National Hospitals Office Code of Practice for Healthcare Records Management

Part 1: Background

Reader Information

Directorate:	National Hospitals Office (NHO)
Title:	NHO Code of Practice for Healthcare Records Management
Document Purpose:	Standards & Recommended Practices—Part 1
Author:	NHO Healthcare Records Management Steering Committee
Publication Date:	October 2007
Target Audience:	All staff in the NHO who work in healthcare records management
Description:	The Code of Practice is a guide to the standards of practice required in the management of healthcare records in the NHO, based on current legal requirements and professional best practice
Superseded Docs:	The retention and disposal schedule replaces the previous retention schedule on acute hospital records outlined on pages 8-9 of the 'Policy for Health Boards on Record Retention Periods' (1999). Version 2.0 replaces Version 1 of Code of Practice.
Review Date:	October 2008
Contact Details:	Winifred Ryan, National Hospitals Office, Quality, Risk and Customer Care Directorate, Mid-Western Regional Hospital (Nenagh) Nenagh, Co. Tipperary, Ireland. **Email**: winifred.ryan1@hse.ie **Web:** www.hse.ie

Foreword

The National Hospitals Office (NHO) is delighted to present the *Healthcare Records Management: National Hospitals Office Code of Practice.* The Code of Practice has been published by the National Hospitals Office as a guide to the required standards of practice in the management of healthcare records in the NHO.

The Code of Practice was drafted by members of the National Hospitals Office Healthcare Records Management Steering Committee and was prepared by utilising published guidance from expert bodies, and existing best practice guidance and standards. Information has also been drawn from various expert groups and reference sources. A national consultation process was undertaken and feedback where appropriate, was incorporated into the final version of the Code.

The Code provides:

1. A framework for consistent, coherent healthcare records management in the National Hospitals Office. This applies to manual records and electronic records (where appropriate).

2. A reference point against which continual improvement and consultation can take place.

The Code applies to NHO hospitals and hospitals providing services on behalf of the Health Service Executive under S.39 of the Health Act 2004. It is allied to work being done on Programme One of the Service Transformation Programmes—*Develop integrated services across all stages of the care journey.*

This is an evolving document because standards and practices in relation to healthcare records management will change over time. It will therefore be subject to regular review and updated as necessary. We welcome and commend the Code of Practice as a means of helping staff to improve their performance in relation to healthcare records management.

Mr John O'Brien, Director of National Hospitals Office.

Dr Mary Hynes, Assistant National Director, National Hospitals Office, Quality, Risk and Customer Care.

Contents

The document has been prepared in seven main parts. There is an overall table of contents following the foreword. Each part of the document also has its own contents page, which provides a detailed breakdown of all the sections and subsections in that part of the document.

Part 1	**Background**	**This part provides the foundation for all standards and recommended practices detailed in the remainder of the document.**
Part 2	Standards	The standards for healthcare records management are described in this section.
Part 3	Recommended Practices for Clinical Staff	This part identifies the recommended practices that are intended to define correct healthcare records management for clinical staff.
Part 4	Recommended Practices for Healthcare Records Staff	This part identifies the recommended practices that are intended to define correct healthcare records management for healthcare records staff.
Part 5	Retention and Disposal Schedule	This part outlines the retention and disposal schedule for healthcare records in the National Hospitals Office.
Part 6	Audit Tool	The audit tool relates to the standards for healthcare records management in the National Hospitals Office.
Part 7	Additional Resources & Appendices	This part includes a glossary, list of abbreviations and a reference list. Appendices include the membership of the National Hospitals Office Healthcare Records Steering Committee and suggested membership for a healthcare records users group.

Contents

Contents

Part 3

Recommended practices for clinical staff

Contents

Contents

Contents

Part 1

Background

Contents – Background

1 Introduction

1.1 Communication

In hospitals the word 'communication' takes many forms, from a formal written document to an informal chat among colleagues. This communication involves the exchange of patient information among healthcare professionals. Structuring and organising patient information in the healthcare record is the responsibility of all users of the healthcare record and can result in improved patient safety and quality of care.

1.2 The importance of record keeping

Within the hospital, the healthcare record performs a number of functions in that it:

- Maintains the history of patient care.
- Records decisions relating to the care plan of the individual.
- Supports the workflow of the clinical and administrative functions within the hospital for clinicians and staff.
- Supports the communication with external sources of medical information such as laboratory and radiology departments as well as consultations and referrals with colleagues.
- Justifies care delivery in the context of legislation, professional standards, guidelines, evidence, research and professional and ethical conduct.

Records are a valuable resource because of the information they contain. High-quality information underpins the delivery of high-quality evidence based safe healthcare for patients, and many other key service deliverables. Information has most value when it is accurate, up to date and accessible when it is needed. An effective records management service ensures that information is properly managed, is available whenever and wherever there is a justified need for that information, and in whatever medium it is required and which is compliant with the relevant legislation.

1.3 Types of record covered by the Code of Practice

The standards and recommended practices contained in the Code apply to healthcare records of all types (including records of patients treated on behalf of the National Hospitals Office in the private healthcare sector where the National Hospitals Office healthcare record is used) regardless of the medium on which they are held.

Introduction

These may consist of:

- Patient healthcare records (electronic or paper based, including those concerning all specialties).
- Emergency department, birth, theatre, minor operations and other related registers.
- X-ray and imaging reports, output and images.
- Photographs, slides, and other images.
- Microform (i.e. microfiche/microfilm).
- Audio and video tapes, cassettes, CD-ROM etc.
- Computerised records.
- Scanned records.

2 The healthcare record

2.1 Introduction

The healthcare record refers to all information collected, processed and held in both manual and electronic formats pertaining to the patient and patient care. It includes demographics, clinical data, images, unique identification, investigation, samples, correspondences and communications relating to the patient and his/her care.

The healthcare record is a legal document designed to provide an overview of the patient's state of health before, during, and after a particular therapy. This overview is normally compiled by different steps:

- Handwritten notes made during clinical encounters.
- Particular events or changes in the patient's health condition that are subsequently entered into the hospital healthcare record.
- The entire body of information is summarized in a cumulative report at the time of patient discharge from the hospital. Each step depends on the healthcare professionals time, resources, experience, and healthcare record routines and may be susceptible to neglect and data loss if documentation cannot be recorded immediately.

2.2 Hospital environment

Many hospitals lack effective mechanisms for managing their records. This has resulted in significant amounts of information either being incorrectly filed or being recorded in poorly managed patient charts. Active management of such information is necessary to facilitate the efficient operation of the hospital and to promote the provision of a high quality, safe service to patients.

2.3 Information governance

Information is a vital asset in the healthcare management of individual patients and the efficient management of services and resources. It plays a key part in clinical governance, service planning and performance management. It is therefore essential that information is effectively managed and that appropriate policies, procedures and organisational structures provide a robust governance framework for information and knowledge management.

The healthcare record

- Each hospital should establish and maintain policies and procedures to ensure that patients are assured that their medical information is treated in confidence and not shared inappropriately. Maintaining a patient's confidentiality is not only an issue of professionalism: it is also a legal requirement as defined in the Data Protection Acts (1988) and (2003).

3 Healthcare records management

3.1 What is records management?

Records management is the systematic and consistent control of all records throughout their lifecycle.

- Systematic — Records need to be managed in a planned and methodical way.
- Consistent approach — Records of the same kind should be managed in the same way. Whether electronic or paper, the management of the record must be consistent.
- Consistency over time — Managing records is always vital whether resources are adequate or scarce.
- Control — Organisations need to control how records are produced, received, organised, registered, stored and retrieved, retained, destroyed or permanently preserved.
- All Records — This includes all documents, active and inactive, formal ones and informal regardless of the medium in which they are held.

To comply with good records management all hospitals should ensure that:

- Complete and accurate records of the hospitals' activities and decisions pertaining to patient care are created as soon as possible after the event.
- Each patient record is registered on the hospital information system.
- Any new information (whether created internally or received from elsewhere) is associated to its correct file title.
- Records are attached in the appropriate order for that file.
- Non-record documentary material, where appropriate, is associated with the official file.
- Records are kept secure and cannot be tampered with.
- Patient confidentiality is maintained at all times.
- All areas used for the storage of records are free of obvious hazards, are protected from fire and flooding, have stable levels of temperature and humidity, and are kept clean and tidy.

