The Walton Centre NHS
NHS Foundation Trust
Excellence in Neuroscience

Clinical Records Management Policy

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Responsible Director:	Medical Director	
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Document Approval, History/Changes	**See Appendix 3.** For further information contact the Governance Department on **Tel:** (0151) 529 5436	

Think of the environment…Do you have to print this out this document? **You can always view the most up to date version electronically on the Trust intranet.**

Executive Summary

This policy details the processes for ensuring that the Trust has in place a comprehensive system for the completion, use, tracking, storage, retrieval, archiving and/ or disposal of clinical records and that record keeping standards are monitored through the clinical audit process.

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1. Introduction

All NHS clinical records are public records under the terms of the Public Records Act 1958. Under the act, the Trust has a statutory duty to make arrangements for the retention, preservation and/ or destruction of such records. In addition, the Trust needs robust records management procedures to meet the requirements set out under the Data Protection Act 1998, the Freedom of Information Act 2000 and the Records Management: NHS Code of Practice.

Good record-keeping is an integral part of governance, professional practice and the mark of the skilled and safe practitioner. In addition, the information held in clinical records both paper and electronic is essential to the planning and delivery of high quality, evidence based patient-centred care and an effective records management policy ensures that such information is properly managed. Information has most value when it is accurate, up to date and accessible when it is needed.

As well as underpinning good patient care, complete, accurate and timely records allow a clear picture of events to be obtained, which is imperative for managing claims and complaints, and for auditing practice and remaining proactive in improving records management practices.

1.1. Aim

This policy details the processes for ensuring that the Trust has in place a comprehensive system for the completion, use, tracking, storage, retrieval, archiving and/ or disposal of clinical records irrespective of format.

2. Scope

This policy outlines how the Trust will manage all types of clinical records. However, implementation of this policy does not replace the duty and professional accountability of staff to protect the confidentiality of the patient and the patient's clinical record. This policy relates to all staff who use clinical records for clinical and/ or administration purposes.

3. Definitions

Clinical Record: anything that contains clinical information regarding an individual patient, which has been created or gathered as a result of any aspect of work of NHS health professionals, and may be contained in any format or media, including paper, electronic, photographs, images and audio and visual recordings.

4. Duties

4.1. Information Governance & Security Forum (IGSF)

The purpose of the IGSF is to promote effective information governance and to establish and maintain a framework which ensures that all information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care and services.

4.1.1 The IGSF is also responsible for ensuring:

- that this policy is implemented, through the Lifecycle Management Strategy, and that the records management system and processes are developed, co-ordinated and monitored

- that there is accountability through all levels of the Trust and will challenge areas of Trust activity where robust controls are not evident, in order to raise standards and strive for continuous improvement.

4.1.2 The Health Records Strategy Group is responsible for:

- approving the pilot stage of a newly developed or amended document
- approving documents for official use across the Trust
- suggesting standardisation (logo, format etc) of design and production
- maintaining a master list of approved documents with individual catalogued document reference numbers
- identifying the training and briefing requirements for staff on new policies / documentation / electronic systems

4.1.3 Medical Director (Caldicott Guardian) is responsible for:

- overseeing access to patient-identifiable information and that it is shared in an appropriate and secure manner.

4.1.4 Health Records Manager is responsible for ensuring:

- that practical guidance and advice on management, retention and disposal of records are available
- that requests for access to healthcare records are managed appropriately
- key performance indicators for records management are monitored and reported to the Health Records Strategy Group
- a quarterly report of availability of case notes is provided to the Health Records Strategy Group which in turn reports to the Information Governance Security Forum
- that any identified issues relating to records management are exception reported to the IGSF
- attendance at the Clinical Electronic Systems Group (CESG) to advise on impact of new systems

4.1.5 Health Records staff are responsible for:

- the safe storage and retrieval of health records within the library
- supporting departments with the retrieval and operational use of the health record within the Health Records Department

4.1.6 All Managers are responsible for ensuring:

- promoting clinical records management
- there are operational systems in place within their teams to fulfil the requirements of this policy
- staff receive appropriate training, including the completion and management of clinical records

4.1.7 All healthcare and support staff have a responsibility for:

- the maintenance, management and care of clinical records in accordance with this policy, as part of their own accountability for governance.
- maintaining the appearance, tidiness, integrity of the record and in the correct order
- the safe custody of health records whilst in their possession. Where health records are in clinical use outside of designated areas, they must be held securely. Where rooms containing health records are unattended, those rooms must be locked.

