Management of Records - Policy and Procedure:

Introduction
The Company has a statutory duty to make arrangements for the safe keeping and eventual disposal of its records. This policy gives the basis for good management of records. The purpose of this policy is to ensure that the organisation adopts best practices in the management of its records so that reliable records are created, they can be found when needed, and are destroyed or archived, when no longer required.

This policy provides for:

- The requirements that must be met for the records to be considered as a proper record of the activity of the organisation, including the provision of care.
- The requirements for systems and processes that deal with records
- The quality and reliability, which must be maintained to provide valuable information and knowledge resource for the organisation

This covers records in all formats, both corporate and patient records, paper and electronic (including emails), created in the course of the organisation's business

Policy Statement
A record is information that has been received, created or maintained by the organisation as evidence of a business activity, patient care, treatment planned, treatment given; and can be in any format – paper, electronic, digital and/or voice. A record is anything which contains information which has been created or gathered as a result of any aspect of the work of employees including agency or casual staff, volunteers and all contracted services.

The organisation will create, use, manage, destroy, dispose of or preserve its records in accordance with all statutory requirements.

Systematic records management is fundamental to the efficiency of the organisation. It enables the organisation to:

- conduct business in an orderly, efficient and accountable manner
- deliver care and services in a consistent and equitable manner
- support and document policy formation and managerial decision making
- provide consistency, continuity and productivity in management and administration
- meet legislative and regulatory requirements including archival and audit
- provide protection and support in litigation
- protect the interests of the organisation and the rights of employees, patients and present and future stakeholders
- support and document current and future research

The organisation ensures that:

- the correct information is captured, stored, retrieved and destroyed/disposed of
- it is protected against unauthorised access
- it is accessible to those who need to make use of it and that the appropriate technical and organisational elements exist to make this possible
- all staff are made aware of and trained in the management of records within their area of work or responsibility

Staff members must ensure that:

The record is present

- the organisation has the information that is needed to form a reconstruction of care, activities or transactions that have taken place

The record can be accessed

- It is possible to located access and evaluate the information and display it in a way consistent with the purpose for which it was created. Records will be signed, dated and appropriately filed

The record can be interpreted

- It is possible to establish the context of the record: who created the document, during which operational or business process, and how the record is related to other records. Records will be legible and easily understood

The record can be trusted

- The record reliably and accurately represents the information that was actually used in or created by the business process, and its integrity and authenticity can be demonstrated

The record can be maintained through time

- the qualities of accessibility, interpretation and trustworthiness can be maintained for as long as the record is needed, perhaps permanently, despite changes of formats or business processes/practices. Records will be protected during their life cycle by ensuring safe and adequate storage facilities

Creating records

Records identification ensures that a link between the record and its business roots/function. A new Service User or Client record will be created upon confirmation of placement within Kingdom Healthcare Delivery Service. This will be either electronic or paper, or both. Where paper records are kept, Service User or Client records should have a designated folder with an index and dividers

Core Standards for paper record keeping

- all writing in care records will be legible
- all entries will be in black permanent ink
- all entries will be signed
- registered nurses will print their name and designation under their signature
- all entries will record the time of entry and be dated
- the 24-hour clock must be used when timing entries
- errors will be crossed through with a single line, initialled and dated (correction fluid must not be used under any circumstances)
- errors must be corrected at the time of entry and not retrospectively
- spaces/lines (gaps) should not be left between entries
- all entries will be recorded in full. Abbreviations will not be used
- entries made by students or trainees will be countersigned by Managers or designated experienced member of Team.
- all entries will be recorded within 24 hours or preferably contemporaneously, that is at the time of activity taking place

Record Keeping Guidelines

1. The care record will bear the full name of the Service User or client on each

2. An entry to the care record should be made by the delivery staff at the end of each shift/visit in line with Regulatory Board Codes of Practice.
3. All records will be filed in chronological order within each appropriate section – most recent on top.
4. The records will contain clinically relevant information only and will not include additional information such as financial information
5. Judgements of a personal nature will not be used in the records. Comments about the patient will be objective, factual and be relevant to their clinical assessment and treatment
6. Wherever possible, records should be written with the involvement of the Service User or Client.
7. All records will record the information given to the patients
8. Electronic records' log in details must never be shared with other staff members

Retention of Records

Disposal of records refers to their appropriate ***destruction*** or their ***transferral*** to Kingdom Healthcare Archive where they can be reached as required until the end of their specified retention period. The appropriate retention periods and associated disposal actions are defined in the table below.

