# **Shifa Medical Practice**

# **Record Keeping Policy and Protocol**

**Document Control**

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**Introduction**

The purpose of this policy and protocol is to actively encourage and support the Practice and  
process of excellent record keeping, both in its clinical and non-clinical environments.

Good record keeping is essential in every aspect of the Practice function.

In the clinical setting, it helps protect the welfare of patients (especially vulnerable adults and  
children) and promotes best-practice from each healthcare practitioner.

Within the non-clinical setting, it is essential in making sure the Practice adopts the highest  
business standards, and maintains a professional approach and appearance. It is also invaluable in ensuring the smooth-running of the Practice on a day-to-day basis.

In both environments there are a number of legal responsibilities which must be adhered to,  
particularly in relation to length of time for keeping records.

**Practice Statement of Intent**

It is the intent of Shifa Medical Practice that the highest standards of record keeping will be upheld within the Practice at all times, and that all legal requirements with regard to record retention time periods and manner of storage are adhered to.

**What is a Record?**

A record is an account of each activity performed by the Practice. It can be stored in either a  
printed or electronic format. It provides a complete history of the Practice’s actions over an  
identified time-period.

**Types of Records Used**

The following record types are kept at the Practice:  
•Health records;  
•Server and PC hard drives  
•Administrative and accounting records;  
•Diaries;

**Policy**

**Responsibility**

Because records are made by every staff member at the Practice, each has his / her own  
responsibility for ensuring these are relevant, accurate, up-to-date, and stored in the correct  
manner.

Dr. Rashid has overall responsibility for record keeping and ensuring that the  
requirements with regard to new legislation and improvements in best-practice are incorporated and maintained.

**Information Quality Assurance**

Practice staff will receive regular training updates with regard to records management and  
information quality. This includes all aspects of record creation, use and maintenance, covering the following points:

•What information should be recorded and in what manner;  
•Why this is being done;  
•Ensure information from patients or carers is cross-referenced with other available records to ensure accuracy;  
•How to identify and correct errors, and report those errors found;  
•What records are being used for (this will help them understand which are the most  
important aspects of the information they are recording and ensure they are included);  
•How information should be updated and how information from other sources can be  
included.

**Record Keeping**

Effective and accurate record keeping is made as a direct result of knowledge of the type of  
records held at the Practice, where they are stored, and their relationship to Practice function.

To facilitate this requirement, the Practice will conduct an annual record audit, which will take  
place each calendar year.

All record keeping systems will contain descriptive and / or technical documentation to enable  
efficient operation of the system and ensure that records are easily understood.

Systems, whether electronic or printed format, will include simple rule-sets for referencing,  
cross-referencing, indexing and, where necessary, protective marking.

**Record Maintenance**

The movement and location of records will be controlled to ensure that a record can be easily  
retrieved at any time, that any outstanding actions can be dealt with, and that there is an  
auditable trail of record transactions.

Storage areas for current records should be clean and tidy; the layout of which should be  
designed to help prevent damage to the records and should provide a safe working environment for Practice staff.

For electronic records; maintenance in terms of back-up and planned migration to alternative  
platforms are designed and scheduled in a manner that ensures continued access to readable  
information.

Equipment used to store current records on all types of media provides storage that is safe and secure from unauthorised access and which meets health, safety and fire regulations.

Additionally, the equipment also allows maximum accessibility of all records, commensurate with their frequency of use.

Non-current records are placed in a designated secondary storage area, bearing in mind the  
ongoing need to preserve important information and keep it confidential and secure. There are archiving policies and procedures in place for both paper and electronic records.  
A business continuity plan is in place to provide protection for all types of records that are vital to the continued functioning of the Practice.

Expertise in relation to environmental hazards, assessment of risk, business continuity and other considerations rests with Dr. Rashid who is the person with overall responsibility for record keeping and their advice should be sought on these matters.

**General Record Keeping Standards**

The Practice’s policy of good record keeping aims to deliver the following standards of patient  
care and business professionalism:  
•Supports the highest standards of clinical care;  
•Supports greater continuity of care;  
•Provides better communication and dissemination of information between clinical and nonclinical teams;  
•Provides an accurate account of treatments given, and promotes best care planning and  
delivery of services;  
•Enables early warning of potential problems (e.g. changes in the patient’s condition);  
•Complies with legal requirements (e.g. Data Protection Act and Access to Health Records  
Act);  
•Assists with the audit process, both in a clinical and non-clinical setting;  
•Supports improvement and advancement in clinical practices and effectiveness of these;  
•Promotes patient choice and decision-making with regard to their treatment and the services on offer;  
•Provides evidence for the basis of legal or professional proceedings;  
•Supports efficiency and accuracy when dealing with suppliers and other outside bodies;  
•Establishes a clear and effective accounting procedure.

**Maintenance of Personal Data**

•All clinical and nonclinical (except cleaner) have been trained on how to maintain  
personal data. Patients are encouraged to inform us of changes (e.g. telephone number/  
address).  
•Contact details are checked when appointments are made both internally and when  
external referrals are initiated.  
•Changes made by staff do not require prior authorisation by either the manager or  
information governance lead. All staff are made aware regarding the importance of  
accuracy.