4.1.8 IT System providers/suppliers have a responsibility to:

- ensure that systems are secure and maintained to enable records retrieval/information as and when needed.
- ensure that staff are trained on new systems when implemented
- advise the Health Records Manager of new systems and system changes which may affect the content of the paper health records.

5. Process

5.1. Completion

5.1.1 All entries in the health record will be:

- Legible and completed in black/blue ball point pen (other colours are permissible if they are indelible and readable on photocopy), Pharmacist will write in purple, however black biro is permissible
- A factual, accurate record of event of intervention, including the provision and identification of medical equipment
- Written up as soon as possible after an intervention has occurred
- **First daily entry** must be dated, timed using 24 hour clock and signed with full name and job title printed
- **Subsequent entries** must be dated and timed using 24 hour clock and signed
- Written in such a way that any alterations or additions are dated, timed and signed whilst ensuring the original entry can still be read – the use of correction fluid is forbidden
- records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or speculation or offensive, subjective statements
- Countersigned by the registered practitioner responsible for the care of the patient, if made by non-registered practitioner in the course of nursing care
- Completed in line with professional codes of practice in relation to record keeping standards e.g. NMC, GMC

5.2. Filing

5.2.1 The health record is bound so that loss of documents and traces is minimised. All staff must ensure that documentation is always securely filed to prevent loss during transportation and all professional notes (e.g. medical, nursing and physiotherapy) must be stored together to provide an accurate picture of the care provided. Exceptions to this may be:

- Large volume records such as ITU charts.
- Records made by psychologists. These may be inappropriate for inclusion but psychology involvement should be noted in the main record
- Records made by Allied Health Professionals (AHPs). AHPs will be expected to write directly into the health record of an inpatient but if care continues on an outpatient basis, only regular reports should be filed in the main inpatient record

5.2.2 All staff must endeavour to file patient records within the health record in a timely manner. If the health record is no longer available, staff should only send documents back to the Health Records Department for filing if they are not available elsewhere. For example, they may be available electronically – e.g. health records on CG Gold.

5.2.3 There are clear instructions on the inside of the health record regarding the filing of documents. All documentation must be filed securely, in date order, behind the appropriate, divider. There is a message pocket on the front cover for all notes/messages.

5.2.4 The structure to be used in the health record is as follows:

a) ID Labels
b) Demographic sheets (most recent at front)
c) Patient Alert Record Sheet – (Orange Card) if patient has an alert
d) DNAR form – if applicable
e) Patient history and continuation sheets
f) Specialist history sheets – insert dividers for specialist history sheets if applicable
g) Advance Decision/Statement – if applicable
h) Correspondence
i) Theatre documentation
j) Investigation reports
k) Nursing records
l) Charts and forms

5.2.5 Detailed filing order is printed on the dividers within the record cover.

5.2.6 All computer produced traces will be securely stored in a secure-stor pouch with the details recorded accordingly in the table on the front. The pouch is to be filed behind the investigation results divider in the case note folder. Stocks of these pouches are held within the Medical Records Department.

5.2.7 Photographs of patients must be put into secure-stor pouch with the details recorded accordingly in the table on the front. A patient label is to be placed on the reverse of each photograph which should be dated. The pouch is then attached in the file. If the photograph is to aid the patient's treatment, then verbal consent should be obtained, and a record of this verbal consent should be written in the case notes. If the photograph is for training or publication (i.e. not for treatment) then consent for patient recording form will need to be completed. (See Consent policy for further information)

5.2.8 Other than the patient ID label, only labels/ stickers approved by the Health Records Strategy Group may be affixed to the front of the health record.

5.2.9 Alerts and sensitivities will be recorded on the Patient Alert Record. The sheet will be filed at the front of the health record. All entries must be dated. When an alert is entered onto the alert sheet and inserted into the health record, a tick must be placed in the designated alert box on the front cover of the health record. The 'alert' may refer to hyper-sensitivity, existence of living will etc.

