Southern Health and Social Care Trust

Records Management Procedures

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1.0 Records Management Procedures

1.1 Introduction

It is a statutory requirement for the HPSS to implement records management as set out in the Public Records Act (Northern Ireland) 1923 Act and in the Disposal of Documents (Northern Ireland) Order (1925).

The international standard of managing records, ISO 15489 defines a record as *"information created, received and maintained as evidence and information by an organisation or person, in pursuance of legal obligations or in the transaction of business."*

1.2 Purpose

The purpose of these procedures is to ensure that the Southern HSC Trust 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.

It is the responsibility of all staff including those on temporary contracts to comply with this procedure

1.3 Scope

The Freedom of Information Act 2000, Lord Chancellor's Code of Practice (S.46), Data Protection Act 1998 and Good Management, Good Records all have implications for Records Management processes.

This guidance has been developed as a minimum standard and should be read in conjunction with the Trust Records Management Policy and relevant professional standards from regulatory bodies e.g. Nursing and Midwifery Council.

HPSS records are public records as defined in the Public Records Act (Northern Ireland) 1923. A "public" record is a record of information created by the activities of the Trust and conveyed by any means (manuscript, typescript, email, film, magnetic tape, map, plan, drawing, account and ledger).

In the context of these procedures, a record is any thing which contains information in any media which has been created or gathered as a result of any aspect of the work of HPSS employees including:

- Administrative/Information Governance (including personnel, estates, financial and accounting records)
- Patient health records (electronic or paper based)
- X-ray and imaging reports, and other images microform/microfiche/film
- Audio and videotapes, cassettes, CD-ROM etc

- Computer data bases, output and disks etc and all other electronic records

This list is not exhaustive.

Section 2 – Records Creation

2.0 Records Creation

Records are created so that information is available in the Trust to:

i. Deliver the services offered by the Trust to the community.
ii. Ensure that appropriate records are kept of the operation of the Trust business and are correctly identified and managed.
iii. Support day-to-day business, which underpins decision-making and the delivery and continuity of care.
iv. Support evidence based practice.
v. Meet legal requirements including requests under the Data Protection Act 2018 and Access to Health Records (NI) Order 1993, requests for information under the Freedom of Information Act 2000 and Environmental Information (Amendments) Regulations 1998.
vi. Assist in the auditing process.
vii. Support archival functions by taking account of the historical importance of material and the needs for future research.
viii. Ensure whenever, and wherever there is a justified need for records to be created for use in the authority, community, and wider public it is done effectively and in line with appropriate legal requirements and recognised good practice.
ix. Assist the Trust in defending any legal claims against it or its staff.

2.1 Filing of Legal Papers and Complaints

Correspondence generated from legal cases and complaints must not be filed within the clinical record. These papers are not relevant to clinical care and are often not disclosable unlike the clinical record.

2.2 Version Control Certificate

Policy documents frequently undergo changes and it is vital that the Trust adopts a ‘version control certificate’, which should be attached to all approved policy documents (Appendix 1). This certificate will demonstrate that the policy is in force and is current, as it will give a revision date for the policy. It will be reasonable to assume that if a policy is being referred to after the revision date on the 'Version Control Certificate’, such policy will no longer be in force.

('Guidance on Version Control of Documents' (Appendix 2) and 'Guidance on Naming Convention' (Appendix 3) has been produced by the Regional Records Management Working Group in 2006).

2.3 Records Registration

Determining which records require registration is a decision that should be made by the Departmental Records Officer and the Records Manager. Registration is a system which allocates a unique identifier (number or alphabetical prefix) to each item. The kinds of records, which are most likely to be placed on a registered file, include:

- Trust records re: functions and procedures
- Trust minutes of meetings
- Personnel, Financial and Estates records
- Contractual information
- Care/clinical records re: patient care or treatment
- Mandatory patient activity returns
- Performance monitoring
- Policy papers (reports, correspondence etc)
- Complaints papers and correspondence
- Research and development papers
- Papers relating to the preparation of legislation
- Relates to the decision-making process, success or failure, of any work or project associated with the file e.g. success or failure to meet targets, standards or other criteria.

Registration will depend on the Trust business need to maintain accountable records of particular activities.

The best practice principles of registration are:

- The file title must be unique and accurately reflect the contents of the file (exclude terms e.g. general or miscellaneous)
- Acronyms and abbreviations used in the title must be those in common use in the organisation
- Both must be relevant to and easily understood by all users
- The reference assigned to each patient file must be unique e.g. PAS or Health & Care Number
- Details should be recorded both on the register and on all associated papers

Types of registered file systems include:

- Alphabetical
- Numerical
- Alpha-numeric
- Keyword

Registration systems should be monitored regularly and reviewed at least once every two years to ensure that they continue to operate effectively and efficiently.

2.4 Electronic Records

With the development of electronic patient records, there will be a need to identify every item which is patient/client related with the relevant Health & Care Number to provide the necessary links through all electronic records.

An Electronic and Document and Records Management System (EDRMS) is a computerised information system that captures, maintains and provides access to documents and records. An EDRMS allows levels of access and security to be set and offers strict and auditable version control. An EDRMS with a functional fileplan in place supports the Trust's obligations under the Freedom of Information Act by facilitating access to information. Within the Trust there is an EDRM (WinDip) which is linked to the Paris Community Information System and can be used to store addition documents from external sources.

(The Regional Records Management Working Group has developed a regional Fileplan which can be adopted by HPSS organisations - Appendix 4).

