Birmingham and Solihull Mental Health NHS Foundation Trust

CARE RECORDS MANAGEMENT AND PROCEDURES (Electronic and Manual)

To be read in conjunction with Care Records Management Policy - C12 Version 7_0		**Clinical**
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THESE PROCEDURES MUST BE READ IN CONJUNCTION WITH THE CARE RECORDS MANAGEMENT POLICY C12 & OTHER ASSOCIATED DOCUMENTS

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1. Introduction

This document outlines the procedures and protocols, which guides staff members in conducting care records[1] activities which will be personal data. This includes the full life cycle of care records operation and management.

For a broader coverage of care records management, refer to the *Care Records Management Policy* document. Staff should ensure that they follow the procedures laid out in this document and only divert from them following instruction from Trust management. It is important to note that Care Records can be considered under Article 15 of the General Data Protection Regulations (GDPR). and Access to Health Records Act 1990 for disclosure should a valid request be received. Please see Access to Information Policy

2. Electronic Patient Record

2.1 Recording in Rio

2.1.1 Rio is the primary Care Record, with accurate and up to date clinical information being recorded in this system and not in the paper Supplementary Health Record (SHR).

2.1.2 The SHR will only contain information that cannot be currently recorded directly into Rio. For example incoming correspondence and Sleep Charts

2.1.3 All information that can be recorded directly into Rio must always be done so and must not be recorded and stored outside of Rio.

2.1.4 All entries by Students or trainees must be checked and validated by a professionally registered member of staff.

2.1.5 Errors made in the Electronic Patient Record (EPR) including wrong patient should **not be deleted** from the record as this may have been relied upon for decision making.

For errors in Rio:

- Errors made in progress notes in Rio can be clearly marked as an error by using the 'mark as error' function and no further action is required.
- Where errors are made in assessment forms in Rio, another assessment form should be added which states in it that an error was made in the form dated xx/xx/xx and the correct information is in this one.
- Any other errors outside of progress notes or assessment forms will need careful consideration from (Chief Clinical Information Officer (CCIO)) after being raised as a call with ICT service desk. Information will only be removed or amended in exceptional circumstances, as there is no audit log or record of the initial error.

[1] See definition in Care Records Policy

For errors in Illy:

- Alert ICT department, who will raise with the manager of the department to confirm
- ICT will remove from Illy if considered a genuine error
- This is fully audited and trackable on Illy

For errors in IAPTus:

- Amendments to clinical contacts can be made by the BHM practitioner who offered the appointment and by admin staff on that practitioner's behalf. Please note that a record of when a clinical contact is accessed and edited is logged on iaptus and can be viewed for audit purposes.
- Updates/amendments can be made within the assessment tab. A copy of the previous version is automatically saved.
- If an error cannot be rectified by the practitioner who added the note, advise an iaptus super user (this includes admin) of the error, along with justification for it to be removed.
- If the error concerns clinical information, advice must be sort from the Team Manager (who may escalate this request to the BHM Clinical Lead/IAO for iaptus) before removal, for a clinical perspective/decision.
- Any deletion should be reported in the non-clinical notes along with the justification for the deletion.
- There is a full audit trail of deleted documents, clinical contacts, measures, etc., on iaptus and these can be reinstated and viewed as necessary (for audit purposes, or complaint/incident investigation).

- Mayden (iaptus developers) can also reinstate information, at the request of the IAO, that is not available to super users, providing this information was saved to iaptus at some point.

- Please refer to the BHM Hitchhiker's guide for further information.

2.1.6 With regard to the standards around timeliness for entering data into the electronic patient recording system please refer to the *Data Quality Policy* for further details.

2.1.7 Demographic information should be checked upon all inpatient admissions at the earliest opportunity and at regular intervals with outpatients.

2.1.8 A physical description of the patient should be entered on the front page of the Rio record for the patient ensuring appropriate factual language is used

2.1.9 Wherever possible a photograph of the patient should also be uploaded, please refer to the *Section 17 Policy* and *Missing Patient Policy*

2.2 Patient details checking form

2.2.1 The Patients Checking Form can be found in Editable Letters on Rio, the electronic patient record system.

2.2.2 The Patient Checking Form should be issued to service users at 6 monthly intervals as a minimum.

2.2.3 Any updates received need to be amended on Rio within 24 hours of receipt of the form and the original form filed in the SHR as this is deemed a legal document – **Not To Be Destroyed**.

2.3 Records for Gender Reassignment Patients

2.3.1 The Gender Reassignment Act 2004 allows those that gain a Gender Recognition Certificate the right to be considered as their acquired gender in the eyes of the law.

2.3.2 Where a patient has applied to have their records changed to the Personal Demographic Service (PDS) to reflect their preferred gender the PDS will create a new NHS number

2.3.3 The Trust is required to create a new record for this person making no reference to their previous NHS number or gender once notified, if they are know to the Trust and the record is active, if the record is not active thenit remains unchanged and should the patient come back into services a new record created using their new NHS number and name

2.3.4 The old record should not be deleted, or changed, however the patient may request to have any factual errors corrected and notes added to reflect their views

2.3.5 It is expected that some but not all of the information from the old record be transferred to the new record for risk and treatment purposes, however this must be in conjunction with both the clinical team and the patient.

2.3.6 Note a patient can request to have their records changed to reflect their preferred gender without making an application to the PDS. In such cases the record should be updated with their preferred name and gender, but a new record should not be created in these instances.

Please contact the Records Department for further information

2.4 Service Users with Unknown Name

2.4.1 Services that provide care to patients where it is difficult to identify the service users name (ie Homeless Team, Rough sleepers Outreach Team, psychiatric liaison and also the place of safety) should contact Records department to obtain a pseudonym from the Unknown Name Register Recording process

2.4.2 Contact the Records department (Head of Records, Deputy Head of Records) to obtain an allocated name and DOB from the register

2.4.3 Records team to allocate using next sequential nato phonetic alphabet for the last name, recording the Rio number once the team have registered against the correct allocated name and DOB

2.4.4 Once the team have registered the individual on the Trust system Rio/Illy/Iaptus, advise Records department of the Trusts identifiable number i.e., Rio. This will ensure correct reporting for the individual going forward and distinction between other Unknown named service users

2.4.5 Records department to update Service Users with Unknown Name Register with the Trusts identifiable number against the allocated name and DOB previously allocated to the team.

2.4.6 Records department to edit the Service Users with Unknown Name Register with the next sequential name and DOB in preparation for future requests for unknown names of service users.