5.3. Volumising (splitting and cross-referencing) Health Records

5.3.1 Health records that are in excess of 7cms are unmanageable in the operational clinical area and will be split into volumes

5.3.2 Staff in the Health Records Department will split the health record on a chronological basis with the most recent documentation in the latest volume.

5.3.3 Volumes will be clearly marked 'Volume 1', 'Volume 2' on the outside cover.

5.3.4 The PAS will be updated to indicate that there are multiple volumes of health records and/ or if they have been scanned, so that appropriate action may be taken to retrieve them.

5.3.5 Only the current volume/s needs to be issued to clinic for outpatient appointments.

5.4. Registration and Creation

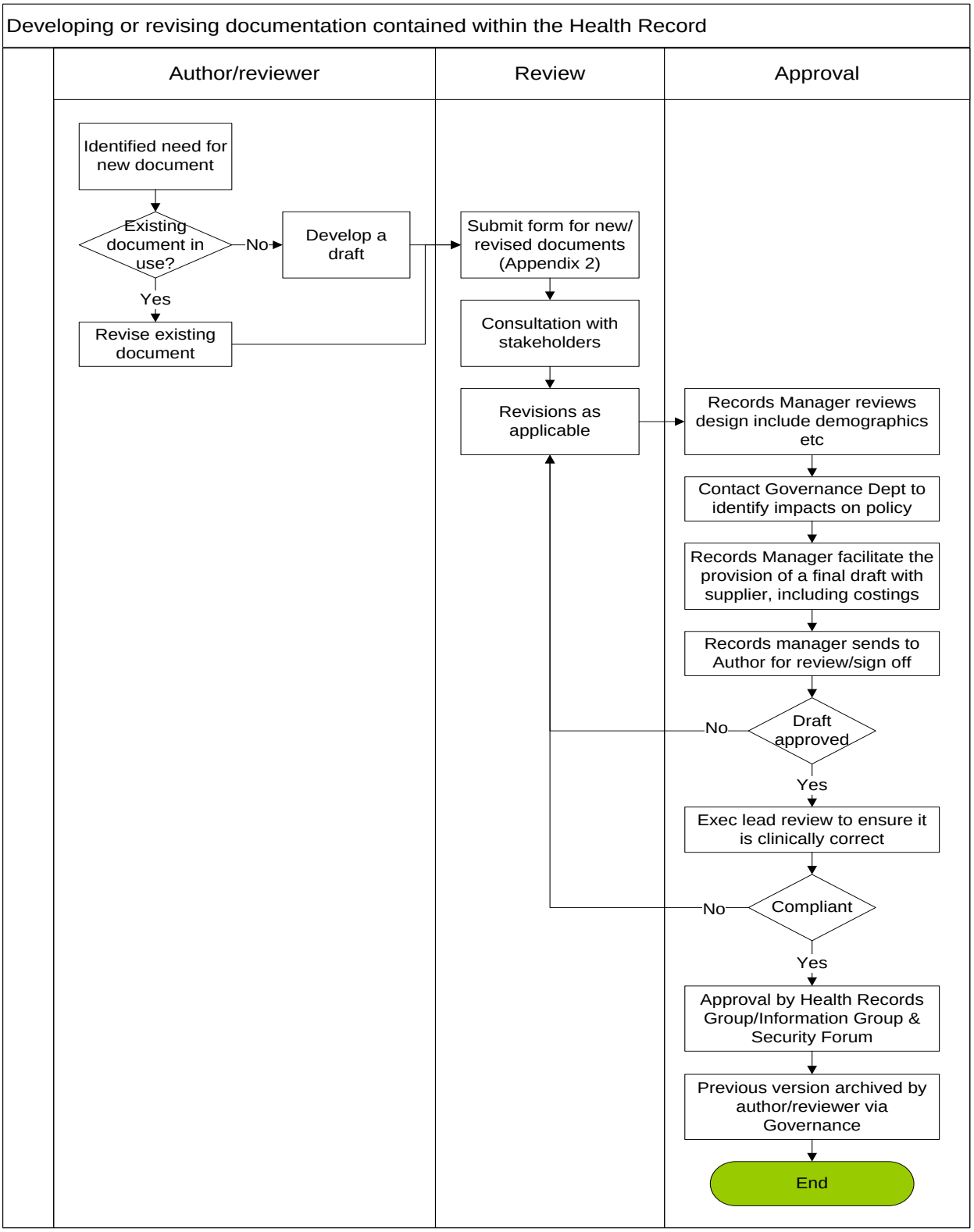
5.4.1 Staff in the Health Records Department will confirm that no record currently exists.