3.2 Other good practices

The following are other good records management practices:

- When a file has been closed, no further documents may be added.
- All documents received for filing should bear the appropriate file number in which the record is to be filed.
- Paper clips and pins must be removed from papers before filing, as these can damage the paper, and when rusted can be a health hazard.
- File covers should provide adequate protection for papers, and should be replaced if they become torn or damaged.
- Files must not contain any loose papers.
- Avoid duplication of papers—only one copy of papers need be filed.
- Files should not start with a paper referring to another paper that is not in the file (copy from another file if necessary).
- Everyone has a responsibility to ensure that all records are put in the correct order in the appropriate files.
- The staff member who initiates a document, is responsible for filing it, or ensuring that it is filed.
- The staff member who issues a document for comment or a form for completion, must ensure that a copy is placed on file.
- If replies or comments are received in response to this document, these replies/ comments must also be filed.

4 Development of healthcare records management Code of Practice

4.1 Introduction

The Code of Practice was developed as follows:

- Extensive literature search.
- Consideration of the opinion of experts knowledgeable in the subject.
- Consideration of the available current best practice, both in Ireland and internationally, that may impact on healthcare records management.[1]
- Development of draft standards and recommended practices for distribution for consultation to key stakeholders.
- Incorporation of feedback, where appropriate into the final version of the Code.

4.2 Definition

Standards = Organisational structures and processes needed to identify, assess and manage specified risks in relation to healthcare records management.

- Each standard has a **title**, which summarises the area on which that standard focuses.
- This is followed by the standard **statement**, which explains the level of performance to be achieved.
- The **rationale** section provides the reasons why the standard is considered to be important.
- The standard statement is expanded in the section headed **criteria,** where it states what needs to be achieved for the standard to be reached.

The Standards reflect the values and priorities of the National Hospitals Office and will be used to direct and evaluate healthcare records management in acute hospitals.

[1] *The Steering Committee would like to acknowledge the assistance of the link people in the NHO hospitals who submitted their hospitals' policies and procedures for consideration. The Steering Committee would also like to thank Professor Iain Carpenter and the Royal College of Physicians, UK for sharing their Draft Standards for Record Keeping – inpatients and their expertise with the Steering Committee.*

Development of the healthcare records management Code of Practice

Recommended Practices = recommendations concerning the structure and content of the hospital record and management of the healthcare records department.

The Recommended Practices are intended to define correct healthcare records management and to promote patient safety. They are also intended to serve as the basis for policy and procedure development in healthcare records management in acute hospitals.

- Each recommended practice has an **introduction**, which summarises the area on which the recommended practice focuses.
- This is followed by the recommended practice **scope**, which explains the objective of the recommended practice and why it is considered to be important.
- The contents section outlines the **contents** of the recommended practice.
- This is expanded in the section headed **procedure**, where it states how each recommended practice can be achieved.

National Hospitals Office Code of Practice for Healthcare Records Management

Part 2: Standards

Reader Information

Directorate:	National Hospitals Office (NHO)
Title:	NHO Code of Practice for Healthcare Records Management
Document Purpose:	Standards & Recommended Practices—Part 2
Author:	NHO Healthcare Records Management Steering Committee
Publication Date:	October 2007
Target Audience:	All staff in the NHO who work in healthcare records management
Description:	The Code of Practice is a guide to the standards of practice required in the management of healthcare records in the NHO, based on current legal requirements and professional best practice
Superseded Docs:	The retention and disposal schedule replaces the previous retention schedule on acute hospital records outlined on pages 8-9 of the 'Policy for Health Boards on Record Retention Periods' (1999). Version 2.0 replaces Version 1 of Code of Practice.
Review Date:	October 2008
Contact Details:	Winifred Ryan, National Hospitals Office, Quality, Risk and Customer Care Directorate, Mid-Western Regional Hospital (Nenagh) Nenagh, Co. Tipperary, Ireland. **Email**: winifred.ryan1@hse.ie **Web:** www.hse.ie

Part 2

Standards

Contents – Standards

Contents

Contents

1 Organisational structure and accountability

1.1 Standard Statement

Responsibility for healthcare records management in acute hospitals shall be clearly defined and there shall be clear lines of accountability throughout the hospital.

1.2 Rationale

The hospital CEO/Manager is responsible for ensuring that there are effective arrangements for healthcare records management in the hospital.

1.3 Criteria

1. Individual responsibility for healthcare records management shall be clearly defined. There shall be clear lines of accountability throughout the hospital from hospital management to healthcare records staff and all healthcare records users, including clinical staff.

2. The scope of responsibility shall include the competence of contractors where the hospital buys in services and professional liability where the hospital sells services to other organisations.

3. Healthcare records management shall be a standard item on the agenda of the quality and risk management committee (or appropriate committee) in the hospital. The healthcare records manager (or designated manager) shall submit regular reports on healthcare records management to the committee.

4. A twice yearly report on the effectiveness of healthcare records management shall be submitted to the quality and risk management committee (or appropriate committee) for review. This committee, which shall include in its membership the hospital CEO/Manager or CEO/Manager nominee, shall present the report to the hospital management team.

5. Each hospital shall identify a healthcare records manager (or designated manager...*see note below*). The duties of the manager shall not be confined to any one aspect of the healthcare records function but shall encompass all healthcare records processes wherever they occur within the hospital.

6. The healthcare records manager (or designated manager) shall have responsibility and authority for developing and monitoring policies, continuous quality improvement and/or strategies for healthcare records management for approval by the quality and risk committee (or appropriate committee).

Organisational structure and accountability

7. The healthcare records manager (or designated manager) shall attend appropriate meetings and conferences, local and national relevant to healthcare records management, which shall increase their knowledge and improve their ability to undertake the role.

8. The healthcare records manager (or designated manager) shall undertake the dissemination of all information, received from the National Hospitals Office/ relevant agencies relating to healthcare records management within the hospital.

9. The healthcare records manager (or designated manager) shall work with clinicians and departmental/line managers to develop and improve the systematic approach to healthcare records management.

10. The healthcare records manager (or designated manager) shall be responsible for ensuring that the healthcare records audit activity under the responsibility of each head of department has been completed.

11. The quality and risk committee (or appropriate committee) shall be responsible for the implementation and monitoring of a healthcare records audit and monitoring programme in each hospital.

12. Each relevant member of staff shall be made aware of their responsibility in relation to the healthcare record.

13. Each hospital shall have a specific and appropriate resource provision for the healthcare records service.

Note: Smaller hospitals may decide that the role of the healthcare records manager is best performed as part of the duties of a healthcare records manager in a larger hospital in the network. What is important is that:

- The hospital CEO/Manager takes active responsibility for healthcare records management.
- The resources devoted to healthcare records management are adequate.

2 Suitability of physical facilities

2.1 Standard Statement

The storage of healthcare records shall take place in a well designed, secure area, which shall be free of obvious hazards, shall be protected from fire and flooding and shall have stable levels of temperature and relative humidity. The facility shall be designed so that it is a secure department with **limited and restricted access.** For guidance see Health Building Note 47. Additional detailed guidance regarding the storage and exhibition of archival documents is available in BS 5454:2000.

2.2 Rationale

Healthcare records are exceptionally important records. They are usually kept for long periods of time, and may in some cases be selected for extended preservation. Suitable physical facilities safeguard the records from damage and destruction, optimise retrieval of records when required and provide a safe working environment.

2.3 Criteria

1. The area shall be maintained in a good condition and shall be cleaned regularly.
2. There shall be lighting over each gangway, including gangways that will exist when mobile units are in operation. The interior shall be light and pleasant with an adequate level of illumination that can be varied to suit functional activities, but overall levels of light shall be as low as possible, because light damages records and makes it more difficult to control temperature. If natural daylight already exists, or is provided for reasons of staff comfort and morale, the records shall be protected from the damaging effects of sunlight.
3. There shall be sufficient electricity supply, computer terminal points and work stations within the facility to allow optimum use of Information Technology (IT), Management Information Systems (MIS) and on-line training.
4. The ventilation system shall be appropriate to provide a comfortable working environment.
5. Temperature shall be maintained as close as possible to 18°C, because excessive heat damages records.
6. The floor covering shall contribute towards the creation of an attractive environment and shall not present a hazard to people with a disability or the movement of wheeled equipment.