2.5 Protective markings

There must be sufficient space on the file cover to indicate the protective marking (if any e.g. Confidential, Restricted). Protective markings must be consistent with the accepted system used in the Trust.

2.6 File Covers

The cover of every file should include:

- File title
- Year in which it was opened
- Date of closure

- Marked ‘closed’ if appropriate
- Date of the first paper
- Date of last paper
- Identification of precedent cases (Glossary)

(The Public Record Office, Northern Ireland, (PRONI) has agreed a file cover for use within the HPSS).

2.7 Record Keeping

Records of all types are valuable because of the information they contain and that information is only useful if it is:

- correctly and legibly recorded in the first place;
- is kept up to date; and
- is easily accessible when needed.

To ensure quality and continuity of services all records should be accurate and up to date. Procedures should be developed to ensure and maintain data quality for both manual and electronic records. These procedures should be passed on to staff who are responsible for recording such information. It is also essential that these procedures are reviewed and updated regularly.

2.7.1 Information Governance

The Trust records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision making, protect the interests of the Trust and the rights of patients, staff and members of the public. They support consistency, continuity, efficiency and productivity and help deliver services in a consistent and equitable way. Information is a corporate asset. The Trust records are important sources of administrative, evidential and historical information. They are vital to the Trust to support its current and future business, including meeting the requirements of Freedom of Information legislation, for the purpose of accountability, and for awareness and understanding of its history, policies and procedures.

Examples of Information Governance :

<u>Minutes of meetings</u>

Transcript of important work related telephone conversations – providing advice, instructions or recommendations, giving permissions and consent and making decisions, commitments and agreements.
Correspondence – letters, email, faxes, internal memos

Draft documents – drafts submitted for comment or approval by others and drafts containing significant annotations.

Integrity of Records

It is the responsibility of each Trust to ensure that all records are complete and authentic and in addition, to be satisfied that all correspondence is present and kept in correct order. The records must:

- provide adequate evidence of the conduct of business to account for a financial transaction including reasons for any decision necessary for that transaction to take place;
- contain verifiable evidence that the transaction was properly authorised;
- provide complete information to document the transaction;
- comply with record keeping requirements arising from the regulatory and accountability directions of the Trust; and
- be comprehensive and document the complete activity i.e. contain a full audit.

2.7.2 Health Care Records

The purpose of the clinical record is to facilitate the care, treatment and support of a particular client.

Patient and client records should be:

- Factual
- Consistent and accurate
- Written in black ink only
- Written as soon as possible after an event has occurred, preferably within 24 hours (Refer to professional guidelines and 'Generic medical record-keeping standards prepared by Royal College of Physicians, see References). Such records should provide current information on the care and condition of the patient (if the date and time of the event differs from that of when the records are written up, this should be clearly noted under the signature, printed name and position/grade)
- Written clearly, legibly and in such a manner that cannot be erased. Erasers, liquid paper, or any other obliterating agents should never be used to cancel errors. A single line should be used to cross out and cancel mistakes or errors and this should be signed and dated by the person who has made the amendment (See References: 'How does the Data Protection Act apply to professional opinions?')

- Accurately dated, timed (24 hour clock) and signed along with the authors printed name and designation. These details should be entered beneath each record entry in the case-notes
- Written, wherever possible, with the involvement of the service user or carer and in terms that the service user or carer will be able to understand
- Bound and stored so that loss of documents is minimised
- The client will be identifiable on each sheet of paper within the notes using prepared labels, or with the minimum of patient's full name, patient ID No. (e.g. H&CN No., Hospital Number), date of birth and their location in the hospital
- All hand-written entries will be in permanent ink
- Healthcare professionals name and designation should be printed and Bleep/Radiopager Number (as appropriate) will be noted against the signature at least once
- Any referrals to multidisciplinary team are documented
- Verbal consent should be recorded in clients' notes together with discussion and explanations given
- No inappropriate personal or offensive comments should be included

Relevant and useful

- Identifying problems that have arisen and the action taken to rectify them
- Providing evidence of the care planned, the decisions made, the care delivered and the information shared
- Providing evidence of action agreed with the patient (including consent to treatment and/or consent to share)

And include

- Medical observations, examinations, tests, diagnoses, prognoses, prescriptions, other treatments
- Relevant disclosures by the patient – pertinent to understanding cause or effecting cure/treatment
- Facts presented to the patient
- Correspondence from the patient or other parties

Patient records should not include

- Unnecessary abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements
- Personal opinions regarding the patient (restrict to professional judgements on clinical matters)
- The name(s) of third parties involved in a serious incident. The name should be included on a separate incident form for cross referencing
- Correspondence generated from legal papers and complaints

Use of Year Stickers on Health Care Records

All departments which use Health Care records should ensure that they hold sufficient stocks of year stickers and apply these on an annual basis to patient records as follows:

- Each patient being seen in a calendar year i.e. between 1st January and 31st December should have a year sticker for that year applied to the edge of the case-note folder. This sticker should be applied only once to each volume and each consecutive year that the patient is seen a New Year sticker for that year should be applied to the case-note folder and all corresponding volumes for that patient.

The purpose of the year stickers is to ensure that it is easy to identify if a patient was seen in a particular year or not. This system also enables fast effective weeding of case-notes each year when it is necessary to weed the records stores for old case-notes for archiving or destruction.