5.4.2 All new patients will be allocated a new health record and a unique patient identifier and, if not present, an NHS Number (using the Summary Care Record as source). All new health records will be assembled in accordance with this policy.

5.4.3 Temporary case notes (yellow case notes) should only be made up in the exceptional circumstances following adherence of the location missing case notes procedure.

5.5. Developing or revising documentation contained within the Health Record

5.5.1 See Flowchart below:



5.6. Confidentiality, Security and Storage

5.6.1 All health records will be stored, distributed, disclosed and disposed of in accordance with relevant legislation and guidance (Data Protection Act 1998, Human Rights Act 1998, Caldicott 1997 NHS Code of Practice for Records Management).

5.6.2 In the Health Records Department, records are filed using terminal digit filing (00-99) in order to facilitate ease of identification and retrieval.

5.6.3 Staff are individually responsible for records in their possession. Records must only be stored in approved and secure locations.

5.6.4 The Medical Records staff must have access to all areas which health records are being stored in. The Duty and On-call Senior Managers must have access out of hours for emergency admissions.

5.6.5 When health records are not required for operational purposes, they must be returned to, and stored in, the Health Records Department: a secure area to which access is restricted to authorised staff only.

5.6.6 The secure transportation of all types of records is a requirement of the NHS Information Governance Standards and the Data Protection Act 1998. Special controls must 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).

Please refer to the Health Records Guidance and Procedure Manual for further guidance.

5.6.7 Health records must not be removed off site unless on official Trust business and the record/s must be tracked to ensure they can be traced if required.

5.6.8 Records required for clinics being provided at satellite clinics are delivered and collected as required by use of reliable transport / couriers; records must be secure at all times and must not be left unattended.

5.6.9 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.

5.6.10 All transport/couriers must be arranged through the Supplies Department on ext. 8814

5.6.11 When health records are requested by another organisation, a photocopy of the records must be sent and the originals retained within the Health Records Department. Under exceptional circumstances (for example: legal reasons), when it is essential to send the original health record a complete copy must be retained within the Trust. If it is impossible to make a complete copy (for example: in an emergency transfer situation) then a summary only should be sent and the originals retained.

5.7. Digitised records

5.7.1 The Trust converts appropriate records into electronically held digitised images. This:

- offers better access to historical patient information and thus enhances patient care
- reduces the amount of storage required
- is the first step towards the electronic patient record of the future

5.7.2 The library of digitised patient records is held in the Health Records Department although other departments also hold their own digitised records.

5.7.3 Access to digitised information is limited to departmental user groups and, on occasion, it is necessary to reconstitute the digitised image into a paper copy. Requests for digitised images (or part images) to be reconstituted should be addressed directly by the Health Records Department: no unofficial copying may be undertaken.

5.7.4 If the reconstituted paper copy is not to be stored in the health record once it use is complete it must be returned to the Health Records Department for confidential destruction.

5.8. Tracing, tracking and retrieval

5.8.1 All case notes are tracked using the Patient Administration System (PAS): **this is mandatory**. Borrowers of case notes are personally responsible for the security and subsequent return to the library of every set of case notes that they borrow.

5.8.2 The location of all health records must be traceable at all times. Borrowers who take or send case notes to another location are personally responsible for ensuring that the computerised case note tracking system is updated immediately. The last recorded borrower is personally responsible for any case notes that are missing. Staff members who transfer health records are responsible for ensuring that the new location is accurately entered on PAS.

5.8.3 Staff receiving case notes in the post should check their location on PAS using the '*Case note Activity Enquiry'* function to ensure that they have been tracked correctly.

5.8.4 Borrowers of case notes are personally responsible for the security and subsequent return to the library of every set of case notes that they borrow.

5.8.5 If a set of case notes is taken from a location outside the medical records library and the recorded borrower is not present, the person taking the case notes is responsible for tracking the case notes to their new location.