Suitability of physical facilities

7. Confidentiality and security of healthcare records shall be maintained at all times; the healthcare records department shall be secure. Unauthorised access to the department shall not be possible.

8. The doors, floor and wall surfaces and furniture of healthcare records departments shall be designed to withstand the constant traffic of healthcare record trolleys and supply trolleys. To minimise damage, consideration shall be given to the use of protective corners and plates and to proper continuation of floor surfacing.

9. Healthcare records shall be stored on fixed and/or mobile shelving units. Other items of equipment which shall be available shall include kick stools and healthcare record trolleys for the movement of healthcare records. To facilitate the completion of tracer cards, trolleys with writing flaps shall be used.

10. There shall be suitable access and facilities for people with a disability who have problems of mobility or orientation. This shall include, besides the wheelchair-bound, those who for any reason have difficulty in walking and those with a sensory handicap such as a visual or hearing impairment.

11. Doors shall be wide enough to allow a clear space for people using a walking aid and for the passage of wheelchairs and trolleys. Door springs shall not be too strong; (otherwise access for people with a physical disability is very difficult).

12. Fire safety training shall be part of induction and orientation of all staff and shall be reinforced throughout their term of employment.

13. Staff shall be aware of the location of fire extinguishers in their work area and fire protection shall be available in high risk areas.

Note: Ideally Healthcare Records facilities should be designed to have alternative methods of heating as conventional wall mounted radiators will interfere with layout by obstructing shelving and hence capacity may be lost.

Shelf filing

14. Healthcare records shall be filed on metal shelves. Shelves shall be in 900mm runs, with side pieces and backing sheets. Note: The optimum length for a mobile unit is approximately 5.4m.

15. Shelves shall be 300mm deep and set with 380mm centres between shelves, and divided by supports at 300mm intervals. The edges of shelving and side pieces shall be rolled.

16. There shall be an adequate amount of space to store all records.

17. The highest shelf shall be accessible by all staff using a kick stool, which allows six levels of shelving.

Suitability of physical facilities

18. Gangways 900mm wide shall be provided between the rows of shelving to allow for trolleys and kick stools. Main access aisles shall be at least 1.5m wide to allow for trolleys passing each other, and for exit in the event of fire.

19. If mobile units are used, sufficient gangways and fixed units shall be allowed so that access is not impeded.

Storage facilities

20. Records shall be retrievable on a 24-hour/7 day arrangement to allow prompt treatment of:

- Emergency admissions.
- Elective admissions.
- Outpatient attendees.

Health and safety

21. A health and safety statement for the area shall be completed.

22. Where hazards are identified, risks shall have been assessed and appropriate control measures to reduce risk and improve staff safety shall be put in place.

3 Management and key personnel

3.1 Standard Statement

Appropriately qualified key personnel shall be in place to ensure that the healthcare records management service is provided efficiently and cost-effectively.

3.2 Rationale

To ensure a high quality and safe healthcare records management service.

3.3 Criteria

Key persons and responsibilities shall be as follows:

1. The *hospital CEO/Manager* shall put in place arrangements to ensure effective and efficient management of healthcare records.

2. A *healthcare records manager* (or designated manager) shall be appointed, shall have formally defined responsibilities in accordance with these Standards and shall be provided with the necessary resources to discharge these responsibilities.

3. The healthcare records manager (or designated manager) shall have an appropriate combination of experience and qualifications to undertake his/her role.

4. The healthcare records manager (or designated manager) shall have designated *healthcare records staff* for the hospital healthcare records service and shall ensure that these personnel have been trained to the necessary standard of competence.

5. *Healthcare professionals* shall have appropriate training on the principles of good record keeping and shall have a good knowledge of the National Hospitals Office recommended practices in relation to the structure and content of the healthcare record and healthcare records management.

6. Appropriate *ICT* expertise and support shall be available for healthcare records management.

4 Education and training

4.1 Standard Statement

Education and Training in relevant aspects of healthcare records management shall be provided to all new and existing staff members (both permanent and temporary).

4.2 Rationale

All clinical and administrative staff should have a general knowledge of the principles of the healthcare records management.

4.3 Criteria

1. **In addition to general induction training there shall be a structured healthcare records management foundation training programme for relevant managers and staff commensurate with their work activity/responsibility to include the following:**

   i. Confidentiality and security of the healthcare record.

   ii. Administrative Access Policy.

   iii. Data Protection Acts (1998) and (2003).

   iv. Freedom of Information Acts (1997) and (2003).

   v. National Hospitals Office Retention and Disposal Schedule.

   vi. Training specific to National Hospitals Office healthcare records management standards and recommended practices

   vii. Customer care.

   viii. Records management principles and practices.

   ix. Reference to healthcare professional standards for healthcare records management.

   x. Hospital in-patient enquiry system.

   xi. Healthcare informatics.

   xii. Information technology training specific to the healthcare records function.

Education and training

2. Induction training in healthcare records management shall be provided to each staff member (where relevant) and shall be recorded in the individuals training record.

3. There shall be a continuing programme of training (internal hospital training on NHO Code of Practice) and education (external professional education) for staff in healthcare records management. Departmental records of staff attendance at further training in healthcare records management shall be kept.

4. Training shall be supported with adequate resources and facilities.

5. Competencies in healthcare records management across the hospital shall be assessed and records shall be kept.

6. A formal appraisal system shall be in place to monitor staff performance and to identify individual training needs.

7. The hospital shall undertake an annual training needs analysis for healthcare records management and shall develop a training plan to support the needs identified.

5 Operational policies and procedures for healthcare records management

5.1 Standard Statement

Written policies, procedures and guidelines for the structure and content of the healthcare record and for the healthcare records service shall be based on National Hospitals Office recommended practices for healthcare records management, shall be available, implemented and shall reflect relevant legislation and published professional guidance.

5.2 Rationale

Formal documented control of healthcare records management within a quality management system is necessary to monitor each aspect of healthcare records management in order to demonstrate compliance with current legislation and guidance. This will reduce risks to patients, staff and the hospital.

5.3 Criteria

The hospital shall operate a quality healthcare records management system in accordance with the following key operational elements of ISO 15489-1, 2001.

1. The hospital shall have documented policies, procedures and guidelines for all of the key elements of healthcare records management as outlined in the recommended practices sections of the NHO Code of Practice. These policies, procedures (where assessed as relevant), shall include:

i. Communication with patients

ii. Confidentiality and Security of patient healthcare information

iii. Structure of the healthcare record

iv. Care and maintenance of the healthcare record.

v. Tracking the healthcare record.

vi. Filing the healthcare record.

vii. Storing the healthcare record.

viii. Retention and disposal of the healthcare record.

Operational policies and procedures for healthcare records management

ix. Managing the large healthcare record.

x. Dealing with duplicate healthcare records.

xi. Dealing with the missing healthcare record.

xii. Creating the temporary healthcare record.

xiii. Transporting the healthcare record off-site.

xiv. Dealing with requests for the healthcare record.

xv. Dealing with patient information requests.

xvi. Dealing with requests for the healthcare record for research purposes.

xvii. Clinic preparation.

xviii. Booking appointments.

xix. Patient admission and follow-up

xx. Patient discharge and transfer.

xxi. Did not attend policy.

xxii. Staff training.

2. All policies and procedures associated with healthcare records management shall comply with current legislation and National Hospitals Office guidance.

3. The quality and risk management committee (or appropriate committee) shall approve policies, procedures and guidelines for healthcare records management in the hospital.

4. There shall be a system to ensure each department or service has a current copy of the approved healthcare records management policies, procedures and guidelines pertinent to its activities.

5. All relevant hospital staff shall be required to read the healthcare records policies and procedures relevant to their area of work and to sign a statement to indicate that they have read, understood and will comply with same.

6. All policies and procedures associated with healthcare records management shall be controlled documents (showing date of issue and revision number) to ensure that current versions are available to all who need to use them.

7. Master copies shall be kept in a secure location.

8. Obsolete documents shall be removed from all points of use.

Operational policies and procedures for healthcare records management

9. A biennial review of all policies, procedures and documents associated with healthcare records management shall be undertaken to check their relevance and issue status.