2.7.3 Continuity of recording in Health Records where services are devolved or patients are transferred.

Where services are devolved to a Trust, the original Trust needs to remain accountable for the service it provided, and may need to be capable of resuming treatment again in the future. The Trust taking over the service needs to be able to provide continuity of care and to account both to patients and possibly to the transferring Trust for the services it is providing. Therefore, both Trusts need to keep records of the service they provide and any relevant information about transfers of responsibility between them.

CREST Guidelines must be followed in relation to the transfer of patient records (see References).

Both Trusts should then apply their own retention and disposal arrangements to the records they hold. As far as the transferring Trust is concerned, the patient episode ends at the point of transfer.

If the service provided is a small part of an ongoing care process then a transfer of care/discharge summary should be sent back to the original Trust at the end of the care spell. If both Trusts are involved in providing ongoing but different services, which have relevance to each other, they should devise appropriate approaches to more regular communication.

Section 3 – Storage of Records

3.0 Storing Paper Records

3.0.1 Current records

When a record is in constant or regular use, or is likely to be needed quickly, it makes sense to keep it within the area responsible for the related work. Storage equipment for current records will usually be adjacent to users i.e. their desk drawers or nearby cabinets, to enable information to be appropriately filed so that it can be retrieved when it is next required. Records must always be kept securely and when a room containing records is left unattended, it should be locked. A sensible balance should be achieved between the needs for security and accessibility.

There is a wide range of suitable office filing equipment available. The following factors should be taken into account:

- Compliance with Health & Safety regulations (must be the top priority)
- Security (especially for confidential material)/the user's needs
- Type(s) or records to be stored, their size and quantities
- Usage and frequency of retrievals
- Suitability, space efficiency and price

3.0.2 Records Stored in the Patient's Home

In some circumstances records may be stored at the patient's home e.g. maternity notes and Community Trust Homecare records. Confidentiality of the record stored in the client's home is the responsibility of the client and they should be informed of their responsibility. Records should be returned to the Trust, when they are no longer required in the Service User's Home.

3.0.3 Closed/Archived records

As the need for quick access to particular records reduces, it may be more efficient to move the less frequently used material out of the work area and into archive storage.

When transferred into an archive, semi-current paper records should be stored on shelves in a way that facilitates retrieval. The records need not be boxed, although boxing may be required where, for example, there are risks from damage by excessive light or by flooding. Records should be stored off the floor, and away from dampness and dust.

The width of aisles and general layout of storage areas must conform to fire, health and safety, and similar regulations.

Large documents, such as maps, should be housed in special storage equipment to ensure that they are not damaged and are readily accessible.

3.1 Storing Non-paper Records

Microfilm and fiche have been used for many years and courts will accept them as evidence in most cases. (Ref BSI BIP 008 Code of Practice on Legal Admissibility and Evidential Weight of Information Stored Electronically). Microfilming is a relatively cost-efficient way to capture and store images of otherwise bulky or deteriorating archival material:

Photograph and film collections assembled by medical and other staff through their work, should be regarded as Public Records and subject to these guidelines. Note that the provisions of the Data Protection Act 1998 on registration of records and restriction of disclosure, relate to photographs of identifiable individuals as well as to other personal records.

The Trust is currently piloting the use of electronic scanning of records and other types of documents within the organisation. Whilst there is obviously a large outlay of financial resources to undertake such a large project there are significant benefits to be gained for the organisation. Some of these benefits are;

- Less storage space is required
- Documents are instantly available to more than one individual at any one time
- There are no associated transport costs to make the document available at various locations
- There is a lesser risk of damage to the documents by way of fire, flood or theft
- Production costs of new documents and pages to a record via a PC is minimal
- There is no risk of loss of a document through misfiling or removal of a document from a central file without the tracking system being updated

Section 4 – Records in Transit

4.0 Records in Transit

Accurate recording of all record movements is essential if information is to be located quickly and efficiently. One of the main reasons why records are misplaced is because record movements are not recorded.

If records are being delivered to another location they should be enclosed in envelopes and sealed for transfer. Any records that may be damaged in transit should be enclosed in suitable padding or containers.

For larger quantities, records should be boxed in suitable boxes or containers for their protection.

Each box or envelope should be addressed clearly and marked confidential with the senders name and address on the reverse.

There are various options if records are to be mailed, such as recorded delivery, registered mail etc. When considering options staff should consider the following:

- Will the records be protected from damage, unauthorised access or theft?
- Is the level of security offered appropriate to the degree of importance, sensitivity or confidentiality of the records?
- Does the mail provider offer 'track and trace' options and is a signature required on delivery?

The records must not be left unattended in transit at any time. When carried in a car they must be locked in the boot.

4.1 Handling and transporting records

- No one should eat, drink or smoke near the records.
- Clinical records being carried on site e.g. from archive to the department, should be enclosed in an envelope.
- Records should be handled carefully when being loaded, transported or unloaded.
- Records should never be thrown.
- Records should be packed carefully into vehicles to ensure that the movement of the vehicle will not damage them.
- Vehicles must be fully covered so that records are protected from exposure to weather, excessive light and other risks such as theft.
- No other materials that could cause risks to records (i.e. chemicals) should be transported with records.
- Records should not be left in unattended vehicles.
- Records of any type should NOT be left in vehicles overnight.

(Please refer to the Trust Policy for the Safeguarding, Movement & Transportation of Patient/Client/Staff/Trust Records, Files and Other Media between facilities and the Policy for the Transfer of Electronic Data).