5.8.6 The location of all health records must be traceable at all times. Staff members who transfer health records are responsible for ensuring that the new location is accurately entered on PAS.

5.8.7 The last recorded borrower is personally responsible for any case notes that are missing.

5.8.8 The Health Records Library will be staffed Monday to Friday 8.30am – 5.00pm. There is a nominated responsible person for the retrieval of medical records within the Trust at all times. In normal working hours this is the Health Records Manager. Out of normal hours i.e. evenings, night-time, weekends and bank holidays this is the Duty Manager, with support if necessary from the On-call Senior Manager and Out of Hours Ward Clerk who is contactable via Bleep 5211.

5.8.9 Health records must be returned to the Health Records Department as soon as possible after use.

5.8.10 Local Health Records Department procedures for the retrieval of health records are available on the trust intranet. The trust is currently developing an electronic resource to ensure that the most up to date PAS manuals/guidance is available to the user. This in turn will support the patient's journey.

5.8.11 Records required for clinical audit or research purposes please refer to the relevant clinical audit or research policy.

5.9. Missing Health Records

5.9.1 A ‘missing health record’ is one that cannot be found or is not available when required for a patient consultation or other purpose e.g. complaint/ incident investigation.

5.9.2 When this occurs staff in the Health Records Department must be notified.

5.9.3 When staff members in the Health Records Department have confirmed the health records are missing, a temporary set of records will be created and PAS updated to show that the temporary set is in circulation.

5.9.4 Staff in the Health Records Department must maintain a log of missing health records and a search conducted on a weekly basis. The dates, and outcomes, of the searches must be entered into the log together with the name of the person who conducted the search. This information will be monitored quarterly through the Health Records Strategy Group.

5.9.5 Every effort will be made to locate any records that cannot be traced. However, when a set of health records has been missing for six months, it is reasonable to assume that they are lost. Accordingly, the temporary set of health records should be converted into a duplicate set and the log of missing records and PAS updated to reflect this change.

5.9.6 If the original health records are located, the temporary or duplicate set of records should be merged with the originals and the missing health records log and PAS updated accordingly

5.10. Preservation, Retention and Disposal

5.10.1 The destruction of records is an irreversible act, while the cost of preserving records worthy of permanent preservation is high and continuing.

5.10.2 The preservation, retention and disposal of health records are undertaken in accordance with the Records Management: NHS Code of Practice, produced by the Department of Health. The health records retention schedule is hyperlinked at 6.10.6 but further guidance may also be obtained from the Trust’s Information Governance Manager.

5.10.3 If a record is not named within the retention schedule then the Information Governance Security Forum together with any other appropriate person/s, will make a local decision on retention requirements.

5.10.4 Department Managers will ensure that records no longer required for use are reviewed as soon as is practicable (whilst remaining in accordance with the retention schedule) so that ill-considered destruction is avoided. The schedule identifies minimum retention periods. A local review may determine whether records are to be selected for permanent preservation, destroyed or retained by the Trust – for litigation or research purposes

5.10.5 Whenever the schedule is used, the guidelines listed below should be followed:

- local requirements/ instructions must be considered before activating retention periods in the schedule
- decisions to destroy records should also be considered locally, in the light of the need to preserve records whose use cannot be fully anticipated at the present time but which may be of value to future generations (a destruction log must be retained)
- recommended minimum retention periods should be calculated from the end of the calendar or accounting year following the last entry on the record
- the selection of files for permanent preservation is partly informed by precedent and partly by the historical context – general rules have been drawn up locally using the

profile of material already selected and the history of the Trust (including pioneering treatments and examples of excellence)

- compliance with the Data Protection Act 1998, in that secure storage is provided and data are not kept for longer than necessary for the purpose for which it was collected

5.10.6 Health records contain sensitive or confidential information. It is therefore vital that confidentiality is safeguarded at every stage of the lifecycle including destruction. Currently all appropriate records are digitised as outlined in the Retention and Destruction Procedure and the paper copies securely stored, prior to destruction.