10. A document management system for the control and management of healthcare records policies and procedures shall be available within the hospital.

11. All electronic data shall be stored securely, backed up and audited regularly.

12. Access to data/records shall be restricted to authorised named persons and specified information shall be maintained in line with the Data Protection Acts.

13. Staff shall have Intranet access.

6 Structure of the healthcare record

6.1 Standard Statement

All records relating to the patient shall be kept in a unified healthcare record file which shall be structured using the National Hospitals Office healthcare record order of filing. The structure shall facilitate documentation of the chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes. The structure shall also facilitate the monitoring of standards, audit, quality assurance and the investigation of complaints.

6.2 Rationale

A unified healthcare record will provide a safe and effective means of communication to all healthcare care providers in a structured agreed format which is easy to access.

6.3 Criteria

1. There shall be a unified healthcare record that all healthcare professionals use.
2. Each patient shall be assigned a unit number which shall be printed on the outside of the healthcare record chart and used as a unique identifier for that patient.
3. The hospital shall follow the National Hospitals Office agreed format for filing of information within the healthcare record.
4. Healthcare record chart covers shall be of 485 gsm quality manila, shall measure 312mm x 240mm, and shall have a gusset along the triple spine to allow for expansion to a maximum of 80mm as more documents are added. The dividers shall be of 200gsm quality card and shall have reinforced/laminated printed tabs.
5. There healthcare record shall contain a designated place for healthcare professionals to record actual allergies/alerts. There shall be a designated place for signing and dating these allergies/alerts.
6. Healthcare records that have become too full (approx. 80mm thick) shall be closed and a new volume shall be opened.
7. There shall be a designated place to indicate the volume number, the date for opening and closing the new volume and the name(s) of the staff member who has opened/closed the healthcare record volume.

Structure of the healthcare record

8. The tracking system shall be updated to include the new volume with any alerts being reproduced on the inside cover.

9. There shall be an appropriate procedure in place to identify duplicate and temporary charts.

10. If more than one set of patients' charts exists, robust and effective systems shall be in place to bring the sets together quickly and effectively.

11. Where there is more than **one** patient identifier, there shall be a cross-referencing system in place on the Patient Administration System (PAS).

12. There shall be no loose documents in the healthcare record.

13. Documents not held in the patient's healthcare record chart shall be stored securely and linked by the patient's unique identifier.

7 Content of the healthcare record

7.1 Standard Statement

The content of the healthcare record shall provide an accurate chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes. The content of each record shall comply with clinical guidance provided by professional bodies and legal guidance provided by the Clinical Indemnity Scheme. This standard shall apply to both hardcopy and electronic documentation.

7.2 Rationale

The healthcare record and its content form an essential part of care allowing communication between healthcare professionals and demonstrating that the practitioner's duty of care has been fulfilled.

7.3 Criteria

Policies and procedures

1. The hospital shall have policies and procedures for the content of the healthcare record.
2. These policies and procedures shall take account of national guidelines on legal and clinical practice requirements.

Implementation of content policy

3. There shall be a written agreed programme for the audit of conformance with healthcare records content policies and procedures.
4. This programme shall apply to each clinical speciality and department.
5. Audit results shall be fed back to staff and shall be used to help to inform and improve healthcare records content practices.

NOTE: The Steering Committee would like to thank the Dublin Hospitals Group Risk Management Forum Documentation sub-committee for their advice and input into Standard 7: Content of the Healthcare Record

Content of the healthcare record

Correct identification

6. The patient's name shall be on each side of each page where patient information is documented and each page shall have the correct unique patient identification number and/or label. This shall also apply to every screen on computerised systems.

7. There shall be no blank spaces or pages between entries.

8. Before the healthcare professional makes an entry in the patient's healthcare record, s/he shall establish that the record belongs to the patient being attended. This shall be done by verifying with the patient and by cross-referencing the patient's wrist band with the healthcare record.

Legibility

9. All documentation shall be clear and legible.

10. When prescribing, writing shall be in un-joined lower case text or block capitals.

11. All entries shall be dated, timed and signed with a clear signature, printed name, title and bleep number (where relevant).

12. All entries shall be in permanent black ink.

Documenting date and time

13. It shall always be clear from the patient record the time that an event occurred and the time that a record was made.

14. The time (24 hour clock) and date (day/month/year) shall be noted against each clinical entry.

15. All entries shall be accurate in relation to date (day/month/year) and time.

Author identification

16. Each hospital site shall have an up to date signature bank of all clinical staff and non-clinical staff that may have occasion to write in the healthcare record.

17. Identification stamp pens, which have the clinician's name printed on a stamp attached to the pen, shall be permissible.

18. All signatures shall be accompanied by a printed name.

Content of the healthcare record

Corrections

19. Records shall not be erased or destroyed but shall be amended if incorrect.

20. Correction fluids shall not be used. The original entry shall remain visible.

21. Deletions or alterations shall be made by scoring out with a single line followed by:

    - Signature (plus name in capitals) and counter signature, if appropriate.
    - Date and time of correct entry.
    - Reason for amendment.

22. Corrections shall be made as close to the original recording as possible.

23. Alterations to prescriptions shall not be permissible. A prescription that is no longer appropriate shall be discontinued and a new prescription shall be written.

Documenting evidence of care

24. Records shall provide information on physical, psychological and social factors that may affect the patient.

25. The chronology of events and reasons for any decision made shall be recorded in the context of a thorough assessment of the patient including relevant history taking.

26. Records shall provide accurate, correct, comprehensive and concise information concerning the condition and care of the patient or client and associated observations.

27. Information shall be factual.

28. All entries in the record by healthcare professionals shall be made as soon as possible after each intervention and at least once every 24 hours during the working week for acute inpatient episodes. There shall be an entry in the record at least twice a week for rehabilitative care.

29. Every record entry (clinician related) shall identify the most senior clinician present at the time the entry was made.

30. The name of the primary clinician who is assuming overall responsibility for the patient's care shall be clearly identifiable in the healthcare record at all times. The name in the patient's record shall be the same clinician's name entered into the Patient Administration System (PAS). Should the primary clinician change during the course of treatment, this shall be noted on the healthcare record and on the PAS.

31. Input into all records shall be multidisciplinary.

Content of the healthcare record

Retrospective entries

32. Retrospective documentation shall be:

- Dated.
- Timed.
- Signed (and counter signed as appropriate).

33. The reason why the retrospective entry is being made shall be clearly stated.

34. It shall be clear that the entry is a retrospective entry.

Abbreviations

35. Abbreviations shall not be used. In the event of abbreviations being utilised, only abbreviations approved by the National Hospitals Office may be permitted.

36. All approved abbreviations shall be written in higher case (capital) BLOCK letters and not in a cursive script and/or in lower case.

37. Other than the abbreviations approved by the National Hospitals Office, on each side of each page the full term shall be used, followed by the abbreviation in brackets. Thereafter the abbreviation may be used on that page.

38. Abbreviations shall not be used on documentation which is used for transfer, discharge or external referral letters.

39. Abbreviations shall not be used on consent forms, death certificates, incident report forms and communications sent from the hospital.

Note: Drugs names shall not be abbreviated (see medications).

Relevancy

40. Records shall be objective and shall describe what is observed.

41. If an incident has not been observed but is relevant to client care then this shall be clear e.g. patient states that...

Content of the healthcare record

Verbal instructions

42. Instructions regarding patient care from a healthcare professional via the telephone shall be documented, dated, signed and counter-signed by the healthcare professional responsible for giving the instructions.

43. If no instructions were given, this shall also be documented.

Abnormal results

44. There shall be a note in the clinical record of any significant abnormal results found or communicated to the healthcare professional. This shall include a record of who has been informed e.g. healthcare professional's name. This note shall be made by the appropriate healthcare professional.

Medications

45. Drugs shall only be administered and documented in the presence of clear unambiguous prescriptions and in accordance with hospital policies.

46. Drug names shall never be abbreviated under any circumstances.

47. Generic names ONLY shall be used for the drug chart.

48. The choice of therapeutic agents used shall remain the responsibility of the clinician.

Language

49. Records shall be written in English.

50. Records shall be completed in terms that the patient and/or the healthcare professional can understand.

51. Records shall be supported by explanations where this may not be possible.

52. Records shall be phrased clearly and unambiguously.

53. Records shall be objective, factual, devoid of jargon, witticisms or derogatory remarks.

Advice

54. Healthcare professionals advice on care, in any format (e.g. verbal, leaflet), shall be documented in notes of advice given.