2.4.7 Records department to keep a record of requests and allocations, also checking to ensure the Electronic Patient Record (EPR) matches the Service Users with Unknown Name Register

2.5 Transcribing Text Messaging/Emailing

2.5.1 There is an approved process in the Trust which permits text messaging/emailing to clients where appropriate consent has been sought. This may only be undertaken with the explicit consent of the client which must be recorded and checked at regular intervals. Further information can be found here: *Emailing Service Users Process*

2.5.2 Once message(s) have been retrieved/sent and actioned, they need to be removed from the messaging system.

2.5.3 The message should be transcribed into service user files. Ensure content of all entries are constructed in an appropriate manner in line with Trust values.

2.5.4 This should also be recorded as a contact on Rio with the exception of appointment reminders.

2.5.5 Further information on this process can be found at *Emailing Service Users Process*

2.6 Enterprise Document and Records Management System (EDRMS) referred to as OnBase

2.6.1 Areas where EDRMS has been implemented will follow revised procedures**.**

2.6.2 Staff and sites involved with scanning in OnBase should follow local processes as advised by the Head of Care Records.

2.7 Patient Deaths

2.7.1 In the event of a patient death staff must complete an eclipse form highlighting the event. See eclipse incident reporting procedure and *The Reporting, Management & Learning from Incidents Policy.*

2.7.2 Systems, including Illy will be updated regularly by the Records Department. IAPTus will be updated by the Birmingham Healthy Minds team, in a timely manner.

2.7.3 On receipt of a daily updated Eclipse reports Records staff will amend the electronic record on Rio and Illy to deceased.

2.8 Progress Notes and Third Party Information

2.8.1 There are times when third party information needs to be recorded in the progress notes. This can take the form of other Service Users names, staff details or third party organisations.

2.8.2 There will be situations where it is clinically appropriate to refer to other Service Users in an others Service Users record. On these occasions the third party Service User should be referred to by their unique system ID i.e. Rio or NHS number and initials; full names must not be used to retain confidentiality.

2.8.3 When staff members names need to be documented within the clinical notes this should be stated in full together with their designation, for example, John Smith, Deputy Ward Manager

2.8.4 When information of family or friends of Service Users needs to be recorded in the notes full name and relationship need to be documented.

2.9 Handwritten Notes

2.9.1 There are times where a clinician will need to complete handwritten notes maybe if they do not have access to the EPR at that point in time, perhaps during a visit.

2.9.2 These can be classified as an 'aide-memoire'/ 'jottings', in that these handwritten notes are used to help the clinical member of staff to write into the electronic record at the earliest point possible.

2.9.3 This type of record should not be retained and should be confidentially destroyed after being transcribed into the EPA (Rio) as soon as possible

2.9.4 All clinical notes should be recorded into the electronic patient record and not in the paper Care Record. Failure to do this could result in undue Clinical Risk and may lead to disciplinary action.

2.9.5 Details of specific requirements are included in the Trust *Data Quality Policy* and associated standards and procedure documents.

2.10 Challenge Screens on Rio

2.10.1 Staff are only permitted to access records where a legitimate reason exists, which for the majority of the Trust is for the provision of direct client care.

2.10.2 It is not appropriate for staff to access their own records, records relating to family members, friends or colleagues. To do so is a breach of confidentiality and is both a disciplinary matter and reportable to the *ICO (Information Commissioners Office)* who can bring a private prosecution against the individual if they feel the incident meets their criteria under Section 170 of the Data Protection Act 2018.

2.10.3 Should staff need access any service user who is not part of their current caseload or team they will be challenged for a valid reason.

2.10.4 A list of reasons is available on the challenge screen and one must be selected before staff can progress further.

2.10.5 The challenge screen will be audited on a regular basis.

2.11 Saving/Uploading Documents into Rio

2.11.1 All electronic documents that are generated by the Trust must be saved into Rio within 48 hours of receipt or 2 working days

2.11.2 These documents will include, but not be limited to, all correspondence, reports and assessments.

2.11.3 All the documents that are saved into Rio will follow defined 'Document Types' and 'Naming Conventions' as detailed in the *Saving Documents in RiO*

2.11.4 For documents where a Rio template is available this must always be used and the document 'sent back' to Rio for saving.

2.11.5 For documents created outside of Rio these must be stored in a designated secure shared network folder. Once the document has been uploaded into Rio the document must be deleted from the network folder.

2.11.6 It is a requirement of the Mental Health Act Code of Practice that a photograph of the patient must be included in their notes when on section 17 leave; please refer to *Section 17 Leave of Absence* policy for further details. Photographs can be uploaded into Rio following the *Saving Documents in RiO*

2.11.7 Video, audio and e-mail records should also be uploaded following the *Saving Documents in RiO*

2.12 Scanning into Rio

2.12.1 The Trust does not allow for information to be scanned and destroyed.

2.12.2 Should a Team have dispensation to scan then *Saving Documents in RiO* must be followed.

2.12.3 If a service believes that there is strong clinical risk associated with not scanning a certain document into Rio, then this must be put forward as part of a business case for submission to the Information Governance Steering Group (IGSG), via the Head of Information Governance, for approval by the appropriate members of the Executive Team.

2.13 Printing and Rio

2.13.1 Rio is a paper-lite system which results in minimal information being filed within the SHR.

2.13.2 Rio provides all its users with accurate up to date clinical information as it is the primary Care Record.

2.13.3 All other documents should remain in Rio and not be printed out and filed into the SHR.

2.13.4 Duplicates of documents should not be retained and should be confidentially destroyed.

3. Document(s)/ Form(s) Transferred from the Old to New Care Record Folder

3.1 When the current SHR folder becomes to full a new folder will need to be created.

3.2 Ensure that the front of the folder is completed as per the procedures detailed in the *Procedure for Creating and Filing within the Supplementary Health Record (SHR)*' and is tracked as per the '*Procedure for Tracking of Care Records*'.

3.3 As a guideline the following forms and documents must be considered to be transferred from old to new Care Record folder:

- External Correspondence and Referrals dated within the last 8 weeks
- Most recent Specialist Assessments and Forms that are not held in Rio
- Investigation results dated within the last 8 weeks

4. Procedures for Merging Paper Care Records Incorporating Duplicate Records and the NHS number

4.1 When identifying that a service user holds two different electronic identifiers within one system, for example two Rio numbers or two IAPTus numbers or two LINKS CarePath (Illy) numbers, you must first ensure that the demographic details match, i.e. name, date of birth, address, GP and the NHS number.

4.2 After checking both of the electronic identifiers of the same service user, you must identify the amount of data recorded against each number; the number holding the most data recorded is the one that will be used.

4.3 Locate and collect all sets of case notes pertaining to both electronic identifiers.

4.4 Please note that the correct NHS number must be recorded for each active service user and must be shown on all clinical communications.

