)
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- Human Rights Act 1998Available from: http://www.legislation.gov.uk/ukpga/1998/42 (accessed 7 December 2016)

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- Ministry of Justice. *Civil Procedure Rules part 31: disclosure and inspection of documents.* Available from: https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part31 (accessed 14 December 2016).

- Ministry of Justice (2009) *Lord Chancellor's Code of Practice on the management of records issued under section 46 of the Freedom of Information Act 2000.* Available from: https://ico.org.uk/media/for-organisations/research-and-reports/1432475/foi-section-46-code-of-practice-1.pdf (accessed 15 December 2016)

- National Data Guardian (2013) *Information: to share or not to share? The information governance review.* Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf (accessed 7 December 2016)

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- See: http://www.bsigroup.com/en-GB/bs-10008-electronic-information-management/ (accessed 7 December 2016)

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19.0 Governance

19.1 Document review history

Version number	Review date	Reviewed by	Changes made
1	01.01.2004		Created
2	1.11.2004		Amended
3	01.08.2005		Amended
4	01.11.2007		Amended
5	01.01.2009		Amended
5.1	01.02.2010		Minor amendment to section 12
6	01.06.2011		Rewritten to incorporate implementation of EDM
7	01.06.2013		Amended section 3.2 and 6.0. Inclusion of section 7.8 and 8.0.
8	27.06.2016		Amended to change CRS to EPR Inclusion of 6.9 Gender Reassignment.

19.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
	Head of Patients' Services	04/07/16			
	Mandatory Training Manager	04/07/16			
	Chief Compliance Officer	04/07/16	06/07/16		
	Medical Director / Caldicott Guardian	04/07/16			
	IT	04/07/16			
	Lead Nurse for Quality & Improvement	04/07/16			
	Information Governance & Security	04/07/16			
	Data Quality	04/07/16			
	Clinical	04/07/16			
	Nursing	04/07/16			
	Gender Reassignment	27/04/16	27/04/16		

19.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Trust wide documentation & Health Records Keeping Standards audit	Auditing	Clinical Governance Department	Annual	Clinical Audit & Standards Committee. Trust wide presentation
Consent audit	Auditing	Clinical Governance Department	Annual	Clinical Audit & Standards Committee.
Quality of scanning	Statistics	Deputy Health Records Manager	Monthly	Patients' Services Clinical Improvement Group
Retrieval of records from around the hospital site	Manual checklist	Medical Records Team Leader	Weekly	Patients' Services Clinical Improvement Group
Training	Statistics	Learning & Development Department	Refer to Learning & Development Policy	Refer to Learning & Development Policy
Tracking of paperlite files	Auditing	Deputy Health Records Manager	Monthly	Patients' Services Clinical Improvement Group

19.4 Equality Impact Assessment

This document has been assessed using the Trust's Equality Impact Assessment Screening Tool. No detailed action plan is required. Any ad-hoc incident which highlights a potential problem will be addressed by the monitoring committee.

Impact	Age	Disability	Sex (gender)	Gender Reassignment	Race	Religion or Belief	Sexual orientation	Marital Status	Pregnancy & Maternity
Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy?	N	N	N	N	N	N	N	N	N
Is there potential for or evidence that the proposed policy will not promote equality of opportunity for all and promote good	N	N	N	N	N	N	N	N	N

relations between different groups?									
Is there potential for or evidence that the proposed policy will affect different population groups differently (including possibly discriminating against certain groups)?	N	N	N	N	N	N	N	N	N
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups?	N	N	N	N	N	N	N	N	N

Appendix 1: Health Records Keeping Standards Training Document

Health Record-Keeping Standards
To be read and completed by all clinical staff.

Accurate health records support both the provision of patient care and business functions. Health records are essential for clinicians to make sound, evidence based decisions regarding a patient's treatment. Milton Keynes Hospital NHS Foundation Trust manages its records in accordance with the Records Management Code of Practice for Health and Social Care 2016, NHSLA Guidelines and CQC Outcome 21 requirements. The integrity, confidentiality and availability of information are imperative for good records keeping.

Health records are an integral part of effective patient care. They are used not only for primary clinical purposes but also for secondary purposes including reporting the activity of hospital services, monitoring performance of hospitals and for research. They remain the most important focus of any patient complaint, litigation or inquest.

Health professionals must be aware of their professional and legal obligations for records keeping. Each governing body (i.e. RCP, NMC etc) has standards which must be adhered to; it is the responsibility of the individual to ensure that they are familiar with these standards. If records are not completed and maintained correctly and in a timely manner, the health professional will be held accountable.