4.2 Tracking / Tracing Records

Managers must ensure that effective systems are in place for tracking the location of files containing confidential information.

Section 5 – Retention of Records

5.0 Retention of Records

Records Closure

A file is closed when:

- Determined by the Trust PRONI approved Disposal Schedule
- Depth of paper reaches 2.5 cm (A continuation file should be opened if required and should be cross referenced)
- The subject matter is finished
- No new papers have been added to the file for two years

Action on Closure

- Complete a Yellow closure sheet (Appendix 5)
- The word 'CLOSED' should be marked/stamped on the outside of the file. If when a file is being closed, the subject to which it relates remains 'live' a continuation file should be opened
- Update records management system
- Consider review process – see review section

Other Practical Points

- Paper clips and pins should be removed from papers before filing, as these will damage the paper and when rusted can be a health hazard. Particular attention to this must be given to those records, which, according to the Disposal Schedule, are to be preserved permanently.
- Flags, either adhesive tabs or strips of paper attached to a page with cellotape, should be avoided – instead use card dividers.
- File covers should provide adequate protection for the papers and preferably have a flap which should be used to prevent papers becoming dog-eared. If they become tatty or torn, new covers should be prepared and the front of the older covers retained inside the new ones. Old covers form part of the original record.
- Files should not be filled too full – they should not be more than 2.5cm thick. Bulky files should be closed and a continuation file opened and cross-referenced with the old part.
- Files must not contain any loose papers.
- Do not use metal tags – instead use the readily available plastic-ended ones.
- Avoid the duplication of papers – only one copy of any piece of information should normally be filed on any one file.
- Papers to be filed should be punched 2.5 cm/one inch in and 2.5 cm/one inch down from the edge to minimize the danger of detachment.
- All papers received for filing should bear a file reference number.
- Papers should be filed in date order with the most recent papers on top. This is very important as the review and access dates are calculated from the date of the last paper on the file and, if the latest document is not on the top, it is likely that the wrong terminal date will be assumed.

- All papers should be filed on the right hand side of the file. Bulky or outsize items can be stored in a pocket or envelope inside the cover on the left hand side.

The length of the retention period depends on the type of record and its importance to the business of the organisation. The destruction of records is an irreversible act, whilst the cost of keeping them can be high and continuing.

The Trust 'Retention & Disposal Schedule' (Appendix 6) takes account of legal requirements and sets out the minimum retention periods for clinical and administrative (both paper and electronic) records.

Records categorised for permanent preservation will need to be initially placed in long term storage with a view to them then being moved to a suitable archive as agreed with Public Records Office, Northern Ireland (PRONI).

Section 6 – Review/Disposal of Records

6.0 Paper records

The Trust Disposal Schedule outlines retention periods and final potential action for all records.

Closed records not selected for destruction, permanent preservation or transfer to PRONI will be subject to a review process. Senior Management should ensure that procedures are in operation within the organisation to review files at the appropriate time.

6.1 Records Review

A Records Review group should be set up at local level and allocated the task of reviewing records.

Trust records are examined or reviewed in order to determine if they are worthy of destruction, retention and permanent preservation. This is because their full value cannot be determined at an earlier stage.

Each record needs to be assessed individually to

- Determine its value as a source of information about the Trust, its operations, relationships and environment
- Assess its importance as evidence of business activities and divisions and
- Establish whether there are any legal or regulatory retention requirements

Where there are records which have been omitted from the Disposal Schedule, consultation should be undertaken with the Records Manager for further clarification.

The procedure for disposal of confidential waste is as follows:

6.1.1 Non-sensitive files/records

I.e. non-confidential waste

Information in public domain:

- Dispose of waste in a black bag

Files/records not normally available to the public:

- Torn into small pieces and disposed in a white Hessian sack (Confidential Waste) for collection by the approved waste management company

6.1.2 Sensitive records

Restricted: Strip - shredded

- Bagged for collection by approved waste management company

Confidential: Cross-cut shredded

- Bagged for destruction by approved waste management company

Secret and Top Secret: Cross-cut shredded

- Bagged for destruction by approved waste management company

When records are destroyed by an external service provider, i.e. an approved waste management company, a Certificate of Destruction must be obtained from the company destroying the records and kept on file at the site of the collection.

The disposal of confidential waste is subject to change by the Environmental Manager. Please contact the Trust Environmental Manager for further guidance.

(A Regional Contract is in place in the Trust for the collection, shredding/destruction and safe disposal of confidential paper and optical/magnetic (audio tapes, CD's, video tapes, films etc) waste).

6.2 Electronic Records

An email message constitutes an official record when the document is made or received in connection with the transaction of Trust business. Email should be retained for the same period of time as the Trust would need to retain such a record if it were in paper format. Under the Freedom of Information Act 2000 certain emails and their content may be 'discoverable' and would therefore be liable to disclosure.

It is good practice to destroy all emails that do not need to be retained for specific business purposes.

Under the Freedom of information Act 2000 it is a criminal offence for any member of staff to deliberately and knowingly destroy information (including emails) under the control of the Trust, which is required for the purposes of disclosure pursuant to a pending application seeking such information. Destruction of such information under these terms may lead to criminal prosecution of the individual responsible for the destruction of the information.

(Please refer to the Trust ICT Security Policy, Internet Policy and Email Policy).

Section 7 – Access to Records

7.0 Access to Records

The improper disclosure of information may be in breach of the law, Trust guidelines/or policy such as on confidentiality and other professional guidelines and may result in legal action by others and/or disciplinary action by the Trust.