4.5 If the NHS number is not shown you can obtain this via the NHS Spine. In order to obtain the service users NHS number, you will require the minimum of name, date of birth, gender, and postcode. If all the details match you must then enter the NHS number onto Rio.

4.6 Merge all set of records correctly, accurately and in date order ensuring the correct number is on the front of each care record.

4.7 Contact the Information Services department requesting them to amalgamate the electronic identifiers informing them of which number is being retained.

4.8 Where you identify that more than one set of records has the same volume recorded on it you must ensure that all sets are re-numbered accordingly.

4.9 Request the additional sets from the location stated on Care Records Tracking (CRT).

4.10 Once all sets have arrived ensure that the date opened is recorded on the front cover and date closed where applicable.

4.11 Re-number the volumes based on when each file was opened.

4.12 If you have more than one file in current operation, then these files will need to be integrated as a whole, which means that the contents will have to be re-filed in the appropriate section in date order with the most recent on top.

4.13 Once all files have been re-numbered and re-filed as appropriate CRT must be updated to reflect both the true amount of volumes in operation and their current location. Please refer to the *Procedure for Tracking Care Records* for further details.

4.14 Where it is identified that there are two electronic records for the same service user an ICT Help Desk call must be raised so that the records can be merged.

5. Procedure for Creating and Filing within the Supplementary Health Record (SHR)

5.1 Front Cover

5.1.1 The front cover of the Supplementary Health Record (SHR) should be completed in full.

5.1.2 Complete information in the space provided, as follows:

5.1.3 BOX 1

- The ***Surname Name*** must be written in *UPPER CASE*, e.g. **BLOGGS**.
- The ***Forenames*** must be written in *UPPER CASE* e.g. **FRED ALBERT.**
- All service users are given a ***NHS number,*** i.e. written **123 456 7890** and this must be entered in this format.
- Registration on the patient electronic recording system will generate a ***Trust Reference number,*** and this must be entered.

5.1.4 BOX 2

- When an SHR folder becomes too large to be used, practically, a new folder must be opened. The following information must be entered, in the space provided:
- The volume of the folder must be entered on the new folder, e.g. Volume 1, for new folder.
- The date the folder was closed must be entered on the old folder.
- The date the folder was opened must be entered on the new folder.
- The disposal date is for Care Records Home Base staff use only.

5.2 Filing into the Supplementary Health Record (SHR)

5.2.1 The SHR will still be required to store documentation that cannot be currently captured directly into Rio for example charts and any documents received externally to the Trust.

5.2.2 Documents and information that is stored into Rio is not to be printed out and filed within the SHR as Rio is a paper-lite system, except for circumstances where a service user's signature is required.

5.2.3 Rio does not replace the need to file documentation that cannot be captured in Rio and as such there should be no outstanding filing older than 10 working days. Failure to file in a timely manner could result in undue Clinical Risk and may lead to disciplinary action.

5.2.4 Ensure clear, accurate, relevant and legible entries are recorded according to the record keeping standards and guidelines of both the NMC, *NMC Record Keeping Standard* and GMC, *GMC Ethical Guidance*

5.2.5 Please refer to how to *Creating and Filing within the Supplementary Health Record (SHR)*

5.2.6 Mental Health Act (MHA) files created and archived upon discharge should be recalled and placed back in circulation should the client return to services within a year, amending dates on the front cover and updating CRT in line with these new dates

5.3 Other Standards and Requirements

5.3.1 Service user information must **not** be clipped, stapled or fixed to the front of the SHR but filed securely as per filing instructions in the inside front cover of the folder.

5.3.2 The use of plastic filing wallets also known as 'Polly Pockets' for filing within the SHR is not allowed, sheets must be filed securely within the record.

5.3.3 Case files, either service users or personnel, should not be defaced in any way.

5.3.4 Defacing includes but is not limited to, striking through information, writing aide memoirs/jottings or instructions to redact information alongside original notes.

5.3.5 Any such activity impairs the usefulness, value and integrity of the file.

5.3.6 All recorded information should always be treated in a respectful and professional manner.

5.3.7 Creation of the care Record, and associated data protection and confidentiality issues, should be discussed with and provided in writing to the service user on engagement with the service or at an appropriate interval thereafter (see *Confidentiality Policy* and *Leaflet 4 'Access to your care records; Your records are safe with us'*).

5.3.8 Diaries should not be used unless there is a specific legitimate reason the user needs one for example they are unable to use any other form of reminder. Under these circumstances there should be minimum information entered in to the diary and it should not be taken away from the office.

5.3.9 Any use of a diary should not be instead of the electronic patient record and should not contain information in isolation to the primary care record.

5.3.10 Managers should ensure that the above procedure is the practice within their own departments, service, or unit and relevant guidance is in place for staff.

5.3.11 Where any records or filing is found that has not been previously identified as missing an eclipse needs to be raised by the finder before the file or filing is processed to allow for transparency for any previous access to records requests

6. Procedure for Tracking of Care Records

6.1 All movements of paper Care Records must be immediately recorded using the Trusts electronic Care Records Tracking (CRT) system.

6.2 All staff involved with maintaining the availability of Care Record must use CRT to record the Care Record movements.

6.3 CRT will record the following (minimum) information:

- The Care Record's Trust reference number and other identifier', e.g., NHS number; IAPTus, LINKS CarePath (Illy), Paragon, ePEX
- Details of current and past Care Record volume(s) and their current location;
- The name of the person requiring the Care Record.
- The name of the person sending the Care Record.
- The name of the person who has received the Care Record.
- The name of the Home Base or satellite base where the Care Record is being tracked to.
- The name of the site where the Care Record has been received into if different from initial site the Care Record has been tracked to.
- Dates when the Care Record was sent
- Date when Care Records was received

6.4 All Care Records transferred or taken off-site must be accounted for and tracked.

6.5 CRT must be regularly reviewed and updated through the use of reports available via the Trusts 'Insight' report suite to ensure that Teams/sites are following Trust procedures.

6.6 Any problems or issues that are encountered regarding tracking of Care Records on CRT should be raised to the appropriate Care Records Home Base.

6.7 Update access to CRT will be granted following training through either the Trusts System Training Team or via the Head of Care Records.

6.8 Read only access to the electronic tracking system is available to all clinical staff.

6.9 The success of any tracking system depends on the people using it and therefore all staff must be made aware of its importance and given adequate and updated training.

6.10 The Head of Care Records will audit the system to review user access and compliance with the procedures.

6.11 Access for CRT will be suspended for irregular users; update training must be completed via e-learning before access can be reinstated. This can be accessed via CRT e-learning by logging into the Learning Zone, choosing Courses and searching for Clinical Records Tracking. Access will be granted within 24 hours of successful completion of e-learning. For further details please refer to *Care Records Tracking* page on Connect.