Staff application forms	Duration of employment
Service User related documents, care plans, risk assessments and communication logs	8 Years from last service date
References received	8 Years from last service date
Payroll and tax information	8 Years from last service date
Sickness records	8 Years from last service date
Annual leave records	8 Years from last service date
Unpaid leave/special leave records	8 Years from last service date
Annual appraisal/assessment records	8 Years from last service date
Records relating to promotion, transfer, training, disciplinary matters	8 Years from last service date
References given/information to enable references to be provided	8 Years from last service date
Summary of record of service, e.g. name, position held, dates of employment	8 Years from last service date
Records held relating to right to work in the UK	8 Years from last service date
Records relating to accident or injury at work	12 years

Essentially, there are two ways of disposing of records:

· Destruction of records which no longer have value

· Records with an enduring value to Kingdom Healthcare being transferred to the company's archive.

Record Storage and Archiving
The organisation has a responsibility for ensuring the effective and efficient operation of all storage facilities. This includes the safe keeping, accessibility and retention of records in accordance with the General Data Protection Regulations (GDPR). Records should be stored in secure areas within the Kingdom Healthcare registered office that is accessible to those authorised staff members.

Records which have been identified as having a long term or historical value or which require to be kept permanently, should, at present, be retained in the section which created them and advice sought from Business Support Manager.

Note:

While records should be disposed of in line with the guidance in the relevant retention schedule, it should be noted that records which are subject to a current ***Freedom of Information*** *request should not be destroyed until at least 40 days after the request has been answered.*

Disposal and destroying of records
Records should be kept for as long as they are needed to meet the operational needs of the organisation, and legal and regulatory requirements with a minimum of 6 years.

Where records have been assessed for record closure, these files may be destroyed, however it is important to remember that most records, even administrative ones, contain sensitive or confidential information. It is therefore vital that confidentiality is safeguarded at every stage of the life cycle of the record, including destruction and that the method used to destroy such records is fully effective and ensures their complete illegibility.

Care must be taken when destroying records. The basic procedures for destruction are:

Destruction of Paper Records

Record Type	***Disposal method***
Non- sensitive files/records, information in public domain	Rubbish bin
Non-sensitive files/records/files not available to the public	Torn into small pieces, bagged for collection by approved disposal firm
Sensitive records restricted	Strip shredded, bagged for collection by approved disposal firm
Sensitive records confidential	Strip shredded, bagged for collection by approved disposal firm
Secret and Top Secret	Cross-cut shredded, bagged for collection by approved disposal firm

Destruction of Electronic Records
A record of destruction of records, showing their reference, description and date of destruction should be maintained and preserved so that the organisation is aware of those records that have been destroyed and are therefore no longer available.

Policy Framework
The records management policy is a specific part of the organisation's overall corporate program and relates to other local and regional policies such as:

- following best practice – records should be managed in accordance with the standards of records management
- Data protection – records need to be managed in accordance with procedures under the General Data Protection Regulations
- Freedom of Information – records need to be managed in accordance with the Freedom of Information Act 2000 and its related codes of practices
- Audit Procedures
- Records have to meet the Organisations internal and external audit requirements

The Registered Manager is required to maintain those records required by the RQIA, commissioning Health Trusts and clients with agreed contracts with Kingdom Healthcare in accordance with the GDPR.

Revision History

Date Revised	Version	
23/09/2019	010	GDPR & F of I full update

Responsibility

- Registered Manager, General Manager, Trainer, Lead Nurses and Co-Ordinators.
- Directors and base staff.
- All front-line healthcare professionals

Associated Documentation

- Daily, weekly, periodic Kingdom Healthcare record keeping document.
- Kingdom Healthcare Archive spreadsheet.
- All documents, paper and electronic versions containing personal data.