As a public body, the Trust's information is held on the basis of need and where information is not required for performing the business of the Trust it will be destroyed in line with retention and disposal schedules.

The Trust will publish or provide information to interested applicants under the Freedom of Information Act 2000, The Data Protection Act 2018 and the Environmental Information Regulations 1998 where the application is correctly presented, any prescribed fee has been paid and information requested is not subject to an exemption.

Both Trust staff and associated professionals are required to ensure they maintain the quality and consistency of records they create and follow the correct local procedures to allow both local and central access as appropriate.

Certain information held by the Trust is exempt from disclosure to the public. Examples of exemptions include information that relates to an individual and information provided in confidence.

Staff who have queries regarding requests for access to records/information should contact the Head of Information Governance in the first instance who will advise on the Trust' s process and where applicable, relevant exemptions.

Section 8 – Audit

8.0 Records Management is ongoing work that is the responsibility of all staff in the Trust and is a fundamental part of their normal duties. It is important to operate in an environment of effective records management which contributes to an improved quality in the services provided the organisation. The Trust will be expected to self-assess and report compliance annually, against the Records Management Controls Assurance Standard. The Trust will undertake regular audit of its records management systems which will include compliance with the Trust's Records Management Policy and this procedures document.

GLOSSARY OF RECORDS MANAGEMENT TERMS

Access. The availability of or permission to consult records.

Active Record. Those records which are retrieved and consulted frequently, or which contain information of immediate relevance to the current activities of the organisation.

Appraisal. The process of evaluating business activities to determine which records need to be captured and how long they need to be kept to meet business needs and the requirements of organisational accountability.

Business Activity. An umbrella term covering all the functions, activities and transactions of an organisation and its employees.

BCS. See Business classification scheme

Business classification scheme (BCS). A conceptual representation of the functions and activities performed by an organisation. The scheme is derived from the analysis of business activity. The BCS contains scope notes and 'terms' that represent and describe functions, activities, transactions or other elements and shows their relationships. The structure of the scheme is hierarchical, moving from the general to the specific. The business classification scheme is used to link records to their business context. This is a key requirement for making and capturing 'full and accurate' records.

Classification.

1. The systematic identification and arrangement of business activities and/or records into categories according to logically structured conventions, methods and procedural rules represented in a classification system.
2. Classification includes determining document or file naming conventions, user permissions and security restrictions on records.

Control. The physical and/or intellectual management established over records by documenting information about their physical and logical state, their content, their provenance, and their relationships with other records. The systems and processes associated with establishing control include registration, classification, indexing and tracking.

Create (a record). The act of making a record (evidence) of business transactions.

Controlled vocabulary. See Thesaurus

Disposal. The implementation of appraisal and review decisions. These comprise the destruction of records and transfer of selected records to the Public Record

Office. They may also include movement of records from one system to another (for example paper to electronic) or the transfer of custody of the records.

Disposal Schedule. A list of the record series of an organisation with directions for how the records are to be disposed of (see Disposal) after their creation and initial use. The schedule is a written statement of how long each series (or group of series) is to be retained (e.g. a period of years or indefinitely), and may also include instructions on when records are to be transferred to secondary storage of archives, or destroyed.

Documents. These are recorded communication with recognisable structure regardless of medium. Not all documents are records in the archival or legal sense.

Documentation. Written facts about a recordkeeping system including its component parts and a manual of instruction detailing rules for use and maintenance of the system.

Electronic Document Management (EDM) helps organisations to exploit their information more effectively by providing better access to stored information. EDM supports the immediate operational requirement for business information.

Electronic Document and Records Management System (EDRMS) ensures that all records are retained and managed within the context in which they were originally created i.e. electronically.

Electronic Records. These are records where the information is recorded in a form that is suitable for retrieval, processing and communication by a digital computer.

File In records management sense, a file (or folder) groups associated records in a logical structure that shows the position of one record in relation to others. By means of a file/folder, a whole group of records can be managed together. Also refers to a set of data held on computer.

Fileplan. A category of electronic records grouped together in a file within a classification scheme.

‘The full set of classes and the folders, which re allocated to them, together make up a fileplan. The fileplan is a full representation of the business of the organisation within a structure, which is best suited to support the conduct of that business and meet records management needs’. (PRO 2002)

Folder. A container for records. Folders are located in the fileplan by being allocated to a category.

Inactive Records. Those records which are seldom accessed, but must be retained for occasional reference, or for legal or archival reasons. See also Active and Semi-active records.

Lifecycle. The life of a record is viewed as consisting of five phases: creation, distribution, use, maintenance and disposal.

Notation. A numbering or coding system.

Precedent Case. The first time a procedure or a certain product or piece of equipment was used on certain groups of patients or individuals in Northern Ireland regardless of the professional who carried it out. 'Precedent case' implies a unique situation, and one which is innovative in nature. (Craigavon & Banbridge Community HSS Trust with approval of PRONI, 2006).

Record. Information created, received & maintained as evidence and information by an organisation or person, in pursuance of legal obligations or in the transaction of business.

Records retention and disposal schedule. See Disposal Schedule.

Records Series. A collection of records having a common subject or theme usually identified by a specific lettercode or number.

Record Audit. Complete and accurate listing of records resulting from a survey Register. A list of records, usually in simple sequence such as date and reference number, serving as a finding aid to the records.