Content of the healthcare record

Patient registration

55. The hospital shall have a system that allocates a unique patient identifier to each patient. Only one record number shall be assigned to each patient. If a patient has been assigned more than one record number, there shall be robust and effective systems in place to merge the records quickly and effectively ensuring that each record has been cross-referenced on the Patient Administration System (PAS). Registration information shall include the following:

    - Title.
    - Full name (forename and surname). The forename should be the name on the patient's birth certificate.
    - Alias: The name by which the patient likes to be known, if different from the patient's name.
    - Address.
    - Two contact telephone numbers (landline and mobile, if possible).
    - Next of kin/Contact in the case of an emergency (name and address).
    - Two contact telephone numbers (landline and mobile, if possible).
    - Patient date of birth.
    - Previous address.
    - Gender.
    - Marital status.
    - Patient's GP and GP contact details.
    - Healthcare record number assigned at registration.
    - Admission referral source.
    - Medical insurance.
    - Mothers maiden name
    - Religious preferences.
    - Ethnicity.
    - Spoken language (indicate if an interpreter is needed).
    - Occupation.

Content of the healthcare record

Patient alerts and allergies

56. Alerts and allergies shall be recorded on the inside of the cover of the healthcare record chart.

57. The information shall be signed and dated and there is an end date for the alert, if appropriate.

58. The hospital shall have a clear procedure regarding who should enter alerts into the healthcare record, when alerts should be entered and the procedure for removing alerts from the healthcare record. These procedures shall be adhered to.

Referral letters

59. Referral letters shall be date stamped on receipt in every department.

60. All referrals shall be recorded on the appropriate ICT management system.

61. All referrals shall be assessed by the appropriate healthcare professional and marked as routine or urgent depending on their clinical need.

62. Where waiting lists exist, the patient's name shall be placed on the waiting list.

63. Where there are no waiting lists, the patient shall be issued with an appointment, if appropriate.

64. The GP/referral source shall be notified of the outcome of the referral.

Admission entry

65. The following minimum, general patient information shall be included in the record entry for acute medical admissions and may also be supplemented with additional specialty information:

    - Reason for clinical encounter.
    - Presenting problem/complaint.
    - History of presenting problem.
    - Current diagnoses.
    - Patient Alerts/Allergies (this should also be recorded on the inside of the front cover).
    - Past illnesses.
    - Procedures and investigations.

Content of the healthcare record

- Medications and diets including nutritional supplements.
- Social circumstances.
- Functional state (Self-care/baseline mobility/walking aids and appliances)
- Family history.
- Systems review.
- Examination findings.
- Results of investigations.
- Problem list.
- Overall assessment.
- Management plan.
- Intended outcomes.
- Information given to patient.

Follow-up entry

66. The following patient information shall be included in the follow up entries for acute medical admissions:

- Reason for clinical encounter.
- Review of case.
- Overall assessment including any change since previous encounter.
- Management care plan.
- Information given to patient and carers.

Content of the healthcare record

Transfer and discharge communication

67. The transfer or discharge communication shall include information under the following headings:

- Hospital Name.
- Patient identification information.
- Validating clinician name and contact details.
- Ward or department or specialty issuing the discharge document.
- Patients' registered GP details/referring clinician if different.
- Admission details.
- Discharge details.
- Final diagnosis.
- Current diagnoses (note if primary or secondary).
- Patient alerts/allergies.
- Procedures and investigations.
- Medications and diets including nutritional supplements.
- Functional state (Self-care/baseline mobility/walking aids and appliances).
- Systems review.
- Examination findings.
- Results of investigations.
- Relevant information on administration of medicines.
- Problem list.
- Any complications.
- Infection status (as appropriate).
- Management care plan.
- Intended outcomes.
- Information given to patient.
- The name and title of the receiving clinician in the case of a transfer.

Content of the healthcare record

68. Transfer/Discharge communications shall be multi-disciplinary where multi-disciplinary care is to be continued.

69. A copy of the transfer/discharge communication which is completed within 48 hours of the patients discharge shall be sent to the patients GP and a further copy is retained in the record.

70. Transfer/discharge communication shall be authorised by the relevant responsible healthcare professionals.

Communication with patients

71. All relevant communication with patients and families shall be documented in the relevant part of the healthcare record.

Documenting consent in the healthcare record

72. Consent shall:

- Be easily and clearly identifiable either on a consent form, which is retained as part of the clinical record, or in the case of verbal consent, documented within the clinical record.
- Contain no abbreviations.
- Clearly state the procedure/treatment/care involved and the risks and benefits of that procedure.
- Clearly identify the patient by name and healthcare record number.
- Clearly identify who has granted or refused consent and/or their relationship to the patient in the case of parent/guardian.
- Have a documented record of what appropriate patient/client information or relevant discussions has been provided to the patient/guardian detailing the procedure/treatment/care, risks, benefits and/or alternative.
- Have a documented record of how this information has been provided (e.g. patient/client information leaflets, verbally etc).
- Be dated and signed by the healthcare professional obtaining the consent, including full name and grade.

73. Verbal consent shall be documented in the clinical record and shall clearly identify the witness, e.g. by name and grade.

74. This standard shall apply to both hardcopy and electronic documentation.

Content of the healthcare record

Patient wishes

75. The involvement of the patient in decisions about his or her care shall be documented in the record under 'patient wishes'.

76. Living Wills or Advance Directives shall be clearly recorded in the notes alongside any resuscitation statements.

Death entry

77. The death entry shall contain the following information:

- Date and time the patient was confirmed dead.
- Date and time of the entry in the record.
- Name and designation of the clinician certifying the patient's death in block capitals.
- Examination made establishing death.
- Events leading to death and cause(s) of death.
- Signature of the clinician certifying death.
- Final diagnosis (to include principal diagnosis and all procedures).

Death notification form

78. When the death notification form is completed, an entry shall be made in the record stating:

- The cause of death as appearing on the death notification form.
- Whether a cremation form has been completed.
- Whether and how the deceaseds' relatives have been informed.
- Whether and how the General Practitioner has been or will be informed.

79. A discharge summary form shall be completed in the event of death.

Content of the healthcare record

Post mortem

80. When a hospital post mortem is performed a provisional diagnosis shall be noted in the healthcare record within 72 hours of confirmation of death and the healthcare record shall be completed within one month following the death (this does not include paediatric post mortems).

81. A consent form for the post mortem shall be filed in the healthcare record.

82. A record of all post mortem meetings with parents, social workers and the multidisciplinary team shall be documented in the healthcare record.

83. A copy of the hospital post-mortem report shall be filed in the healthcare record.

Confidentiality and security

84. Procedures shall be in place within the hospital regarding the confidentiality and security of patients' healthcare records.

85. There shall be a clause in all staff contracts regarding confidentiality of patient care.

86. Ongoing training regarding confidentiality shall take place at local level.

8 Audit and monitoring

8.1 Standard Statement

Audits shall be carried out to ensure that the procedures for healthcare records management conform to the required Standards and that the processes undertaken conform to the procedures. The audit results shall be used to identify opportunities for improvement.

8.2 Rationale

Audit is necessary to provide evidence that the system of healthcare records management in place is effective.

8.3 Criteria

1. Audit of healthcare records management shall include:

   - Accountability arrangements.
   - Staff knowledge, expertise and resources.
   - Processes, including risk management arrangements.
   - Policies, procedures and guidelines.

2. Each relevant head of department shall be responsible for preparing a written agreed programme which shall ensure that all aspects of healthcare records management within their department are audited at least once a year.

3. Each relevant head of department shall be responsible for ensuring that the audit is conducted in accordance with this programme.

4. Each relevant head of department is responsible for ensuring that remedial actions are carried out for any deficiencies found and for verifying the efficacy of remedial actions undertaken.

5. The healthcare records manager (or designated manager) shall be responsible for ensuring that the audit activity, under the responsibility of each relevant head of department has been completed.

6. The quality and risk committee (or appropriate committee) shall be responsible for the implementation and monitoring of a healthcare records audit and monitoring programme in each hospital.