7. Procedures for Reporting Missing Care Records

7.1 Paper Care Records that are unavailable (missing or mislaid) when required must be reported in line with the following Trust procedure and record the missing Care Record on Eclipse. For further guidance please refer to the *The Reporting, Management & Learning from Incidents Policy*.

7.2 Staff must initially check to ensure there has not been a misfile where the file should be located.

7.3 Once staff are sure the paper Care Record has not been misfiled staff must look on the electronic patient record and see who has had recent contact with the Service User and ask them if they have the Care Record.

7.4 If the last person to have contact with the Service User does not have the file then a physical search of the building must take place, for example on top of desks, in cabinets etc.

7.5 If the paper Care Record cannot be found within 2 working day following the physical search then;

a. Manager for that Team/ Site needs to be informed
b. The appropriate Care Records Home Base notified

7.6 Home Base will need to track the appropriate volume to 'Missing File' on CRT and in the comments field on CRT note the Eclipse number on the day they are notified that a Care Record is missing.

7.7 If at a later date the 'missing' volume is found, the appropriate Care Records Home Base needs to be informed on the same day so that the volume can be 'tracked' out of 'missing' and the volume becomes an active volume and staff are able to track its movements.

7.8 A report of missing Care Records will be generated and submitted to the Information Governance Assurance Group on an annual basis as a minimum.

7.9 Home Base Care Records staff will run regular reports for missing files and attempt to locate, and update CRT accordingly.

8. Procedure for Off-site Semi-Permanent Storage and Retrieving Care Records

8.1 Off-site Semi Permanent Storage of Care Records

8.1.1 Teams must only retain the current SHR for service users they are currently treating

8.1.2 All Care Records from satellite bases that temporarily store records must return the Care Record to a Home Base once the service user has been discharged.

8.1.3 Satellite bases must not retain Care Records following discharge in case of re-referral into the Service they must be tracked back to a Care Record Home Base to be archived or scanned.

8.1.4 Care Records required for research purposes or records needing to be kept longer than statutorily required can be kept off-site in semi-permanent storage. Any records requested to be kept on site for research, or other purposes should be brought to the attention of the Head of Care Records.

8.1.5 A sticker should be placed on the front of the Care Record to indicate it is being kept for research purposes or a longer period to be introduced, e.g. 'RESEARCH PURPOSE'.

8.1.6 The procedure is as follows:

- Track the Care Records(s) that are to be stored off-site on CRT to the off-site storage location and state the box number in the 'Recipient name' field.
- Generate a bar code label and ensure that is fixed to the top left hand corner of the Care Record.
- If the Care Record already has an archiving bar code label then this Care Record must be tracked on the electronic tracking system to the off-site storage location

with the box number in the 'Recipient name' field and returned to the box that it was retrieved from.

- The off-site semi-permanent storage providers electronic system must be completed by Care Records Home Base staff in all instances where Care Records are being sent off-site for semi-permanent storage

8.1.7 Deceased patients and any other group of records that reaches the age of destruction if earlier than the normal SHR for example Mental Health Act and observation files should be in separate boxes, in the same year the file was closed, however following the above procedure.

8.1.8 Make up box, place appropriate barcode number, provided by supplier on the front of the box. When the Home Base has several boxes full to capacity, they can arrange for them to be collected.

8.1.9 The Records staff will be responsible for archiving of all records off-site within their Home Base.

8.1.10 Only Records staff are permitted to send and retrieve Care Records from the off-site semi-permanent storage provider.

8.1.11 If Satellite sites wish to retrieve a record from the off-site semi-permanent storage provider this must be done via a Care Records Home Base.

8.1.12 If Satellite sites wish to retrieve a record from the off-site semi-permanent storage provider as an urgent request, the cost of this request will be passed onto the Team. The cost of this provision will be approximately £100.00 per request.

8.2 Retrieval of Care Records, Care Records Filed On Site including Home Bases and Satellite Sites

8.2.1 Paper Care Records can be retrieved on a daily basis during working hours from any site or Team that hold the records.

8.2.2 To determine where the Care Records are for any Service User the electronic tracking system (CRT) should be used.

8.2.3 Once the location for the Care Records has been determined Trust staff should contact the site or Team direct and request the records that are required.

8.2.4 The records that have been requested must be tracked out to the requester by the member of staff who is sending the records. These records are then shown as being 'In Transit to' to the requester on the electronic tracking system.

8.2.5 Once the records have been received by the requester they must be shown as being 'Received' into the site or Team, thus reflecting the true location of the records on the

electronic tracking system.

8.2.6 Care Records will only be issued to authorised members of staff, in possession of an appropriate Trust identification card.

8.2.7 For access to Care Records out of hours, see the various procedures for Access Care Records out of Hours. For the following Home Base:

- The Barberry Centre

8.3 Care Records Archived off-site

8.3.1 All paper Care Records that are held off-site in semi-permanent storage are shown as being tracked to '*Iron Mountain*' on the electronic tracking system (CRT).

8.3.2 All retrievals of paper Care Records from the Trusts off-site semi-permanent storage provider must only be done through Records staff.

- Requests to the off-site semi-permanent storage provider must be submitted electronically via the Home Base generic Records Department e-mail address: *bsmhft.recordsdepartment@nhs.net*

8.3.3 Information which is required for the retrieval of the records is Trust Reference number, box number and volume being requested, if more than one record for the Service User is being located within the same box.

8.3.4 If Satellite sites wish to retrieve a record from the off-site semi-permanent storage provider this must be done via a Care Records Home Base.

8.3.5 If Satellite sites wish to retrieve a record from the off-site semi-permanent storage provider as an urgent request, the cost of this request will be passed onto the Team. The cost of this provision will be approximately £100.00 per request.

8.3.6 This retrieval must be in accordance with the Trust *Save Haven Procedures*.

8.3.7 All Care Records being received from off-site semi-permanent storage provider will be delivered to the requesting Home Base who must record that the Care Records have been retrieved from Iron Mountain and subsequently tracked out to the initial requester on the electronic tracking system.

8.3.8 Designated Care Records Home-bases are:

Home Base	**Telephone Number**
Barberry Centre	0121 301 2335
Northcroft	0121 301 5271
Trust Headquarters – Records Management Team	0121 301 1155

9. Procedure for Retention, Disposal and Permanent Preservation of Care Records

9.1 Retention of Care Records

9.1.1 All Care Records are retained in accordance with the Department of Health: *Record Management Code of Practice for Health and Social Care 2016*.