Retention. The continued storage and maintenance of records for as long as they are required by the creating or holding organisation until their disposal, according to their administrative, legal, financial and historical evaluation.

Review. The examination of records to determine whether they should be destroyed, retained for a further period or transferred to the Public Record Office.

Scheduling. The production of a schedule or list of public records for which pre determined periods of retention have been agreed between the Departmental Record Officer of the Organisation concerned, and the Public Record Office.

Scope note. Defines the meaning of a term or combination of terms in a business classification tool and guides user on how such terms should be applied. It facilitates

consistency in usage by discouraging personal interpretations by different people across the organisation.

Semi-active records. A category of records in between active and inactive records. Previous year records which are needed for reference when the current year's work is being done, are an example of semi-active records.

Series. See Record Series.

Thesaurus

An alphabetical presentation of a controlled list of terms, linked together by semantic, hierarchical, associative or equivalence relationships. Such a tool acts as a guide to allocating classification terms to individual records (AS/ISO 15489, Part2, Clause 4.2.3.2.) Source - National Archives of Australia; Overview of Classification Tools – July 2003

Thesaurus
1. In a thesaurus, the meaning of the term is specified and relationships to other terms are shown. A thesaurus should provide sufficient entry points to allow users to navigate from non-preferred terms to preferred terms adopted by the organisation.
2. Classification tool comprising an alphabetical presentation of a controlled list of terms linked together by semantic, hierarchical, associative or equivalence relationships.

Tracking. Capturing and maintaining information about the movement, use and transaction of records.

Transaction.

1. The smallest unit of business activity. Uses of records are themselves transactions
2. The third level in a business classification scheme

("Records Management: Standards for the management of Government Records; Information Surveys, 1999, Public Record Office")

(Kennedy, J. & Schauder, C. Records Management, a guide to corporate recordkeeping. Longman, 1998.)

Glossary of Recordkeeping Terminology. National Archives of Australia. 2004. ISBN1920807268
www.naa.gov.au/recordkeeping/rkpubs/recordkeepingglossary.html

PRO/The National Archives Requirements for Electronic Records Management Systems 3: Reference Document 2002)

References

Generic medical record-keeping standards. Prepared by the Health Informatics Unit of the Royal College of Physicians, 2007 (includes 12 generic record keeping standards which are applicable to any patient's medical record).
http://hiu.rcplondon.ac.uk/clinicalstandards/GenericRecordKeepingStandards.pdf

Policy on the Transfer of patients/clients and their records to another hospital or in-patient facility
http://intranet/HTML/PandP/documents/PolicyonTransferofPatientsclientsandtheirrecordstoanotherhospitalorinpatientfacility.pdf

How does the Data Protection Act apply to professional opinions?
Data Protection Good Practice Note, 2006. Information Commissioner's Office - www.ico.gov.uk

Southern Health and Social Care Trust Policy for the Safeguarding, Movement & Transportation of Records and Files Link

Records Management Strategy 2019, Southern Health & Social Care Trust
Records Managemetn Strategy

Records Retention and Disposal Schedule, Southern Health & Social Care Trust (January 2011) http://sharepoint/pr/ig/RM/good-mamagement-good-records_2011.pdf

APPENDIX 1 – Version Control Certificate

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Version: Reference number/document name:
Supersedes	Supersedes:
Originator	Name of Author: Title:
Scrutiny Committee & SMT approval	Referred for approval by: Date of Referral: Scrutiny Policy Committee Approval (Date): SMT approval (Date):
Circulation	Issue Date: Circulated By: Issued To:
Review	Review Date: Responsibility of (Name): Title:

APPENDIX 2 – Guidance on Version Control of Documents

1.0 Introduction

Using Version Control helps to identify where changes have been made to a document and to ensure that everyone is using the most recent version of a document. This is particularly useful when a document is being produced or reviewed collaboratively, for example, by a project team, committee, etc.

The content of a document under Version Control is never overwritten. However, each time modifications are made to a document a new version is created which then becomes the current version. Every version number for a given document shall be unique.

The guidance outlined in Section 2.0 of this section will assist in the application of Version Control of all Trust documents, for example policies, procedures etc. To assist in the application of Version Control, a flow diagram has been developed (See Appendix 2a).

1.0 Applying Version Control to Documents

Each version of a document shall be given an issue number, in the format of 'Version X_Y', where 'X' and 'Y' are numbers.

2.1 Initial Draft of a Document

When a document is initially produced, prior to formal organisation approval, it shall be versioned as 'Version 0_1 Draft'. Subsequent versions of the initial document shall be described as 'Version 0_2 Draft', 'Version 0_3 Draft' etc.

Where documents are in draft, a 'DRAFT' watermark should be incorporated into the document.

1.2 First Approval of a Document

When a document is formally approved for the first time by the Trust, it shall be issued as 'Version 1_0'.

2.3 Initial Review of an Approved Document

Good practice suggests that documents should be reviewed regularly to ensure that they are up-to-date, relevant and not obsolete.

During the review of the formally approved document 'Version 1_0', if an amendment is required a new version of the document should be created incorporating the amendment. This will be versioned as 'Version 1_0 Draft1'.

Subsequent changes during the review of document 'Version 1_0', will be versioned as 'Version 1_0 Draft2', 'Version 1_0 Draft3' etc.

How a document will be versioned following formal approval for the second time will depend upon the significance of the changes since the issue of 'Version 1_0':

- If the changes are considered to be **minor** e.g. spelling, grammar, 1 line change, then the document will be issued as 'Version 1_1'; or
- If the changes are considered to be major e.g. Addition/Removal of a section, legislative changes, change in processes, then the document will be issued as 'Version 2_0'.