Audit and monitoring

7. Audit results shall be fed back to the healthcare records manager (or designated manager), the healthcare records committee, relevant staff and the hospital management team.

8. Audit results shall be included in the quality and risk management annual report (or appropriate annual report).

9. Audit results shall be used to help to inform and improve healthcare records management practices.

10. The audits shall be carried out by appropriately trained auditors.

11. The hospital management team shall submit an annual assurance statement on audit findings for consideration and approval by the Network Manager.

12. The Network Managers shall submit annual assurance statements to the Director of the National Hospitals Office.

13. External national audits of healthcare records management shall be carried out as appropriate under the direction of the Assistant National Director, National Hospitals Office, Quality, Risk and Customer Care.

9 Key performance indicators

9.1 Standard Statement

Key performance indicators that are capable of showing improvements in the efficacy of healthcare records management in the hospital shall be used.

9.2 Rationale

Key performance indicators are designed to demonstrate improvement in the performance of healthcare records management services over time.

9.3 Criteria

Environment

1. Confidentiality of healthcare records shall be maintained at all times. The healthcare records department shall be secure. Unauthorised access to the department shall not be possible.

2. Healthcare records shall be retrievable on a 24/7 day arrangement to allow prompt treatment of emergency admissions, elective admissions and outpatient attendees.

3. The storage of healthcare records shall take place in a well designed, secure area, which shall be free of obvious hazards, shall be protected from fire and flooding and shall have stable levels of temperature and relative humidity.

The healthcare record

4. There shall be a unified healthcare record that all healthcare professionals use.

5. There shall be no loose documents in the healthcare record chart.

6. The patient's name shall be on each side of each page where patient information is documented and each page has the correct unique patient identifier. This shall also apply to every screen on computerised systems.

7. All entries in the record by healthcare professionals shall be made as soon as possible after each intervention and at least once every 24 hours during the working week for acute inpatient episodes. There shall be an entry in the record at least twice a week for rehabilitative care.

Key performance indicators

8. All entries shall be dated, timed and signed with a clear signature, printed name, title and bleep number, where relevant.

9. There shall be a signature bank of all clinical staff and non-clinical staff that may have occasion to write in the healthcare record.

Management and personnel

10. The *hospital CEO/Manager* shall put in place arrangements to ensure effective and efficient management of healthcare records.

11. A *healthcare records manager* (or designated manager) shall be appointed, shall have formally defined responsibilities in accordance with these Standards and shall be provided with the necessary resources to discharge these responsibilities.

12. The healthcare records manager (or designated manager) shall have designated *healthcare records staff* for the hospital healthcare records service and shall ensure that these personnel have been trained to the necessary standard of competence.

Education and training

13. Induction training in healthcare records management shall be provided to each staff member (where relevant) and shall be recorded in the individuals training record.

14. A formal appraisal system shall be in place to monitor staff performance and to identify individual training needs.

Audit and monitoring

15. The hospital management team shall submit an annual assurance statement on audit findings for consideration and approval by the Network Manager.

16. Audit results shall be used to help to inform and improve healthcare records management practices.

Key performance indicators

Service quality

17. Staff, patients and key stakeholders shall be encouraged to use feedback procedures to the hospital for any concerns/level of satisfaction in relation to healthcare records management in the hospital.

18. The hospital shall have in place a formal system for recording and analysing customer complaints in relation to healthcare records management.

19. The hospital shall have in place a programme to reduce customer complaints in relation to healthcare records management.

10 Communication and consultation

10.1 Standard Statement

All information provided to patients shall be delivered in a form which is clear, courteous and which the patient can understand.

10.2 Rationale

The way in which information is given to the patient can help the patient to understand their illness, management options and the reasons for intervention.

10.3 Criteria

1. All communications shall be delivered in a form and manner that the patient understands.
2. All communications with patients shall be personalised and the information concerning the appointment, date, time, location and special instructions shall be written clearly and without ambiguity.
3. All relevant staff shall receive formal training in customer care, telephone skills, communication skills and in using the patient systems appropriate to their area of work.
4. Communication with patients shall take account of local ethnic minorities and non-Irish nationals.
5. Communication with patients shall take place in a confidential manner and patient privacy shall be respected.
6. Staff, patients and key stakeholders shall be encouraged to use feedback procedures to the hospital for any concerns/level of satisfaction in relation to healthcare records management in the hospital.
7. The hospital shall develop and implement a practical methodology for sharing best practice both internally and with key stakeholders in relation to healthcare records management.
8. The hospital shall have in place a formal system for recording and analysing customer complaints in relation to healthcare records management.
9. The hospital shall have in place a programme to reduce customer complaints in relation to healthcare records management.

11 Clinical coding

11.1 Standard Statement

The hospital shall use HIPE (Hospital In-Patient Enquiry System), a computer based health information system which collects clinical and administrative data on discharges, day cases and deaths from acute hospitals.

11.2 Rationale

HIPE coding performs an essential function in providing quality, accurate and uniform health information and greatly contributes to the continuous growth of health knowledge.

11.3 Criteria

1. Clinical coders shall undergo regular training under the guidance of the HIPE Unit, Economic Social Research Unit (ESRI).
2. The coding system used shall be ICD-10-AM 4th edition (the Australian modification of the international classification of diseases produced by the World Health Organisation).
3. Clinical staff shall participate in validating the coding process.
4. Clinical coding shall be complete for all inpatient and day case episodes within the timescale set down by the Department of Health and Children/ ESRI guidelines, i.e. March 31st and September 30th.
5. The HIPE coordinator shall be responsible for and shall implement regular audits of the quality of clinical coding.

National Hospitals Office Code of Practice for Healthcare Records Management

Part 3: Recommended Practices for Clinical Staff

Reader Information

Directorate:	National Hospitals Office (NHO)
Title:	NHO Code of Practice for Healthcare Records Management
Document Purpose:	Standards & Recommended Practices—Part 3
Author:	NHO Healthcare Records Management Steering Committee
Publication Date:	October 2007
Target Audience:	All staff in the NHO who work in healthcare records management
Description:	The Code of Practice is a guide to the standards of practice required in the management of healthcare records in the NHO, based on current legal requirements and professional best practice
Superseded Docs:	The retention and disposal schedule replaces the previous retention schedule on acute hospital records outlined on pages 8-9 of the 'Policy for Health Boards on Record Retention Periods' (1999). Version 2.0 replaces Version 1 of Code of Practice.
Review Date:	October 2008
Pictures:	All pictures in this document were taken with the kind assistance of the staff in South Tipperary General Hospital.
Contact Details:	Winifred Ryan, National Hospitals Office, Quality, Risk and Customer Care Directorate, Mid-Western Regional Hospital (Nenagh) Nenagh, Co. Tipperary, Ireland. **Email**: winifred.ryan1@hse.ie **Web:** www.hse.ie

Part 3

Recommended Practices for Clinical Staff

Contents – Part 3

Structure of the healthcare record

Content of the healthcare record

Contents

Figures—Structure of the healthcare record

Contents

Structure of the Healthcare Record

1 Unified healthcare record

1.1 Introduction

It is considered to be in the best interest of patients and their care that the full history of their care is available to the current multidisciplinary team. The healthcare record should follow the patient through every discipline in the hospital in which that patient receives care. Documents within the record should reflect the continuum of patient care.

1.2 Scope

The objective of this procedure is to ensure that all patients treated in the hospital have a unified healthcare record, in order to provide comprehensive clinical information for effective treatment.

1.3 Contents

Section One: Healthcare record chart

Section Two: Contents of the healthcare record

Section Three: Marking the healthcare record chart

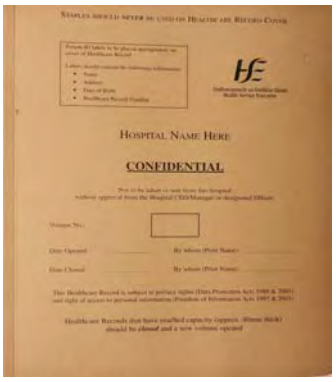


Figure 1-1: National Chart

1.4 Procedure

Section One: Healthcare record chart

- Healthcare record charts should be of 485 gsm quality manila, measure 305mm x 240mm, and have a gusset along the triple spine to allow for expansion to a maximum of 80mm as more documents are added. The dividers should be of 200gsm quality card and should have reinforced/laminated printed tabs.
- Each patient is assigned a unit number which is printed on the outside of the healthcare record chart and used as a unique identifier for that patient.