9.1.2 Recommended minimum retention periods must be calculated from the end of the calendar year following the last entry on the document.

9.1.3 Where a paper Care Record is labelled with an appropriate sticker it must be considered for permanent preservation and the advice of the Chief Archivist at Birmingham Central Library of an appropriate place of deposit obtained.

9.1.4 The provisions of the Data Protection Act 2018 must be complied with.

9.1.5 Annual review of Care Records retained by the Trust, which are approaching the end of their retention period, should be undertake by the Home Base Care Records staff in conjunction with the Head of Care Records.

9.2 Disposal of Care Records

9.2.1 When destroying records, confidentiality must be maintained at all times.

9.2.2 Where a contractor provides this service, it is the responsibility of the Trust in conjunction with the Head of Care Records that this is undertaken in line with Trust and NHS guidelines and satisfies that the methods used throughout all stages including transport to the destruction site provide satisfactory safeguards against accidental loss or disclosure.

9.2.3 Trust wide communications will be issued to advise staff of process and ask staff to inform the Head of Care Records if they are aware of any Care Records that need to be retained outside of the retention period and the reason why so that can be identified and excluded from disposal.

9.2.4 A catalogue of all Care Records that are scheduled to be destroyed must be recorded, (see the *Corporate Records Management Policy*) and reflected on CRT (Care Records Tracking).

9.2.5 The management of the process will be the responsibility of Care Records Home Base staff in conjunction with the Head of Care Records.

9.2.6 The Disposal of Records log will be presented to the Information Governance Steering Group annually to advise of any record disposal

9.3 Permanent preservation at Local Authority Records Office

9.3.1 Where Care Records fall within the period that permanent preservation needs to be considered these will be identified on CRT (Care Records Tracking).

9.3.2 Arrangements of permanent preservation should be made by the Head of Care Records in conjunction with the Corporate Records Management Officer. This will be made with the Local Authority Records Office for the transporting and storage of the records.

9.3.3 Written confirmation of all records to be sent for preservation must be completed. This includes records of paper, microfiche/film, and computer media by Care Records Home Base staff in conjunction with the Head of Care Records and the Corporate Records Management Officer.

9.3.4 Access to the records will only be available through an arrangement with the Local Authority Records Office at Birmingham Central library.

10. Transportation of Care Records

10.1 Internal Transportation

10.1.1 The use of blue secure bags, boxes or tamperproof envelopes to transport Care Records around the Trust is a mandatory requirement. Failure to comply with this requirement could lead to a breach of confidentiality which may lead to disciplinary action.

10.1.2 All movements of records must be tracked using the Trust's electronic tracking systems, as detailed in the *Procedure for Tracking Care Records.*

10.1.3 All Care Records must be transported by one of the following methods

- Secured boxes
- A blue plastic holdall (for transporting several records)
- A blue plastic pouch (for transporting 1-3 records)
- A grey tamper proof self-seal envelope (for transporting 1-3 records, to be used once and then disposed of)

Alternative methods of delivery, other than the above, to transport Care Records internally should not be used. For example, clear sleeves and standard brown/ white envelopes are considered inappropriate as they have a greater potential to lead to breaches of confidentiality by being mislaid or seen by unintended recipients. Such breaches of confidentiality may lead to disciplinary action.

10.1.4 When preparing for the transport of care records ensure that all filing is secured within the Care Record (please refer to the procedure for *Creating and Filing within the Supplementary Health Record (SHR)* for further details).

10.1.5 Refer to *Medicines Code* Policy for secure transportation of medicines to clients in the community.

10.1.6 If using a blue plastic pouch or holdall you must ensure that the security tag is used to fasten the bag zip in place therefore making the transport bag tamperproof.

10.1.7 If you are using a grey tamper proof envelop to transport the Care Records the envelop must be sealed before being put into the internal post and the following must be recorded on the front of the package;

- Recipient Name and role in full
- Site Name and Team
- State 'Internal Post' in the top right of the package
- State senders name and location in the top left of the package

Upon delivery the seal should be intact giving moderate assurance that the Care Record has not been tampered with. If a secure bag arrives with the security seal tag broken or the tamper proof envelop open an incident must be logged on Eclipse as a potential breach of confidentiality. (For further guidance please refer to *The Reporting, Management & Learning from Incidents Policy*)

10.1.8 The grey tamper proof envelopes are only to be used only once. Once they have been used they are to be discarded and not re-used. The re-use of tamper proof envelopes is considered inappropriate as they have a greater potential to lead to breaches of confidentiality by being mislaid or seen by unintended recipients. Any such breaches of confidentiality must be logged on Eclipse and may lead to disciplinary action.

10.1.9 The Home Base/satellite staff dealing with the outgoing Care Record must ensure that they record the Care Record as being tracked out to the outward destination along with the requestors name on the electronic tracking screen. This is to ensure that the journey of the Care Record(s) is traceable at all times.

10.2 External Transportation

10.2.1 The Trust should not release original records to third parties and only copies of records should be sent wherever possible. All Care Records (originals) transported externally from BSMHFT must be sent by recorded delivery in a single use tamper proof plastic envelope.

10.2.2 All original Care Records that are leaving the Trust must be tracked on the electronic tracking system using the tracking location 'Non-Trust Location, Third Party'.

10.2.3 The comments field within the electronic tracking system must be updated to include;

- Contact name
- Contact number
- Contact address
- Reason

This is to ensure a record of their journey is recorded in the event that they should be mislaid. Failure to comply with this requirement would need to be logged on Eclipse as a potential breach of confidentiality which may lead to disciplinary action.

10.2.4 The package must be labelled as follows:

- Recipient Name and role in full
- Full postal address
- State 'External Post' in the top right of the package

10.2.5 It must be recorded on the tracking system that the Care Records have left their normal storage area where they are being sent using the tracking code 'Non-Trust, Third Party'.

10.3 Transportation by non-Trust approved means

10.3.1 Transportation by Personal Vehicle

All records must be safeguarded from theft, damage, or destruction. Care Records being transferred should follow these guidelines:

- Care Records must not be left unattended in a vehicle.
- The person transporting the record at the time is responsible for its safekeeping.
- No one else in the vehicle should handle the Care Records unless they are authorised to do so.

10.3.2 Records sent by taxi

- Where any Care Record, including loose notes, need to be transported by taxi a request must be submitted to 'Amey' (Trust approved transportation) who will arrange this with an approved taxi provider.
- They should be packaged as detailed in *External Transportation* procedure.
- In exceptional circumstances contracted transport service staff may deliver medicines to service users at home. In these circumstances a member of the Pharmacy or the team caring for the service user must confirm the medicines have been received (see *Medicines Code policy*)

10.4 Transportation by Electronic Means

10.4.1 Email/Fax

Please refer to Trust *Safe Haven Procedures*.

