



<p style="text-align: center;">Storage and retention of health care nursing records</p>
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Storage and Retention of Health Care Nursing Records

Policy Statement

All nursing records maintained as part of the patient, client, resident's care, are the property of Brent tPCT. This also includes diaries and message books used on ward/clinic areas and diaries held individually by staff.

Rationale

Safe storage and retention of records reduces the risk to the Trust and maintains confidentiality on behalf of the patient, client and resident.

Nurses are personally responsible and accountable for ensuring they promote and protect the interests, privacy and dignity of their patients and clients, at all times. This must be irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs.

Criteria for Inclusion

All nursing staff employed by the trust, qualified and unqualified, on permanent, temporary, bank and agency contracts

Expectation of the Nurse by the Trust

1. Record Storage

- ❖ Nursing records must be kept confidentially at all times and in a locked filing cabinet when not in use.
- ❖ Records held in the home should be kept in an agreed safe place, away from the sight of casual visitors to the home.
- ❖ When records are requested by medical staff, and are sent off site, a tracer card should be used in order to recall / verify record existence and its whereabouts.
- ❖ When in use, records must be used in such away to retain confidentiality at all times and should never be left unattended.
- ❖ Where shared care records are in use, (LD, DN, CCN, PD & OPS) each service / agency must ensure the others' data is not compromised / follow locally agreed systems

- ❖ As far as possible there should only ever be one record for every patient/ client or child.
- ❖ Where records are stored off Trust property, systems must be in place to ensure confidentiality is maintained at all times.
- ❖ If records are mislaid or awaiting receipt, and an urgent interim duplicate is started, the original and duplicate must be joined up at the earliest possible opportunity.
- ❖ When transporting records in person, the nurse must ensure security, either in a locked briefcase carrier or in the boot of a car.
- ❖ At no time should a nurse carry records on public transport without taking due care that security and confidentiality are maintained, whatever the circumstances.
- ❖ When records are transferred from one site to another, via internal mail this must be in a sealed envelope marked private and confidential.
- ❖ A record of transfer details should be maintained both at the sending and receiving sites.
- ❖ Comparison data should be available on CIS to view against the patient / clients name & MPI number, logging current whereabouts of record.
- ❖ Adult files of discharged / deceased should be stored by month and year of final contact / date of closure of episode of care.
- ❖ If arrangements are in place for discharged / deceased records to be stored in the central inactive records store, this should only be actioned after a 2 year period of storage in the local clinic or hospital permanent file (P/F), in case of any need / request to review or revisit the file

Specific to children's records

- ❖ A child's preschool health visitor (HV) record should be transferred from the HV to school Nurse (SN) within the term that a child starts in the school's reception class, in order to confirm continuity.
- ❖ If a child's record ceases to be required there, elsewhere in the trust, or within British Isles, this record must be kept available for future access up to the age 18. Ideally this will be in an 'Active' Permanent Child Central Storage system, but otherwise locally on clinic site at the last point of access, separate to the clinic P/F.
- ❖ Children's records should always be filed by year of birth and then alphabetically
- ❖ A record should not be transferred on, without first confirming the child's new address
- ❖ Apart from child protection, Looked After Children (LAC) and special needs children, records should be requested by the new professional prior to transfer.
- ❖ For all those in the above vulnerable categories, it is the responsibility of the current health professional to seek out the receiving professional in order to minimise delay of transfer
- ❖ Child Protection records must be transferred via the Child Protection office in order to be sent recorded delivery

Across the Trust there is known to exist different methods of storage, across all of the nursing disciplines there are also known to be different types of records; whatever system is in use, the above principals must be applied to ensure safe practice at all times.

Where these variations are seen as best practice the following differences are documented.