2.4 Subsequent Reviews of a Document

If further changes are to be made to document 'Version 1_1', the draft version will be described as 'Version 1_1 Draft1', 'Version 1_1 Draft2', 'Version 1_1 Draft3' etc.

If further changes are to be made to document 'Version 2_0', the draft version will be described as 'Version 2_0 Draft1', 'Version 2_0 Draft2', 'Version 2_0 Draft3' etc.

3.0 The Change Log

A Change Log should be created which will detail the changes made during the lifecycle of a document and allow a reader to identify where modifications have been made within each version of a document. Therefore, the Change Log should contain an entry for every version of a document.

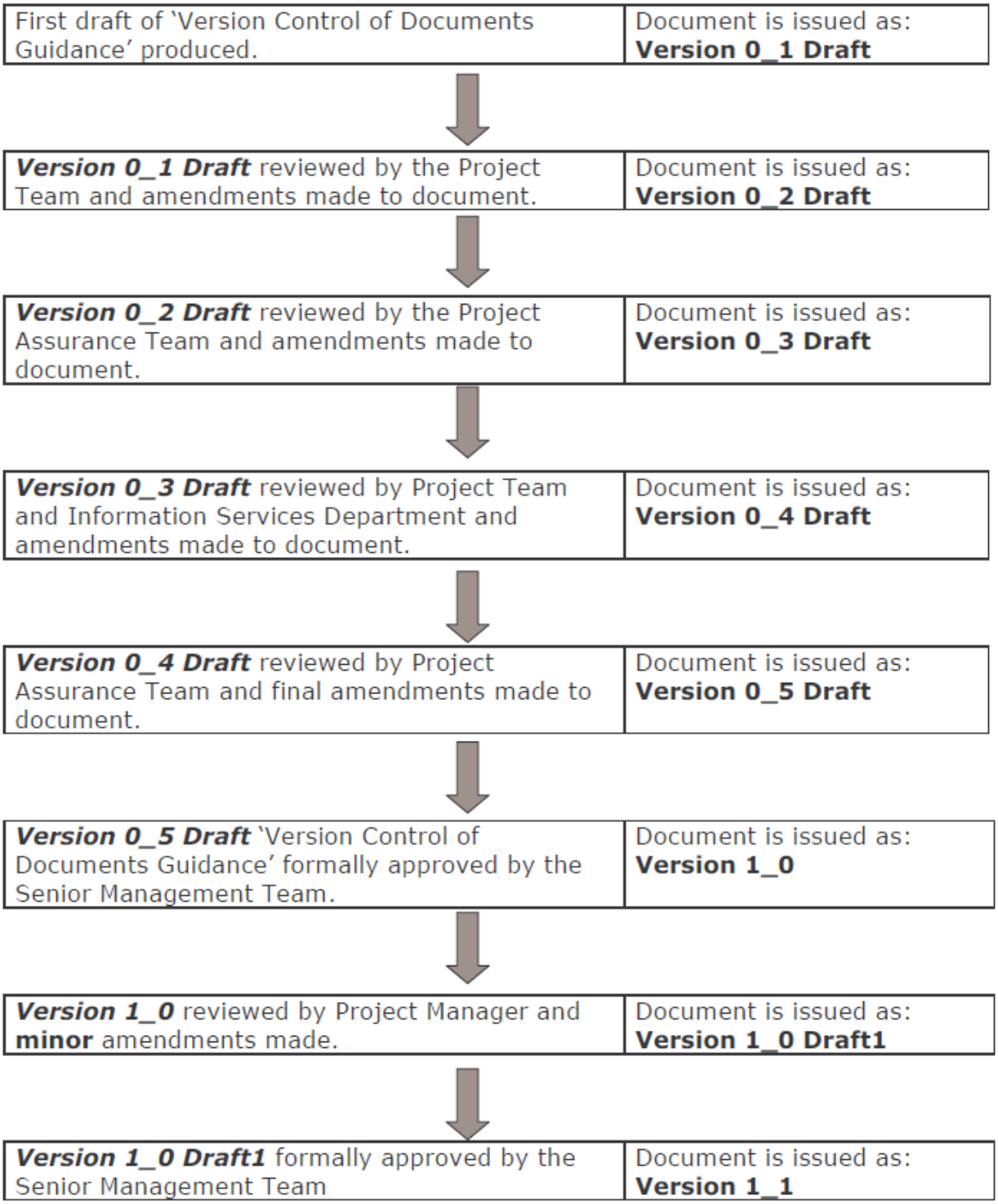
Each entry should include details of the following:
- The version number;
- The date the version number was assigned;
- The author of the changes; and
- A brief description of the modifications associated with the version. This should be no more than a few concise phrases but sufficient enough to outline the changes.

The Change Log should appear at the beginning of a formally approved document and should describe the changes between the first formally approved version and subsequent approved versions.

The author should retain the more detailed Change Log of a document between draft versions. An example of a Change Log for a document is contained in Appendix 2b.