10.5 Keeping Care Records at Home

10.5.1 Care Records must ONLY be taken home in exceptional circumstances, only if approved as part of Team process which must have the agreement of the Head of Care Records. Request must be submitted to the Head of Care Records in writing.

10.5.2 Where it is impossible to return records to a Trust base at the end of a working day it will be permissible for records to be held overnight by staff in their homes.

10.5.3 They must be secured in approved Trust sealed blue pouches/holdalls or tamper proof envelopes.

10.5.4 Under no circumstances must records be left in vehicles at any time. Responsibility for the record remains with staff that are in possession of it. The Trust expects the record to be treated as if it were your own personal record and safeguarded appropriately.

10.5.5 The Care Records must be secured in a safe place in your home, until returned to the normal storage area, ensuring its integrity and confidentiality at all times

10.5.6 Records must be returned to Trust premises next calendar day. If staff are on sick leave for more than 2 days, then arrangements must be made to return the care record(s) to the normal storage area.

10.5.7 All Care Records taken home must be recorded as being kept off-site overnight by the Team on the tracking system using the tracking location 'Non-Trust Location, Third Party', following agreement from The Head of Care Records.

10.5.8 The comments field within the electronic tracking system must be updated to include;

- Contact name
- Contact number
- Contact address
- Reason

This is to ensure a record of their journey is recorded in the event that they should be mislaid. Failure to comply with this requirement could lead to a breach of confidentiality which may lead to disciplinary action.

11. Storage and Maintenance of Care Records Protocol

11.1 All Home Base areas are secure environments and only authorised staff are allowed to access.

11.2

11.3 Storage should be in a suitable secure environment, which has easy access and appropriate safe to ensure the records are not damaged or destroyed. All records storage areas must meet with Health and Safety requirements.

11.4 The Head of Care Records is responsible for approved storage locations.

11.5 The day-to-day responsibility for the standard of the Care Records of inpatients and service users attending outpatients is the responsibility of the ward clerks, medical

secretaries, receptionists, outpatient clerks, and their line manager.

11.6 Staff members managing the Care Records must ensure Care Records are regularly checked to ensure no damage has occurred, or if it has to be replaced before it is further damaged.

11.7 Care Records, which are no longer required i.e. discharged files or previous volumes, must be sent to the relevant Home Base for return to the off-site semi-permanent storage provider.

11.8 Teams must retain the current SHR for service users they are currently treating.

12. Shelving and Boxing

12.1 Records should be stored on shelves or in cabinets in a way that facilitates easy retrieval. This will not only provide for access to the records but will also make security checks more efficient.

12.2 Paper records need not be boxed, although boxing may be required where, for example, there are risks from damage by excessive light or by flooding, or where there is a high probability that certain records will be selected for permanent preservation or archived off-site.

12.3 Film should be stored in dust-free metal cans and placed horizontally on metal shelves. Microfiche sound recordings and videotape should be stored in metal, cardboard, or inert plastic containers, and placed vertically on metal shelving, where appropriate.

12.4 Computer disks and tapes must be stored in durable boxes not susceptible to mould, damp, or water.

12.5 Computer, media, and microfilm/fiche must be kept in a fireproof safe.

12.6 Records should be stored off the floor to provide some protection from flood, dampness, and dust.

13. Protection against Fire and Water

13.1 All storage facilities must be protected by an automatic fire detection and alarm system including smoke detectors, installed and maintained.

13.2 Portable fire extinguishers must be provided and should be installed at various points within the storage areas.

13.3 Staff should be instructed in the location and use of fire fighting equipment, and fire drills should be undertaken periodically.

13.4 Records must not be stored where there may be a danger of leakages from pipes or radiators or flooding.

14. Environment

14.1 Managers must ensure fluctuations in temperature are monitored as they may cause significant damage to the care records, whether paper format or other media.

14.2 If the humidity within the storage area rises at any time, there is a great risk of mould growth. Managers of care records must be vigilante as damage could be irreversible to paper, microfilm/fiche or computer media.

14.3 Care Records must be stored away from direct sunlight.

15. Requests for access to the Care Record

15.1 All requests for originals or copies of Service Users or Staffs own information must be referred to the Information Request .mailbox; *bsmhft.informationrequests@nhs.net*

15.2 Please refer to *Confidentiality* Policy (IG01) *Access to Information Policy* and Subject Access Requests Procedures for further details.

16. Hybrid Mail

16.1 Hybrid Mail is the solution the Trust use in the management of external post.

16.2 As with normal postage sometimes letters are undelivered. It is the sender's responsibility to check their Hybrid Mail account regularly to ensure all letters have been sent appropriately and to manage those that have been returned or rejected by deleting from their account and investigating reasons for the return or rejection and acting accordingly.

16.3 Record staff regularly review Hybrid Mail and alert staff of any rejected and returned post.

16.4 For further information please refer to *Hybrid Mail*.

17. Key Definition

17.1 **Records Management** is a discipline which utilises an administrative system to direct and control the creation, version control, distribution, filing, retention, storage and disposal of records, in a way that is administratively and legally sound, whilst at the same time serving the operational needs of the Trust and preserving an appropriate historical record. The key components of records management are:

- record creation;
- record keeping;
- record maintenance (including tracking of record movements);

- access and disclosure;
- closure and transfer;
- appraisal;
- archiving;
- disposal.

17.2 The term ***Records Life Cycle*** describes the life of a record from its creation/receipt through the period of its 'active' use, then into a period of 'inactive' retention (such as closed files which may still be referred to occasionally) and finally either confidential disposal or archival preservation.

17.3 In this policy, ***Records*** are defined as 'recorded information, in any form, created or received and maintained by the Trust in the transaction of its business or conduct of affairs and kept as evidence of such activity'.

17.4 ***Information*** is a corporate asset. The Trust's records are important sources of administrative, clinical, evidential, and historical information. They are vital to the Trust to support its current and future operations (including meeting the requirements of Freedom of Information legislation), for the purpose of accountability, and for an awareness and understanding of its history and procedures.

18. Glossary

18.1 **ACCESS**
The availability of, or permission to consult, records. (The National Archives, Records Management Standard RMS1.1).

18.2 **APPRAISAL**
The process of evaluating an organization's activities to determine which records should be kept, and for how long, to meet the needs of the organization, the requirements of Government accountability and the expectations of researchers and other users of the records. (The National Archives, Records Management Standard RMS 1.1).

The process of distinguishing records of continuing value from those of no value so that the latter may be eliminated. (The National Archives, Definitions in the Context of the Seamless Flow Programme).