5.10.7 The Trust follows the NHS guidance for the retention and disposal of health records – use the following link to access the NHS retention schedule for health records (Annex D1)

5.11. Access to Health Records

5.11.1 Under the Data Protection Act 1998 and Access to Health Records Act 1990, the right of 'subject access' allows an individual (subject to certain restrictions) to gain access to personal data, including a copy of their medical records. This includes any electronically held digitised copies

5.11.2 The following requests for access must be made in writing to:

- Customer Care Team
  - Patient/relative
  - Police
  - Ombudsman
- Health Records Department
  - Solicitors/insurance (third parties) - Medical Legal Clerk
  - Other hospitals/DSS - Medical Legal Assistant

5.11.3 Personal data contained within the health record may be shared with other people/ organisations only with the written permission of the patient/ personal representative and in accordance with the Data Protection Act.

5.12. Duplicate Records

5.12.1 The Data Protection Act states that the minimum necessary personal information should be retained. Where duplicated information exists the Trust may decide on an appropriate 'master' copy and dispose of duplicates. The media for the 'master' record may be decided on a case-by-case basis, although for clinical records it will often be most appropriate for the master copy to be filed in the main clinical record.

5.12.2 Where the patient has two (or more) sets of paper records then the Medical Records Officer/Team Leader is then notified of the merge so that the paper records can merged.

6. Training

6.1.1 Information Governance training covering the Data Protection Act, Caldicott Guidelines, FOI, Confidentiality, is provided at Induction and online annually. Record Keeping and Records Management training is provided at induction.

6.1.2 For a full list of staff group to receive the training please refer to Appendix 1 of the Trust's Corporate Induction and Mandatory Training Policy.

6.1.3 It is the responsibility of Department/ Line Managers to identify which staff require system training. Training is requested by the line manager on a training application form available from the IT Training Manager.

6.1.4 The appropriate training manager will allocate a date and time for training and inform the staff member and Departmental/Line Manager who has requested the training.

6.1.5 On completion of training staff will be issued with appropriate level password access.

6.1.6 Training records will be maintained by the individual system trainer.

7. Monitoring

Minimum requirement to be monitored	Frequency of monitoring	Process for monitoring	Responsible individual/ group/ committee to undertake audit/ report etc	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of any action plans	Responsible individual/ group/ committee for monitoring of any action plans and implementation
duties	Bi-annually	Review of policies	Assistant Divisional General Manager (ADGM) & Health Records Manager (HRM)	ADGM/HRM Business & Performance Committee	ADGM/HRM Business & Performance Committee	ADGM/HRM Business & Performance Committee
legal obligations that apply to records	Bi-annually	Review of policy	ADGM/HRM	ADGM/HRM Business & Performance Committee	ADGM/HRM Business & Performance Committee	ADGM/HRM Business & Performance Committee
How a new health record is created	Bi-annually	Review of policy	ADGM/HRM	ADGM/HRM Business & Performance Committee	ADGM/HRM Business & Performance Committee	ADGM/HRM Business & Performance Committee
How health records are tracked when in current use	Quarterly	Quarterly Report to Board	HRM	HRM / Business & Performance Committee	HRM / Health Records Strategy Group	HRM / Health Records Strategy Group
How health records are retrieved from storage	Quarterly	Incident Reports	Health Records Strategy Group	Health Records Strategy Group	Health Records Strategy Group	Health Records Strategy Group
process for retention, disposal and destruction of records	Adhoc – At least annually	PAS Report of Tracking	Health Records Manager	Health Records Strategy Group	Health Records Strategy Group	Health Records Strategy Group
Basic record keeping standards which must be used by all staff	Annually	Documentation Audit (Appendix 1)	Audit department	Clinical Effectiveness Group	Clinical Effectiveness Group	Clinical Effectiveness Group
Process for making sure a contemporaneous record of care is completed	Annually	Documentation Audit (Appendix 1)	Health records manager + Audit department	Clinical Effectiveness Group	Clinical Effectiveness Group	Clinical Effectiveness Group
How the organisations trains staff in line with the training needs analysis	Monthly	Performance report	T+D Department	Business & Performance Committee	Business & Performance Committee	Business & Performance Committee

