SWANSEA BAY UNIVERSITY HEALTH BOARD
RECORDS MANAGEMENT POLICY

This document may be made available in alternative formats and other languages, on request, as is reasonably practicable to do so.

This policy has been screened for relevance to equality. No potential negative impact has been identified so a full quality impact assessment is not required.

Please Read the policy in conjunction with the following documents:

HB13.1 Compilation of Records Policy
HB13.2 Records Tracking Policy
HB13.3 Minimum Retention and Destruction Policy
HB13.4 Storage and Security of Records Policy

Document Author:	**Director of Digital Services**
Approved by:	**Digital Data Research & Innovation Committee**
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CONTENTS

1. INTRODUCTION

It is the aim of Swansea Bay University Health Board to ensure that All records whether held in paper or electronic format are managed to the highest possible standards to ensure security, confidentiality, availability and ease of use, at all times and align with the Health Board Digital Strategy.

This is achieved by:

- Establishing clear accountability for the management of All records at Health Board, hospital and clinic levels.
- Ensuring that legislative, national, and local standards are implemented and consistently adhered to.
- Ensuring that control measures exist at the different hospitals and off-site storage facilities to monitor the management and use of All records, and remedy problems that come to light.
- Ensuring that all staff involved in the collation and use of the record receive the appropriate training / information to undertake their duties; and that through staff departmental induction and mandatory Information Governance training, all staff are properly informed of the importance of the record for clinical and managerial purposes.
- Ensuring that Records Services are provided efficiently and effectively across the wide geographical area of the Health Board is of paramount importance.

There are a number of key documents that set out the best practice guidelines for the management of NHS records and includes their creation, use and final disposal:

- Records Management Code of Practice for Health and Social Care 2022
- All Wales Information Governance Policy 2021
- Minimum Retention & Destruction Policy

A health record is defined as:

> "*Any record which consists of information relating to the physical or mental health or condition of an individual, and has been made by or on behalf of a health professional in connection with the care and treatment of that individual.*"

Records are a valuable resource because of the information they contain. Information is only useful if it is correctly recorded in the first place, is regularly updated and is easily accessible when it is needed. Information is essential to the delivery of high quality healthcare and effective records management. The records and formats will include (but is not limited to):

- Records of patients treated by SBUHB including health and care records
- Records of private patients treated on NHS premises
- Records of patients treated on behalf of the NHS in the private healthcare sector

 Adult Service user records where there is integration with health services e.g. jointly held records

This list is not exhaustive.
A health record is everything (paper or electronic) that contains information which has been created or gathered as a result of any aspect of the delivery of patient care, including (but not limited to):
 Personal health records (electronic, microfilmed, scanned images & paper based)
 Theatre Registers and all other registers that may be kept
 X-ray and imaging reports, output and images
 Photographs, slides and any digital images
 Audio and video tapes, cassettes
 Digitised images/Digital Records (scanned)
 Emails
 Text messages (SMS)

This list is not exhaustive.

2.	THE AIM AND ACCOUNTABILITY OF RECORDS MANAGEMENT SERVICES

The aim of all Services that manage and are accountable for the storage and security of a patient's record is to ensure that procedures are in place to bring together the health professional and accurate, relevant, reliable paper patient documentation or electronic records at the correct time and place to support patient care.

In achieving this aim, ALL Records Services should fulfil statutory and other legal requirements, ensure staff and patient safety within the departments and ensure custody and confidentiality of patient information/electronic systems at all times within the patient's record.

Patient's Records are a valuable resource because of the volume of clinical information they contain. Information is only usable if it is correctly recorded in the first place, is regularly updated, and is easily accessible when it is needed. Clinical information is essential to the delivery of high-quality evidence-based health care on a day-to-day basis and an effective records management service ensures that such information contained within the patient's record is properly managed.

The same storage and security principles should also be adhered to for all other records types across the Health Board.

3. ACCOUNTABILITY FOR PATIENT RECORDS

Patient's records are an essential part in the delivery of patient care. They contain critical information about the diagnosis, treatment and progress of individual patients. Patient's records must therefore be complete, accurate and accessible to all health professionals at the point of care.

The Chief Executive and senior managers are personally accountable for the quality of patient records within the organisation, and all line managers and supervisors must ensure that their staff, whether administrative or medical, are adequately trained and apply the appropriate guidelines.

All staff within the Health Board are responsible for any patient records they create or use. This responsibility is established at, and defined by, law. All staff who access, record, handle, store or otherwise come across information has a personal common law duty of confidence.