18.3 **SEAMLESS FLOW PROGRAMME, THE NATIONAL ARCHIVES**
The Seamless Flow Programme involves the creation of a seamless flow of digital records from creation in government departments, to preservation in the archives, through to delivery on the web. The programme is about linking together existing components and automating manual processes. The process of developing the seamless flow approach will allow the review and streamlining of other aspects of its architecture – notably catalogues and web searching. The development of an internet-

based delivery system for digital records is a key component of The National Archives' response to the Government's 2005 target.

18.4 **ARCHIVES**

Those records that are appraised as having permanent value for evidence of on-going rights or obligations, for historical or statistical research or as part of the corporate memory of the organization. (The National Archives, Records Management Standard RMS 3.1).

It is a legal requirement for NHS records selected as archives to be held in a repository approved by The National Archives; see Place of Deposit below.

18.5 **AUTHENTICITY**

An authentic record is one that can be proven:

- to be what it purports to be;
- to have been created or sent by the person purported to have created or sent it;
- to have been created or sent at the time purported.

To ensure the authenticity of records, organizations should implement and document policies and procedures which control the creation, receipt, transmission, maintenance and disposition of records to ensure that record creators are authorized and identifiable and that records are protected against unauthorized addition, deletion, alteration, use and concealment. (BS ISO 15489-1:2001(E)).

18.6 **CLASSIFICATION**

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. (BS ISO 15489-1:2001(E)).

18.7 **CONVERSION (see also MIGRATION)**

The process of changing records from one medium to another, or from one format to another. (BS ISO 15489-1:2001(E)).

18.8 **CORPORATE RECORDS**

Records (other than care records) that are of, or relating to, an organization's business activities covering all the functions, processes, activities and transactions of the organization and of its employees.

18.9 **CURRENT RECORDS**

Records necessary for conducting the current and on-going business of an organization.

18.10 **DESTRUCTION**

The process of eliminating or deleting records beyond any possible reconstruction. (BS ISO 15489-1.2001(E)).

18.11 **DISPOSAL**

Disposal is the implementation of appraisal and review decisions. These comprise the destruction of records and the transfer of custody of records (including the transfer of selected records to an archive institution). They may also include the movement of records from one system to another (for example, paper to electronic). (The National Archives, Records Management Standard RMS1.1).

18.12 **DISPOSITION**

A range of processes associated with implementing records retention, destruction or transfer decisions, which are documented in disposition authorities or other instruments. (BS ISO 15489-1:2001(E)).

18.13 **ELECTRONIC RECORD MANAGEMENT SYSTEM**

A system that manages electronic records throughout their lifecycle, from creation and capture through to their disposal or permanent retention, and which retains their integrity and authenticity while ensuring that they remain accessible. (The National Archives, Definitions in the Context of the Seamless Flow Programme).

18.14 **FILE**

An organized unit of documents grouped together either for current use by the creator or in the process of archival arrangement, because they relate to the same subject, activity or transaction. A file is usually the basic unit within a records series.

18.15 **FILING SYSTEM**

A plan for organizing records so that they can be found when needed. (The National Archives, Records Management Standard RMS 1.1).

18.16 **CARE RECORD**

A single record with a unique identifier containing information relating to the physical or mental health of a given patient who can be identified from that information and which has been recorded by, or on behalf of, a health professional, in connection with the care of that patient. This may comprise text, sound, image and/or paper and must contain sufficient information to support the diagnosis, justify the treatment and facilitate the on-going care of the patient to whom it refers.

18.17 **HOME BASES**

Long term storage of discharged records prior archiving off-site, will be in one of a number of designated ‘home bases’, each managed by a care records manager. Two home bases are in operation and cover the entire Trust.

18.18 **INDEXING**

The process of establishing access points to facilitate retrieval of records and/or information. (BS ISO 15489-1:2001(E)).

18.19 **INFORMATION AUDIT**

An information audit looks at the means by which an information survey will be carried out and what the survey is intended to capture.

18.20 **INFORMATION COMMISSIONER**

The Information Commissioner enforces and oversees the Data Protection Act 2018 and the Freedom of Information Act 2000.

18.21 **INFORMATION SURVEY/RECORDS AUDIT**

A comprehensive gathering of information about records created or processed by an organization. (The National Archives, Records Management Standards and Guidance – Introduction Standards for the Management of Government Records) It helps an organization to promote control over its records, and provides valuable data for developing records appraisal and disposal procedures. It will also help to:

- Identify where and when health and other records are generated and stored within the organization and how they are ultimately archived and/or disposed of;
- Accurately chart the current situation in respect of records storage and retention organization-wide, to make recommendations on the way forward and the resource implications to meet existing and future demands of the records management function.

18.22 **INTEGRITY OF RECORDS**

The integrity of a record refers to its being complete and unaltered. It is necessary that a record be protected against unauthorized alteration. Records management policies and procedures should specify what additions or annotations may be made to a record after it is created, under what circumstances additions or annotations may be authorized and who is authorized to make them. Any unauthorized annotation, addition or deletion to a record should be explicitly identifiable and traceable.

18.23 **JOINTLY HELD RECORDS**

A record held jointly by health and social care professionals, for example in a Mental Health and Social Care Trust. A jointly held record should be retained for the longest period for that type of record, i.e. if social care has a longer retention period than health, the record should be held for the longer period.

18.24 **MICROFORM**

Records in the form of microfilm or microfiche, including aperture cards.

18.25 **MIGRATION (see also CONVERSION)**

The act of moving records from one system to another, while maintaining the records' authenticity, integrity, reliability and usability. (BS ISO 15489-1:2001(E)).

18.26 **MINUTES (MASTER COPIES)**

Master copies are the copies held by the secretariat of the meeting, i.e. the person or department who actually takes, writes and issues the minutes.

18.27 **MINUTES (REFERENCE COPIES)**

Copies of minutes held by individual attendees at a given meeting.

18.28 **NHS NUMBER**

Introduced in 1996, the NHS number is a unique 10-character number assigned to every individual registered with the NHS in England (and Wales). The first nine characters are the identifier and the tenth is a check digit used to confirm the number's validity. Babies born in England and Wales are allocated an NHS number by Maternity Units, at the point of Statutory Birth Notification.

The NHS number is used as the common identifier for patients across different NHS organizations and is a key component in the implementation of the NHS CRS.

18.29 **NHS RECORDS (Public Records Act)**
All NHS records are public records under the terms of the Public Records Act 1958 sections 3(1)–(2). All records created and used by NHS employees are public records.

18.30 **PAPER RECORDS**
Records in the form of files, volumes, folders, bundles, maps, plans, charts, etc.