**Record Keeping within Consultations Protocol**

All clinical staff must adhere to the Practice's record keeping within consultations protocol.

The following information should be routinely recorded to ensure completeness in the patient  
record (you may wish to include Read Codes for various entries so that you are able to undertake searches at a later date for audit purposes - templates within the clinical system can be devised and used to ensure consistency and accuracy).

•Discussion that takes place within the consultation;  
•The reason the patient has attended;  
•Clinician’s findings (including conditions that were looked for and not found);  
•Proposed treatment plan and whether the patient agrees with this;  
•Any medication prescribed and how they can report side effects;  
•Any follow up plans;  
•Information given on lifestyle changes and health promotion and whether the patient refuses to access this (e.g. smoking cessation clinic, weight management);  
•Any refusal to accept surgical intervention once referred (see referral protocol);  
•Any discussions on choice;  
•Any discussions regarding particular needs of the patient.

Where the consultation takes place at the patient’s home, the clinician must ensure notes of the consultation are transferred to the patient record as soon as possible.

Do not alter an entry or disguise an addition. If the notes are factually incorrect, then the  
amendment must make this clear.

Avoid unnecessary comments (patients have the right to access their records and a flippant  
remark might be difficult to explain).

All new diagnoses should be recorded and any consultations that take place regarding the  
diagnosis should be recorded under that heading.

Any injections given should be recorded together with the name and batch number of the  
vaccine given and the site (e.g. left deltoid, right buttock). Patients must be advised on possible reactions or side-effects and what they should do if they experience any.

Where minor surgery or coil-fits are undertaken, ensure disposable instruments are used (or  
where reusable instruments are used, an accurate sterilisation record is kept).

Record batch numbers where applicable. Patients must be advised on possible reactions or side effects and what they should do if they experience any. Detail any follow-up requirements (e.g.check-up or stitch removal).

**Challenges to Data**

Patient's have the right to challenge the accuracy of sensitive data held within the record. At  
times, inaccuracies may be found by members of the clinical team or when records are  
transferred in. All such inaccuracies should be brought to the attention of the information  
governance lead. All such changes will require discussion, authorisation and documentation  
within the medical record when and if agreed to carry out.

**Health Record Retention Periods**

**GP records, including medical records relating to HM Armed Forces or those serving a period of imprisonment**•GP records, wherever they are held, other than the records listed below will be retained for  
10 years after death, or after the patient has permanently left the country unless the patient  
remains in the European Union.  
•In the case of a child, if the illness or death could have potential relevance to adult  
conditions, or have genetic implications for the family of the deceased, the advice of  
clinicians should be sought as to whether to retain the records for a longer period.  
•Maternity records will be kept for 25 years after last live birth.

**Photographs (where the photograph refers to a particular patient it should be treated as part of the health record) NB In the context of the Code of Practice a ’photograph’ is a print taken with a camera and retained in the patient record.**

•Retain for the period of time appropriate to the patient / specialty, e.g. children’s records are  
retained as per the retention period for the records of children and young people.  
•Mentally disordered persons (within the meaning of the Mental Health Act 1983) - 20 years  
after the last entry in the record or 8 years after the patient’s death if patient died while in  
the care of the Practice. Unless there is a clinical reason for retaining the digital image and a  
print is placed on the patient’s record, there is no requirement to retain the digital image.

**Diaries – health visitors, district nurses and Allied Health Professionals**

•2 years after end of year to which diary relates. Patient-specific information is transferred to  
the patient record. Any notes made in the diary as an ’aide memoire’ are also transferred to  
the patient record as soon as possible.

**Non-Health Record Retention Periods**

**Accident register (Reporting of Injuries, Diseases and Dangerous Occurrences register)**

•10 years.

**Appointment records (GP)**

•2 years (Provided that any patient-relevant information has been transferred to the patient  
record). At the end of the 2 year retention period, the Practice will consider if there is an  
ongoing administrative need to keep the records/books for longer. If there is an ongoing  
need to retain these records/books, then a further review date will be set (either 1 or 2 more  
years)

**Audit records (e.g. organisational audits, records audits, systems audits) – internal & external in any format (paper, electronic etc)**

•2 years from the date of completion of the audit

**Complaints (See also litigation dossiers), correspondence, investigation and outcomes**

•8 years from completion of action

**Flexi-working hours (personal record of hours actually worked)**•6 months

**Freedom of Information requests**

•3 years after full disclosure.  
•10 years if information is redacted or the information requested is not disclosed  
**GMS1 forms (registration with GP)**

•3 years  
**Manuals – policy and procedure (administrative and clinical, strategy documents)**

•10 years after life of the system (or superseded) to which the policies or procedures refer

**Patient Advice & Liaison Service (PALS) records**

•10 years after closure of the case

**Patient information leaflets**

•6 years after the leaflet has been superseded

**Quality and Outcomes Framework (QOF) documents (GP Practice records)**

•2 years

**Serious incident files**

•30 years

**Accounts – annual (final set only)**

•30 years

**Bank statements**

•2 years from completion of audit

**Bills, receipts and cleared cheques**

•6 years

**Ledgers, including cash books, ledgers, income and expenditure journals, nominal rolls, non-exchequer funds records (patient monies), tax forms and VAT records**

•6 years after end of financial year to which they relate