Unified healthcare record

Section Two: Contents of the healthcare record

Figure 1-2: Sections of the healthcare record

- ***Administrative Section***
- Patient labels.
- Registration Sheet.
- Relevant Billing/Private Insurance Forms (pending completion only).
- ***Correspondence Section***
- Referral Letters.
- Discharge Communication.
- Ambulance Transfer Sheets.
- Other correspondence relevant to patient care.
- ***Clinical Notes***
- Clinical Notes (inpatient and outpatient).
- Patient Emergency Department Card.
- ***Nursing Notes***
- Temperature & Observation Sheets.
- Fluid Balance Sheets.
- Nursing Care Plans.
- Intensive Care Unit Nursing Notes.
- Theatre Nursing Care Plans.
- Evaluations.
- ***Procedure***
- Procedure Forms.
- Anaesthetic Records.
- Epidural Infusion Records.
- Implants Record.
- Blood Loss Sheet.
- Swab Count Sheet.

Unified healthcare record

- Instrument Count Sheet.
- Theatre Checklist.
- Post-operative orders from the surgeon.
- **Consent**
- Consent Forms
- ***Clinical Measurement***
- Cardiovascular/Haemodynamic.
- Vascular.
- Neurophysiology.
- Pulmonary Function.
- GIT Physiology.
- Urologic Physiology.
- Audiology Reports.
- EEGs.
- ***Laboratory Results***
- Biochemistry Results.
- Haematology/Blood Group Results.
- Microbiology Results.
- Immunology Results.
- Histopathology and Hospital Post-Mortem Reports.
- Molecular Diagnostic Results.
- ***Radiology and Diagnostic Imaging Results***
- Radiology and Diagnostic Imaging Reports.
- Videofluoroscopy Reports.
- ***Prescribed Medicines and Nutritional Supplements***
- ***Health and Social Care Professionals***

Unified healthcare record

Section Three: Marking the healthcare record chart

- When a healthcare record chart is created, ensure that the **volume number** and the **date opened** are clearly marked, dated and signed on the front cover.
- Ensure the **patient identifier** is placed in the appropriate space on the cover of the healthcare record chart.
- In the absence of an electronic monitoring system a current **year sticker** should be applied to indicate chart activity.
- Ensure **colour sticker** is placed on the healthcare record chart to facilitate terminal digit filing in the healthcare record library.
- Ensure **RIP sticker** is placed on the front cover of the healthcare record chart in the event of patient death.
- Ensure (removable) **warning sticker** is placed on the front cover of the healthcare record chart in the event that there are two patients with the same first and second names in the same location.

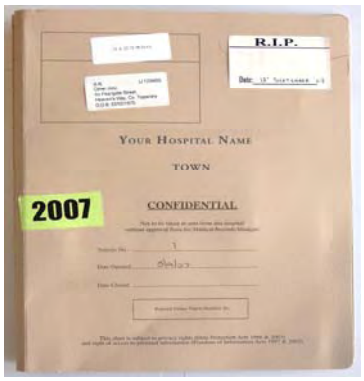


Figure 1-3: RIP sticker

Figure 1-4: Warning sticker

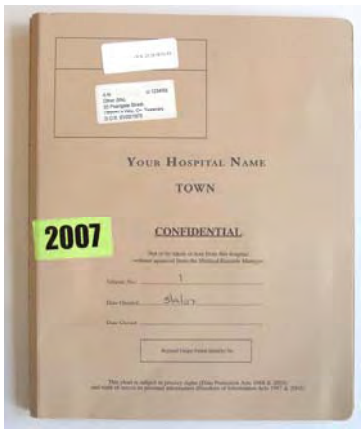


Figure 1-5: Year sticker

Figure 1-6: Terminal digit filing sticker

2 Healthcare record order of filing

2.1 Introduction

Good healthcare records are needed for good patient care. To ensure that patients are treated efficiently and effectively the current medical team need easy access to high quality healthcare records. All staff should be aware of their responsibilities for the upkeep, correct filing and acceptable presentation of healthcare records.

2.2 Scope

Correct filing in the healthcare record is extremely important for ease of retrieval of information and also to assist in the coding of these healthcare records.

2.3 Contents

Section One: Administrative section

Section Two: Correspondence section

Section Three: Clinical notes

Section Four: Nursing notes

Section Five: Procedure and consent

Section Six: Clinical measurement

Section Seven: Laboratory results

Section Eight: Radiology and diagnostic imaging results

Section Nine: Prescribed medicines

Section Ten: Health and social care professionals

2.4 Procedure

Directions for entry/filing of information are provided on the divider of each section of the chart and should be adhered to.

Healthcare record order of filing

Section One: Administrative section

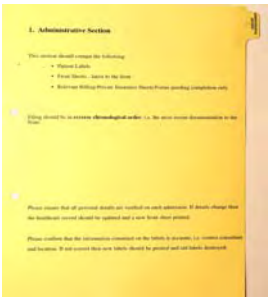


Figure 2-1: First Divider—Administrative Section

- There should be a current, dated front sheet in the front of the healthcare record chart for every patient's first point of contact with the hospital. This sheet contains the patient's personal details. Thereafter, patient details on the front sheet are checked for accuracy on each patient attendance. If there is any change in patient details a current, accurate front sheet is placed in the front of the healthcare record chart.
- Administrative staff who record or input information must be identified on the patient's front sheet.
- All details should be obtained at time of registration/admission. In the event that some details are omitted, then it becomes the responsibility of any member of staff who is dealing with the patient to obtain the missing information from the patient or the patient's relatives at the earliest opportunity and pass this on to the appropriate personnel.
- This information should be passed onto the admissions office or ward clerk for entry into hospital information system and then an updated front sheet provided.
- There should be sufficient addressographs labels in the administrative section at all times.
- All addressographs are checked for accuracy on each patient attendance. If there is any change in patient details the addressographs are to be removed from the healthcare record chart, shredded and replaced with a current, accurate set.
- The minimum data set on each patient label should include the following patient information—healthcare record number, name, address, date of birth, clinician and department.

Section Two: Correspondence section

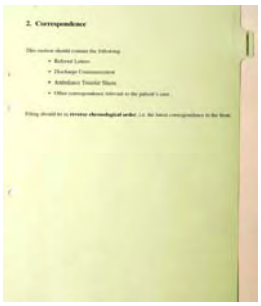


Figure 2-2: Second Divider—Correspondence

- This section contains referral letters, discharge communications and any other correspondence relevant to the patients care.
- Filing should be in reverse chronological order, i.e. the most recent documentation to the front; this includes the letters sent to and from the hospital.
- Do not store more than one copy of each letter of correspondence unless notes have been made on both copies.

Healthcare record order of filing

Section Three: Clinical notes

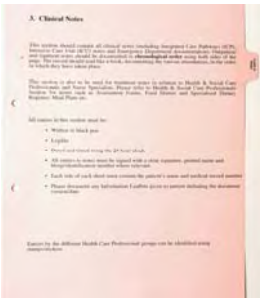


Figure 2-3: Third Divider—Clinical Notes

- Each side of each sheet where patient information is documented must have an addressograph. In the absence of addressograph labels, the patient's name, healthcare record number and date of birth should be written.
- All entries must be dated, timed and signed with a clear signature, printed name, title and bleep number, where relevant.
- Filing should be in chronological order. The record should read like a book, documenting the various attendances, in the order in which they have taken place.
- Any page seen to be falling out must be reinforced and filed back into the appropriate place.
- The medical social worker should determine if it is appropriate to include certain sensitive information in this section of the healthcare record.
- Any audio-visual recordings taken by healthcare professionals should be documented in this section of the healthcare record.