8. References

- The Data Protection Act 1998 - http://www.opsi.gov.uk/Acts/Acts1998/ukpga_19980029_en_1
- Records Management: NHS Code of Practice (2006) - http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131747
- NHS Code of Practice on Confidentiality 2003 (DoH) - http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253
- Access to Health Records Act 1990 - http://www.opsi.gov.uk/acts/acts1990/ukpga_19900023_en_1
- Good Medical Practice: General Medical Council (2006) http://www.gmc-uk.org/guidance/good_medical_practice.asp
- Guidelines for Records and Record Keeping: Nursing and Midwifery Council (2009) - http://www.nmc-uk.org/aArticle.aspx?ArticleID=3791
- Code of Professional Conduct: Nursing and Midwifery Council (2010) http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Record-Keeping-Guidance.pdf

8.1. Supporting policies/documents

- Health Records Guidance and Procedure Manual
- Lifecycle Management Strategy
- Consent Policy
- Corporate Induction & Mandatory Training Policy
- Information Governance policies and procedures
- IT policies and procedures
- Retrieval of health records SOP

Appendix 1 - Multidisciplinary Documentation Audit of Record Keeping

FOR ONE COMPLETED EPISODE OF CARE

SPECIALITY: Neurology ☐ Neurosurgery ☐ Pain Services ☐

HOSPITAL NO: _____

DATE OF ADMISSION: _____

WARD: _____

BASIC RECORD KEEPING STANDARDS

1.	**Are all entries legible?**	Yes	☐	No	☐
2.	**Are all entries in black/blue ink?**	Yes	☐	No	☐
3.	**Are all entries signed?**	Yes	☐	No	☐
4.	**Are all entries dated?**	Yes	☐	No	☐
5.	**Are all entries timed using 24 hour clock?**	Yes	☐	No	☐
6.	**Are all entries made by students & support staff countersigned by registered health professional?**	Yes	☐	No	☐
7.	**For each 1st daily entry:-**				
	Practitioner name printed	Yes	☐	No	☐
	Designation documented	Yes	☐	No	☐
8.	**Alterations:-**				
	a) Mistakes crossed through with single line	Yes	☐	No	☐
	b) Initialled	Yes	☐	No	☐
	c) Dated	Yes	☐	No	☐
	d) Has correction fluid been used?	Yes	☐	No	☐
9.	Are all entries factual and free from meaningless phrases or irrelevant speculation?	Yes	☐	No	☐
10.	Is there any unnecessary use of abbreviations or jargon within the record?	Yes	☐	No	☐

PHYSICAL CONDITION OF HEALTH RECORDS

11.	**General condition of health records:-**	Good	☐	Acceptable	☐	Poor	☐
12.	**Have documents been stapled to the front of the record?**	Yes	☐	No	☐		
13.	**Patient name and number only on front of the record?**	Yes	☐	No	☐		
14.	**Are the records over full?**	Yes	☐	No	☐		
15.	**Are there any loose / unfiled sheets**	Yes	☐	No	☐		
16.	**Have any documents other than identification labels been filed in back pocket?**	Yes	☐	No	☐		

Comments_____

_____

Appendix 2 - Submission form for new/revised documents (including design guidance)

Title	**Management of clinical records**	
New, Amendment or Pilot	Application for pilot ☐ Application for Approval: New Document ☐ Application for Approval: Amended Document ☐	
Originator (Committee/Dept/Name)		
Consultation Process (Members/Working Party)		
Funding identified (Budget Code)		
Training need identified? – if yes please liaise with T&D Manager		
Health Records Strategy Group Consultation	**Date**	**Pilot/ Amendments/ Final Approval**

Guidance on the Design of a Specialty Document

Specialties are free to design the content of their forms as required but within the design guidelines set out below.

<u>The form must have:</u>

- A title
- The Trust logo
- Specialty/Department name
- A 1.5cm margin on all sides
- Perforation holes which do not impinge onto the text
- Adequate space on right-hand side for a full signature and date
- Footer which contains the document identifier: this will be allocated by the Health Records Manager/Supplier and will include:
    - Specialty name
    - Document name
    - Document Number
    - The last two numbers of the year the document was introduced or updated