18.31 **PERMANENT RETENTION**
Records may not ordinarily be retained for more than 20 years. However, the Public Records Act provides for records, which are still in current use to be legally retained. Additionally, under separate legislation, records may need to be retained for longer than 20 years, for example Occupational Health Records relating to the COSSH (Control of Substances Hazardous to Health) Regulations, or records required for variant CJD surveillance.

Section 33 of the Data Protection Act permits personal data identified as being of historical or statistical research value to be kept indefinitely as archives.

18.32 **PERSONAL DATA**
Data which relates to a living individual who can be identified from that data or from data and from other information which is in the possession of, or is likely to come into the possession of the data controller (eg our Trust) (Data Protection Act).

18.33 **PLACE OF DEPOSIT**
A record office, which has been approved for the deposit of public records in accordance with section 4(1) of the Public Records Act 1958. This is usually the record office of the relevant (i.e. county, borough, or unitary) local authority. A list of those repositories recognized by The National Archives for the deposit of NHS archives is in Annex E. Contact details for them are to be found in the ARCHON (known as 'Find an Archive') directory on its website:

'https://discovery.nationalarchives.gov.uk/find-an-archive

An organisation wishing to have records preserved as archives should consult with The National Archives in the first instance, unless that organization has an existing working relationship with an approved Place of Deposit.

Some individual hospitals have themselves been appointed as a Place of Deposit. In practice, these have tended to be those larger hospitals, which can commit the resources necessary to provide appropriate conditions of storage and access and to place them under the care of a professionally qualified archivist. The National Archives can provide advice to any organization wishing to apply for Place of Deposit status. Further information about the work of archivists in NHS Trusts is available from the Health Archives Group.

18.34 **PRESENTATION**
The transfer to a third party (for example a University) of public records which have been rejected by The National Archives but which are not destroyed, under section 3(6) of the Public Records Act 1958.

18.35 **PRESERVATION**
Processes and operations involved in ensuring the technical and intellectual survival of authentic records through time. (BS ISO 15489-1:2001(E)).

18.36 **PROTECTIVE MARKING**
The process of determining security and privacy restrictions on records.

18.37 **PUBLICATION SCHEME**
A publication scheme is required of all NHS organizations under the Freedom of Information Act. It details information, which is available to the public now or will be in the future, where it can be obtained from and the format it is or will be available in. Schemes must be approved by the Information Commissioner and reviewed periodically to make sure they are accurate and up to date.

18.38 **PUBLIC RECORDS**
Records as defined in the Public Records Act 1958 or subsequently determined as public records by The National Archives.

Records of NHS organizations (and those of predecessor bodies to NHS organizations) are defined as public records under the terms of the Public Records Act 1958 sections 3(1)–(2). NHS records are not owned by the NHS organization that created them and may not be retained for longer than 20 years without formal approval by The National Archives, (The National Archives).

Records of services supplied within NHS organizations but by outside contractors are not defined as public records, but are subject to the Freedom of Information Act.

18.39 **PUBLIC RECORDS ACT 1958**
For further information, including the text of the Act, see The National Archives' website:

www.nationalarchives.gov.uk/information-management/legislation/public-records-act/

18.40 **RECORDS**

Information created, received and maintained as evidence and information by an organization or person, in pursuance of legal obligations, or in the transaction of business. (BS ISO 15489.1).

An NHS record is anything, which contains information (in any media), which has been created or gathered as a result of any aspect of the work of NHS employees – including consultants, agency or casual staff.

18.41 **RECORDS MANAGEMENT**

Field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and disposition of records, including processes for capturing and maintaining evidence of and information about business activities and transactions in the form of records. (BS ISO 15489-1:2001(E)).

18.42 **RECORD SERIES**

A series is the main grouping of records with a common function or subject – formerly known as 'class'. (The National Archives)

Documents arranged in accordance with a filing system or maintained as a unit because they result from the same accumulation or filing process, or the same activity, because they have a particular form, or because of some other relationship arising out of their creation, receipt or use. (International Council on Archives' (ICA) General International Standard Archival Description or ISAD(G)).

https://www.ica.org/sites/default/files/CBPS_2000_Guidelines_ISAD%28G%29_Second-edition_EN.pdf

A series comprises the record of all the activities that are instances of a single process. A series may be large or small: it is distinguished not by its size, but by the fact that it provides evidence of a particular process. If an activity takes place that is unique, rather than an instance of a process, its records form a series in their own right. (Elizabeth Shepherd and Geoffrey Yeo, Managing Records: a handbook of principles and practice (Facet 2003)).

18.43 **RECORD SYSTEM/RECORD-KEEPING SYSTEM**

An information system, which captures, manages and provides access to records through time. (The National Archives, Records Management: Standards and Guidance – Introduction Standards for the Management of Government Records).

Records created by the organization should be arranged in a record-keeping system that will enable the organization to obtain the maximum benefit from the quick and easy retrieval of information. Record-keeping systems should contain descriptive and technical documentation to enable the system and the records to be understood and to be operated efficiently, and to provide an administrative context for effective management of the records, including a documented set of rules for referencing, titling,

indexing and, if appropriate, the protective marking of records. These should be easily understood to enable the efficient retrieval of information and to maintain security and confidentiality.

18.44 **REDACTION**

The process of removing, withholding or hiding parts of a record due to either the application of a Freedom of Information Act exemption or a decision by The National Archives to restrict access where sensitivity, copyright or data protection issues arise. (The National Archives, Definitions in the Context of the Seamless Flow Programme).

18.45 **REGISTRATION**

Registration is the act of giving a record a unique identifier on its entry into a record-keeping system.

18.46 **RETENTION**

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

18.47 **REVIEW**

The examination of records to determine whether they should be destroyed, retained for a further period, transferred to an archival establishment, or presented to a third party (for example a University).

18.48 **SATELLITE BASES**

BSMHFT premises which act as satellite to a specified home base. The Care records manager will have responsibility for promoting good record keeping across its satellite bases in conjunction with Administration Leads

18.49 **TRACKING**

Creating, capturing and maintaining information about the movement and use of records, (BS ISO 15489-1:2001(E)).

18.50 **TRANSFER OF RECORDS**

Transfer (custody) – Change of custody, ownership and/or responsibility for records, (BS ISO 15489-1:2001(E)).

Transfer (movement) – Moving records from one location to another, (BS ISO 15489-1:2001(E)).

Records identified as more appropriately held, as archives should be offered to The National Archives, which will make a decision regarding their long-term preservation.

18.51 **WEEDING**

The process of removing inactive/non-current care records from the home base where the care record has been stored to a designated secondary storage area after a locally agreed timescale based on the date the record was received into the home base.