It is the responsibility of **all staff** to conform to this policy, in respect of composition, legibility, storage, security, confidentiality, tracking, sharing, releasing, and retention of patient records in the fulfilment of their duties, and the record folder and contents must be maintained in accordance with Health Board requirements which have been incorporated into the function of the Information Governance & Cyber Security Assurance Group (IGCAG). The destruction of any patient's medical records must only be undertaken for the acute patient's record by Health Records staff, or in areas where they manage their record separately from the Acute Health Record by qualified staff, in line with the Records Minimum Retention and Destruction Policy.

All staff must accept the responsibility, and have a personal commitment to filing documentation timely and accurately within the records as required by the Health Board.

All Staff are responsible for reporting and assisting with investigating any incidents relating to the management of records/ record keeping. All incidents should be recorded on Datix to ensure the Information Governance Department and Digital Services Directorate are made aware of the number of incidents being identified by the Records Service for reporting purposes.

All staff who require access to patient records must be clear about their personal responsibility for compliance with relevant policies, and that non-compliance may result in disciplinary action.

The responsibility for the safe custody of patient records, and provision on demand, must always be with the last recorded contact. All staff need to be educated as to the importance of the record, and be conscious of their own personal responsibility and the acceptance of ownership.

All staff need to take responsibility for sharing patient information contained within the record both internally and externally – advice may be sought from the Information Governance Department if required. The All-Wales Information Governance Policy and Information Governance Procedures provide guidance also.

Patients and their legal representatives have a right under data protection legislation to request a copy of their personal data, which includes their record (a Subject Access Request). Any request for information held within the record should be directed to the Access to Health Records Department.

Policies have been developed to ensure that all patient records are managed appropriately within the organisation, and in line with WG guidelines, legislation, Records Management Code of Practice for Health and Social Care 2022.

The same overarching principles should also be adhered to for all other records types across the Health Board.

4. LEGAL CONTEXT

This policy must be applied in conjunction with the laws relating to confidentiality, data protection, and the patient's rights of access to their records and the staff's duty of care to patients to make proper records. Managers in all Departments/Services must ensure that staff are also aware of these rules.

5. THE PURPOSE OF A PATIENT RECORD

- It is a legal requirement to keep records;
- To provide accurate, current, comprehensive and concise information concerning the condition and care of the patient and associated observations;
- To provide a record of any problems that arise and the action taken in response to them;
- To provide evidence of care required, intervention by professional practitioners and patient responses;
- To include a record of any factors - physical, psychological or social, that appear to affect the patient;
- To provide a continuous record of events and the reasons for the decision made;
- To support standard setting, quality assessment and audit;
- To provide a baseline record against which improvement or deterioration may be judged;
- To provide a framework for care planning and assist in communication amongst professionals;
- To enable the patient to receive effective continuing care;
- To enable the patient to be identified without risk or error;

- To facilitate the collection of data for research/education, service evaluation and audit;
- To support epidemiology
- The information can be used for legal proceedings and complaints management.

6.	MONITORING THROUGH AUDIT

Good record keeping is necessary to promote the quality of records, which in turn reflects the quality of care delivered across the Health Board.

It is the responsibility of the Delivery Units and Clinical Audit department to ensure that the audits are undertaken on regular basis.

7.	CLINICAL TRIALS

Research Teams use databases to flag research participants and when identified a sticker is placed on the inside cover of a patient's medical records where patients have been involved in clinical trials, so that Records staff retain the records in line with NHS Wales Records Management Code of Practice for Health and Social Care 2022.

8.	TRAINING

To implement and maintain compliance with this Policy, staff must be adequately trained, and fully aware of their responsibilities for record keeping/management. This is achieved in a number of ways:

- Departmental Induction Programmes
- Personal Annual Development Reviews – PADR
- Mandatory Information Governance Training must be completed at commencement of employment and undertaken every two years subsequently. Action plans are developed from the results of audits.

9.	POLICIES

This document incorporates the following policies:

<u>Compilation of Records Policy</u>

Policy Aim – To ensure that all staff recognise and accept personal responsibility for the compilation, content and recording of information within the patient record.

This covers electronic, and all paper records

Records Tracking Policy

Policy Aim – To ensure that staff recognise and accept responsibility for ensuring that records can be located on request, by appropriately tracking every set of records that they handle on the iFIT computer system

Minimum Retention and Destruction Policy

Policy Aim – The aim of this policy is to ensure that the retention period for All records is maintained in accordance with Statute law as outlined in this document. The Health Board has an individual responsibility to retain all records securely, in line with legal timeframes.