Appendix 3 - Version Control

Version	Section/Para/ Appendix	Version/description of amendments	Date	Author/Amended by
1.1		Renamed to Clinical Records Management Policy	02/2014	J. Renshall
1.1		Changed to Trust policy layout and operational procedures removed.	02/2014	J. Renshall
1.1	4	Introduction rewritten (1)	02/2014	J. Renshall
1.1	4	Definitions added (3)	02/2014	J. Renshall
1.1	4	Rewording of duties (4)	02/2014	J. Renshall
1.1	6	Basic records keeping standards changed to include – - Use of blue biro - Subsequent entries must be dated and timed using 24 hour clock and signed - Countersigned by the registered practitioner responsible for the care of the patient, if made by non-registered practitioner in the course of nursing care - Completed in line with professional codes of practice in relation to record keeping standards e.g. NMC, GMC	02/2014	J. Renshall
1.1	6	Health Records Structure reworded and now included in Filing (5.2)	02/2014	J. Renshall
1.1	7	Volumes now rewritten and included in 5.3	02/2014	J. Renshall
1.1	8	Creation of a new record – rewritten and renamed Registration & Creation (5.4)	02/2014	J. Renshall
1.1	8	Developing or revising documentation contained within the Health Record (5.5) inserted (including flow chart)	02/2014	J. Renshall
1.1	9	Security of Health Records – rewritten and now included in Confidentially, Security & Storage (5.6)	02/2014	J. Renshall
1.1	9	Transportation of Health Records – rewritten and renamed Confidentially, Security & Storage (5.6.4)	02/2014	J. Renshall
1.1	10	Case Note Tracking – rewritten and renamed Tracing, Tracking & Retrieval (5.8)	02/2014	J. Renshall
1.1	11	Retention & Destruction of Health Records – rewritten and renamed Preservation, Retention and Disposal (5.10)	02/2014	J. Renshall
1.1	12	Disclosure of information rewritten and renamed Access to Health Records section 5.11	02/2014	J. Renshall
1.1	13	Appendix 7 – Monitoring Table removed as an appendix and moved to section 7	02/2014	J. Renshall
1.1	15	Appendix 4 - Multidisciplinary Documentation Audit of Record	02/2014	J. Renshall

		Keeping renamed appendix 1		
1.1	16	Addition of appendix 2 – Submission form for new/revised documents	02/2014	J. Renshall
1.1		Clinical Content section removed	02/2014	J. Renshall
1.1		Filing & Imaging section remove	02/2014	J. Renshall
1.1		Legal Obligation that apply to records section removed	02/2014	J. Renshall
1.1		Appendix 1 – Notes on the Standards for Health Records removed	02/2014	J. Renshall
1.1		Appendix 2 – Clinical Records Keeping Commandments removed	02/2014	J. Renshall
1.1		Appendix 3 – Audit Duties removed	02/2014	J. Renshall
1.1		Appendix 5 – Outpatient Clinic Pulling & Preparation List removed	02/2014	J. Renshall
1.1		Appendix 6 – Retrieval of scanning from Cosmo Graphis Gold (GC Gold) removed	02/2014	J. Renshall

Translation Service

This information can be translated on request or if preferred an interpreter can be arranged. For additional information regarding these services please contact The Walton centre on 0151 525 3611

Gellir gofyn am gael cyfieithiad o'r deunydd hwn neu gellir trefnu cyfieithydd ar y pryd os yw hynny'n well gennych. I wybod rhagor am y gwasanaethau hyn cysylltwch â chanolfan Walton ar 0151 525 3611.

هذه المعلومات يمكن أن تُتَرْجَم عند الطّلب أو إذا فضّل المترجم يمكن أن يُرَتَّب للمعلومة الإضافيّة بخصوص هذه الخدمات من فضلك اتّصل بالمركز ولتون على
0151 5253611

ئەم زانیاریە دەکرێت وەربگێڕدرێت کاتێك کە داوابکرێت یان ئەگەر بەباش زاندرا دەکرێت وەرگێڕێك ئامادە بکرێت (ڕێك بخرێت) ، بۆ زانیاری زیاتر دەربارەی ئەم خزمەتگوزاریانە تکایە پەیوەندی بکە بە Walton Centre بە ژمارە تەلەفۆنی ١٥١٥٢٥٣٦١١ .

一经要求，可对此信息进行翻译，或者如果愿意的话，可以安排口译员。如需这些服务的额外信息，请联络Walton中心，电话是：0151 525 3611。