The following requirements must be adhered to when making any handwritten entries within a patient record:

- Patient ID label must be affixed to each document, if a label is not available the Patient NHS number, MRN and Full Name (First and Surname) must be written in the top right corner.
- All entries must be completed in black ink, apart from Pharmacy who are permitted to use green ink
- All entries must be signed, have the staff member's name and designation printed alongside, with contact details (i.e. bleep / mobile number) and be dated and timed (using 24 hour format)
- Stamps with Name and Designation are permitted provided a signature, date and time are also entered.
- All entries must be legible
- The entry within the record must accurately reflect the communication and information given to the patient.
- If an error is made, this must have a single black line through it with a signature and be noted in a second entry which must be signed and dated. The incorrect entry must never be deleted or covered using correction fluid.
- Allergies and Hypersensitivities must be recorded in on the Alert Sheet.

All consultations, treatment plans, observations and verbal communications with a patient must be recorded and must be filed within the appropriate section of the paperlite folder. **Remember - If it is not written down it did not happen.** For any further information please contact the Health Records Manager or Medical Director.

I confirm I have read and understood the above standards and am aware of my responsibilities relating to records keeping.

Not applicable to my job role – Please tick box ☐

Name…… **Signed……..**

Job Role…… **Date……...**

Appendix 2: Standards for Documentation Audits

The following standards are used to audit documentation within the Trust:

1. Royal College of Physicians (2015) *Generic medical record keeping standards.* Available from: https://www.rcplondon.ac.uk/projects/outputs/generic-medical-record-keeping-standards (accessed 9 December 2016)

2. Nursing and Midwifery Council (2015) *The code: professional standards of practice and behaviour for nurses and midwives.*Available from: https://www.nmc.org.uk/standards/code/ (accessed 9 December 2016)

3. NHS Litigation Authority (2013) *NHSLA risk management standards 2013-14 for NHS trusts providing acute, community, or mental health & learning disability services and non-NHS providers of NHS care.*Available from: http://www.nhsla.com/safety/Documents/NHS%20LA%20Risk%20Management%20Standards%202013-14.pdf (accessed 9 December 2016)*See Section 1.8 Health Record-Keeping Standards (p.49).*

4. General Medical Council (2013) *Good medical practice.*Available from: http://www.gmc-uk.org/guidance/good_medical_practice.asp (accessed 9 December 2016) *See Domain 2: Safety and Quality.*

5. The Royal College of Surgeons of England (2014) *Good surgical practice.* Available from: https://www.rcseng.ac.uk/standards-and-research/gsp/ (accessed 9 December 2016) *See Section 1.3 Record your work clearly, accurately and legibly (p.21)*

6. Care Quality Commission (2015) *Regulation 17: Good Governance.* Available from: http://www.cqc.org.uk/content/regulation-17-good-governance#full-regulation (accessed 6 December 2016)

7. Milton Keynes University Hospital NHS Foundation Trust. *Health Records Policy.* (Version 8) 2016.

8. Milton Keynes University Hospital NHS Foundation Trust. *Medicines Management Policy.* (Version 7) 2015.

9. Milton Keynes University Hospital NHS Foundation Trust. *Policy & guidelines for consent to examination or treatment.* (Version 10) 2016. Milton Keynes University Hospital NHS Foundation Trust. *Hospital post mortem consent policy.* (Version 5) 2015.

Appendix 3: Audit Report Template

Please follow the link below to access the Audit Report Template

http://nww.mkgeneral.nhs.uk/uploads/file/CGSU/Report.doc

Checklist for policy and guidelines documentation

By submitting a document for review/approval you are confirming that the document has been checked against the checklist below to ensure it meets the Trust standards for producing Trust Documentation (for support please contact your Governance Facilitator/Patient Safety Lead.

Check	Tick
Latest template	☐
Fonts should be arial 14 for headers 12 for main body	☐
Clear Title (and saved with this title)	☐
Authors Job title:	☐
Authors Division:	☐
Department/Groups this document applies to:	☐
Approval Group/approved by:	☐
Date of approval:	☐
Review date:	☐
Approval group (according to policy requirements):	☐
Last review date:	☐
Unique Identifier: if known (new documents will be assigned at publication)	☐
Status: Approved	☐
Version numbers are the same throughout document	☐
Scope: Who will use this document?	☐
To be read in conjunction with the following documents:	☐
Latest CQC fundamental standards referenced:Trust intranet page with fundamental standards	☐
Footers completed to match main page : (on all pages)	☐
References are updated (contact the library (Lynda Plant 3077) for help if required)	☐
Consultation history includes key stakeholders required to embed document. Pharmacy are consulted if the document contains medication	☐
Audit and monitoring criteria is completed and clear (where possible reference the relevant section of the policy)	☐
Draft watermark is removed	☐
Include full & correct consultation history	☐
Dissemination should be clear	☐
Check relevant hyperlinks work	☐

Completed by name:	Position:	Division	Date