The policy will underpin all operational procedures and provide assurance and assistance to staff in terms of activities connected with the retention and destruction of records, ensuring that the Confidential disposal of ALL records is undertaken by approved contractors, ensuring that patient confidentiality is maintained at all times.

All staff must also ensure when destroying records or information that an inventory is retained of all records destroyed including the date of destruction on all Health Board Tracking/Recording Systems.

This policy will provide a framework that all staff will work too, which will ensure compliance with the Records Management Code of Practice for Health and Social Care 2022 on the retention/destruction/ of patient and staff records/information.

If there is a need to retain a record beyond the recommended minimum retention period as outlined in the Records Management Code of Practice for Health and Social Care 2022; then this will need to be formally approved by the Information Governance & Cyber Assurance Group IGCAG.

It may be deemed appropriate to select some records for permanent preservation. Selection should be performed in consultation with health professionals, and archivists from an appropriate place of deposit.

Storage and Security of Records Policy

Policy Aim – To ensure that all staff recognise and accept personal responsibility for ensuring that records are stored in safe and secure environments at all times, and in line with other relevant approved policies and procedures. This applies to all paper and electronic records.

All of the above policies are all supported by local procedures held within each of the services and libraries that manage their own records.

Please Note

The 'Records Management Policy' is a SBUHB overarching Policy, which is not only applicable to Acute and Non-Acute patient records, but also applies to the overall management and governance of all other record types held across the Health Board i.e., occupational therapy records/ mental health records/ community nursing records/ human resources and corporate records. Therefore, the directives and guidance for all other record types should be adhered to in line with this policy.

10. REFERENCES & FURTHER READING

- Records Management Code of Practice for Health and Social Care 2022
- Health Board Digital Strategy 2025
- All Wales Information Governance Policy 2021

11. REVIEW

This policy will be reviewed every three years or more frequent where the contents are affected by major internal or external change such as:-

- Changes in legislation
- Practice change or changes in system/technology; or
- Changing methodology

Annex: Policy Amendments – Version Control

Revision History

Date	Version	Author	Revision Summary
01/01/2025	V4	Jennifer Nagle Head of Health Records & Clinical Coding	Amended /updated previous Policy
07/04/2025	V 4.1	Jennifer Nagle Head of Health Records & Clinical Coding	Incorporated comments received from Management/Service Leads involved in the non-acute audit of records
22/04/2025	V4.1	Jennifer Nagle Head of Health Records & Clinical Coding	Circulated to IGCAG members for comments/feedback
02/06/2025	V 4.2	Jennifer Nagle Head of Health Records & Clinical Coding	Amended to reflect feedback provided by the DDR&IC
15/06/2025	V 5	Jennifer Nagle Head of Health Records & Clinical Coding	Final Policy Update

Approvers

This document requires the following approvals:

Date	Version	Name	Position
09/06/2025	V4	Information Governance & Cyber Security Group	IGCAG members
	V4	Digital Data Research & Innovation Committee	DDR&IC members

Amendments to the Policy

Document Name	Document Number	Page	Point/section	Changes
Health Records Policy	HB13	Front page		Footer amended, Updated approval dates. Amended the name of the policy
		Page 2	1-introduction	Reference to Health record has been removed, now Health Board Wide Policy. Updated reference to key documents.
		Page 3	2-Aim of the Health Records Service	Title Amended. Reference to Health record has been removed
		Page 3	3- accountability for patient's records	Reference to Health record has been removed.
		Page 4	3- accountability for patient's records	Updated Governance Reporting Structure , and Records Management Code of Practice for Health and Social Care 2022 Grammar amendments
		Page 5	Section 4-legal context	Grammar amendment, Reference to Health record has been removed
		Page 6	Section 6 Monitoring through audit	Reference to Health record has been removed

		Page 6	Section 7- Clinical Trials	Reference to Health record has been removed
		Page 6	Section 8 - Training	Expanded 1st paragraph
		Page 7	Section 8 - Training	Updated training requirements.
		Page 7	Contents- Section 9	Amendments made to Policy Names
		Page7/ 8	Contents- Section 9	New paragraphs developed for the Minimum Retention and Destruction Policy to reflect the Records Management Code of Practice for Health and Social Care 2022
		Page 8	Contents- Section 9	Reference to Health removed from Storage and Security Policy
		Page 9	Section 10 References and Further Reading	The relevant policies applicable to this policy have been updated.