APPENDIX 2a

Example Flow Diagram on the application of Version Control



APPENDIX 2b

The Change Log

Version	Date	Author(s)	Notes on Revisions/Modifications
Version 1_0	10 February 2005	Information Services	
Version 1_1	30 September 2005	Information Services	Updated Contact Details
Version 2_0	31 March 2006	Information Services	New section added on Communication Channels

APPENDIX 3 - Guidance on Naming Convention

Yearmonthdate_title_documenttype_version_originator

Example: **20180104_InformationGovernanceQuarterly_Report_V1_PMcManus**

8.0 Guidance: Best Practice

Year: Use 4 digits for the year and two for the month and date for example yyyymmdd_

Title: Include enough keywords to identify the document. Up to four may be used. Do not Include 'and', it', etc. Do not use abbreviations.

Capitals: Use a capital letter at the start of each word. Do not place a space in between words.

Underscore: The purpose of the underscore is to break up each part of naming convention and to assist the search facility.

Full stops and dashes: Should not be used.

Document type: Refers to a report, minutes, agenda, circular, email, letter (letterin; emailin for a letter or email message which has been received/scanned).

Addressee Name: It is best practice if the name of addressee makes up part of a title.
Example: 20180515_ComplaintResponseBloggsJ_letter_V1_IG

Version: Use
V0_1 for a document which you are working on
V0_2 for a document you are working on (second draft prior to approval)
V0_3 for a document you are working on (third draft prior to approval)
V1_0 for a document which has been approved
V1_1 for a document which has undergone minor amendments
V2_0 for a document which has undergone major amendments

Draft: Only include if a document is a draft, otherwise leave out.

Originator/Author: Use either of the following;

1. surname in full and initial. Example GrahamC; or;
2. abbreviations denoting Department or Team as know in the corporate environment. Example CA (Corporate Affairs); RM (Records Management); HR (Human Resources)

APPENDIX 4 – Fileplan by The Regional Records Management Working Group

FILEPLAN – LEVELS ONE & TWO

Level One

CORPORATE MANAGEMENT
ESTATE SERVICES
FINANCIAL MANAGEMENT
HUMAN RESOURCE MANAGEMENT
INFORMATION & COMMUNICATION
INFORMATION MANAGEMENT & TECHNOLOGY
SERVICE DELIVERY
SUPPORT SERVICES

Levels One & Two

CORPORATE MANAGEMENT
- AUDIT
- BUSINESS CONTINUITY PLANNING
- BUSINESS PERFORMANCE
- BUSINESS PLANNING
- EQUALITY PLANNING & MONITORING
- GOVERNANCE
- LEGAL SUPPORT
- MEETINGS
- OFFICIAL FUNCTIONS & VISITS
- ORGANISATIONAL DEVELOPMENT
- STATUTORY RESPONSIBILITIES
- STRATEGY

ESTATE SERVICES
- PREMISES
- PROGRAMMES & PROJECTS
- STATUTORY RESPONSIBILITIES
- SUPPLIES & EQUIPMENT
- TELEPHONE SYSTEMS
- VEHICLES

FINANCIAL MANAGEMENT
- ACCOUNTING FOR INCOME & EXPENDITURE
- ASSET MANAGEMENT
- FINANCIAL GOVERNANCE
- FINANCIAL PLANNING & CONTROL
- PAYROLL
- STATUTORY RESPONSIBILITIES

HUMAN RESOURCE MANAGEMENT

- ATTENDANCE MANAGEMENT
- GRIEVANCE & DISCIPLINE
- INDUSTRIAL RELATIONS
- PERSONNEL FILES
- SECURITY MANAGEMENT
- STAFF PERFORMANCE MANAGEMENT
- STAFFING
- STATUTORY RESPONSIBILITIES
- TRAINING & DEVELOPMENT
- WORKFORCE PLANNING

INFORMATION & COMMUNICATION

- BRIEFINGS
- CONTACTS
- GOVERNMENT ENQUIRIES
- INFORMATION ACCESS REQUESTS
- MARKETING
- MEDIA RELATIONS
- PUBLICATIONS & REFERENCE MATERIAL
- RECORDS MANAGEMENT
- STATUTORY RESPONSIBILITIES
- WEBSITE CONTENT MANAGEMENT

INFORMATION MANAGEMENT & TECHNOLOGY

- ASSETS & SERVICES
- PROGRAMMES & PROJECTS
- SECURITY MANAGEMENT
- STATUTORY RESPONSIBILITIES
- SYSTEMS MANAGEMENT
- USER SUPPORT

SERVICE DELIVERY

- COMMISSIONING
- CONSULTATION
- MONITORING
- NEEDS ASSESSMENT
- PLANNING
- STATUTORY RESPONSIBILITIES

SUPPORT SERVICES

- COMMISSIONING
- MONITORING
- STATUTORY RESPONSIBILITIES

APPENDIX 5 (Print on a yellow sheet of paper)

Southern Health and Social Care Trust

CLOSED RECORDS FORM

PLEASE ENSURE THAT YOU READ THE CLOSED RECORD PROCEDURE BEFORE COMPLETING THIS FORM

COMPLETE ALL SECTIONS IN BLOCK CAPITALS

Record/Client Name: _____

Record/Client Unit Number (if applicable):_____

Address of Patient (if applicable): _____

Record Type: _____

Date of Birth (if applicable): _____

Date Record Created (if applicable)_____

Date Record Closed:_____

Team Name: _____

Team Address:_____

Retain to: _____

Final Outcome (as per GMGR):_____

APPENDIX 6 – Retention & Disposal Schedule

The Retention & Disposal Schedule is on the Department of Health's website at https://www.health-ni.gov.uk/topics/good-management-good-records/disposal-schedule-work-areas