- ❖ **District Nursing** – There are 2 sets of records that interlink. Day to day records are shared with S/S carers and retained in the patient's home, in order that individual nurses and carers can record contemporaneously, and communicate across agencies. The patient's main file is retained at clinic base while there is a current episode of care. The 2 records are amalgamated on the patients discharge or transfer
- ❖ **Health Visiting** - Day to day recording is undertaken with the parent / carer via the PCHR (Red book). Separately a Child Health record is generated on the birth of a baby / a child's movement into the area, and is stored in locked filing cabinets at the clinic base of the named HV. Information given to the parent regarding specific issues to that child / family are recorded both in PCHR and CHR. The CHR will hold all letters, and other documents pertaining to that child / family. The transfer of CH records from HV to SN should happen within a month of the child starting school
- ❖ **School Nursing** – School Health records are generated as and when a child starts school. These are amalgamated with the CH records on transfer from the HV to the SN, as and when the child starts school (between 4-5 years of age). School Health records are stored on school site in locked filing cabinets belonging to the Trust. School education personnel do not have access to these records. In some instances where there are child protection issues, school health records may be stored at a clinic site in order to facilitate easy access during the summer school holidays
- ❖ **Child Protection / Looked after Children** – These services generate a central file for all children identified in these categories. The files are retained confidentially and should contain nothing that is not also documented in the child's main HV or SN file.
- ❖ **Community Children's Nursing** – Separate records are kept on hospital site in locked filing cabinets. All children will have either a health visitor or school nurse, with whom the CCN will liaise regularly until discharge, to ensure coordinated team working
- ❖ **Learning Disabilities** – Each unit creates a new care plan on admission. Care plan files are kept together with the existing medical file in a locked cabinet on the unit. Out patient records are kept in a locked cabinet in the Medical secretaries office. Discharged files are forwarded to the Mental Health Act Administrator and stored in a locked storage room.
- ❖ **Older Peoples Service** –Intermediate Care records are generated on admission to Willesden Community Hospital. CMH records accompany the patient on

admission. CMH records are stored in a lockable filing cabinet and current management records, which are interdisciplinary in nature, are stored in a lockable trolley, which is kept in a lockable office. Transfer of records between Willesden and CMH is generally facilitated by nurse to nurse transfer, in a sealed envelope, marked 'private and confidential'. All such transfers are logged in the Senior Cover Diary. The Consultant has access to these records and may retrieve them as and when required. Completed ward diaries and stored in a locked storeroom.

- ❖ **Physical Disabilities** –The notes are multidisciplinary. Each discipline involved with the patient writes in chronological order. The notes are stored in a locked cabinet. Notes are retained for 11 years following last treatment or death, if they have been supplied with any equipment, otherwise they are destroyed after 8 years.
- ❖ **Specialist Nursing** – each of these disciplines generates its own file for the nature of work undertaken, but also ensures the key health worker (where there is one) is kept informed at all times, of specialist input on behalf of their client / patient.

2. Records, which are no longer active, must be kept for the following periods of time:

Adults	8 years from the most recent episode of care, their discharge or their death
Children and Maternity	25 years (7 years after reaching their 18 th birthday)
	NB For some children with special needs, this may be longer & should be decided individually, especially where care has transferred to specialist adult services
Parent held records	These remain the property of Brent tPCT whilst the family is resident in Brent. The record becomes the property of the receiving authority when the client is transferred. The retention of the PCHR record remains with the family.

Children who have been 'Looked After' For life – ie DO NOT DESTROY – these YP may return to request vital information about their childhood. Health records may be the only available source they can access to learn about their early years and health issues.

Clinical Diaries / Message books 7 years (NB 1 year for office diaries)

Nurse diaries, used for visiting purposes, whether supplied by the Trust or purchased individually for work purposes, and **message books** must be handed to the manager as and when they are requested, and on the day the nurse leaves the employment of the Trust.

Nurses are responsible for the safety of all their diaries until such time, as they are requested or that time delay allows for their incineration.

All records remain the property of the Trust at all times.

References

These guidelines should be used in conjunction with:-

- ❖ Risk Management Policy No RP27 & any future Trust wide record storage policies, contained within Risk Policy Folders
- ❖ School Nursing Policy No SNP05 Access to School Health Records

Further information can be found at www.nmc-uk.org and via RCN www.rcn.org and CPHVA www.amicus-cphva.org

Professional Nursing Forum

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