Section Four: Nursing notes

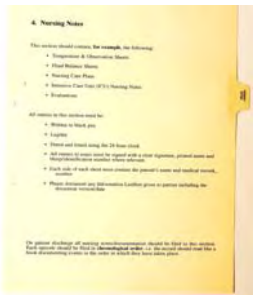


Figure 2-4: Fourth Divider—Nursing Notes

- This section is for all relevant nursing documentation.
- Each side of each sheet where patient information is documented must have an addressograph. In the absence of addressograph labels the patient's name, date of birth and healthcare record number should be written.
- All entries must be dated, timed and signed with a clear signature, printed name, title and bleep number where relevant.
- Filing should be in chronological order, i.e. the record should read like a book documenting events in the order in which they have taken place. This allows prompt and precise retrieval of data.
- Any audio-visual recordings taken by nursing staff should be documented in this section of the healthcare record.

Healthcare record order of filing

Section Five: Procedure

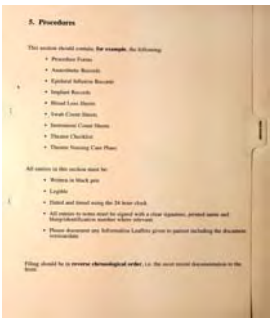


Figure 2-5: Fifth Divider—Procedures Section

- Each side of each sheet where patient information is documented must have an addressograph. In the absence of addressograph labels the patients name, healthcare record number and date of birth should be written.
- All entries must be dated, timed and signed with a clear signature, printed name and bleep number where relevant.
- The procedure note for all procedures must be held in this section, although the corresponding report may be filed elsewhere.
- Filing should be in reverse chronological order, i.e. the most recent documentation to the front.

Section Six: Consent

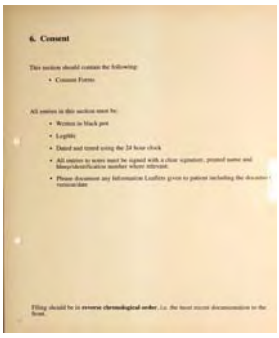


Figure 2-6: Sixth Divider—Consent Section

- Each side of each sheet where patient information is documented must have an addressograph. In the absence of addressograph labels the patients name, healthcare record number and date of birth should be written.
- Each operation/procedure record must have a corresponding consent form filed with it.
- All entries must be dated, timed and signed with a clear signature, printed name and bleep number where relevant.
- Filing should be in reverse chronological order, i.e. the most recent documentation to the front.

Section Seven: Clinical measurement

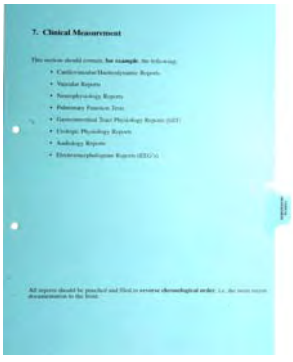


Figure 2-7: Seventh Divider—Clinical Measurement Section

- An addressograph should be placed on each sheet/ report. In the absence of addressograph labels the patient's name, healthcare record number and date of birth should be written.
- All sheets/reports should be punched and filed in reverse chronological order, i.e. the most recent documentation to the front.
- Only one copy of each report to be filed in this section unless notes have been made on both copies.

Healthcare record order of filing

Section Eight: Laboratory results

Figure 2-8: Eighth Divider—Laboratory Results

- The laboratory results section is sub-divided and has corresponding mount sheets as follows:
  - i. Biochemistry results (green)
  - ii. Haematology/Blood Group results (pink)
  - iii. Microbiology results (yellow)
  - iv. Immunology results (blue)
  - v. Histopathology results and Hospital Post Mortem reports (A4 white)
  - vi. Molecular Diagnostics (grey)
- All reports must be signed within twelve hours of the result being delivered back to the ward. This signature is placed on the results form adjacent to the results.
- All reports must be signed by a clinician before being filed. The resulting action to be taken is recorded in the healthcare record.
- Laboratory results should not be filed unless they have been signed as read and action taken by a clinician.
- Only one copy of each report to be filed.
- Each mount sheet has eleven self-adhesive strips which facilitates the filing of eleven reports on each sheet. These are numbered with number one being the first report to be filed, etc.
- While every effort is made to file reports in date order, it is advisable to check the date of the report that you are referring to.
- When a mount sheet is full, additional reports should never be sellotaped or stapled to the full mount sheet. A new mount sheet should be added in reverse chronological order with the most recent mount sheet on top for each result type.
- The mount sheet should correspond to the colour of the laboratory result forms.
- A5 (small) reports should be filed on the radiology mount sheet from the bottom of the page upwards.
- A4 (full page) reports should be punched and filed directly behind the mount sheet in reverse chronological order.

Healthcare record order of filing

Section Nine: Radiology and diagnostic imaging results

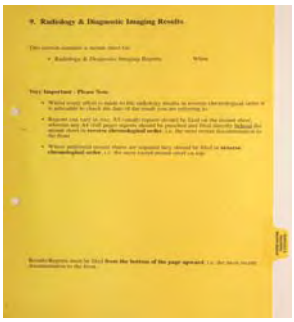


Figure 2-9: Ninth Divider—Radiology & Diagnostic Imaging Results

- This section contains radiology and diagnostic imaging reports.
- All reports must be signed within twelve hours of the result being delivered back to the ward. This signature is placed on the results form adjacent to the results.
- All reports must be signed and dated by a clinician before being filed. The resulting action to be taken is recorded in the healthcare record.
- Radiology and Diagnostic imaging results should not be filed unless they have been signed as read and action taken by a clinician.
- Only one copy of each report to be filed.
- Each mount sheet has eleven self adhesive strips which facilitate the filing of eleven reports on each sheet. These are numbered with number one being the first report to be filed etc.
- While every effort is made to file reports in date order, it is advisable to check the date of the report that you are referring to.
- When a mount sheet is full, additional reports should never be sellotaped or stapled to the full mount sheet. A new mount sheet should be added in reverse chronological order with the most recent mount sheet on top for each result type.
- A5 (small) reports should be filed on the radiology mount sheet from the bottom of the page upwards.
- A4 (full page) reports should be punched and filed directly behind the mount sheet in reverse chronological order.

Healthcare record order of filing

Section Ten: Prescribed medicines

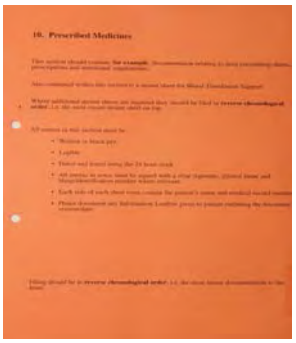


Figure 2-10: Tenth Divider—Prescribed Medicines

- This section should contain all documentation relating to prescribed medicines and nutritional supplements.
- Each side of each sheet or drug healthcare record where patient information is documented must have an addressograph. In the absence of addressograph labels the patient's name, healthcare record number and date of birth should be written.
- All entries must be dated, timed and signed with a clear signature, printed name and bleep number, where relevant.
- Filing should be in reverse chronological order, i.e. the most recent documentation to the front.

Section Eleven: Health and social care professionals

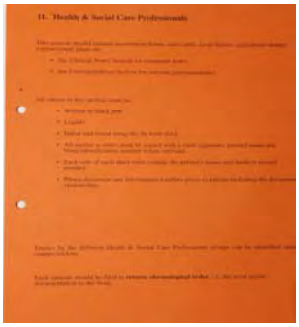


Figure 2-11: Eleventh Divider—Health & Social Care Professionals

- All health and social care professionals will use this section to file assessment forms, care cards, food diaries, specialised dietary regimes/meal plans etc.
- Each side of each sheet or drug healthcare record where patient information is documented must have an addressograph. In the absence of addressograph labels the patient's name, healthcare record number and date of birth should be written.
- All entries must be dated, timed and signed with a clear signature, printed name, title and bleep number where relevant.
- Filing should be in reverse chronological order, i.e. the most recent documentation to the front.
- Entries by health and social care professional groups can be identified using stamps/stickers.

3 Documents not held in the healthcare record

3.1 Introduction

Due to the complexity or sensitive nature of various types of records, not all records may be suitable to be held in the main healthcare record**. However, all of these records should be identified using the patient's unique identifier.**

3.2 Scope

The purpose of this procedure is to outline the documents that should not be included in the main healthcare record.

3.3 Content

Section One: General principles

3.4 Procedure

Section One: General principles

The following documentation should not form part of the main healthcare record:

- Administrative access requests.
- Billing details.
- Child protection reports.
- Complaints.
- Coroners post mortem reports (unless consent from the coroner is obtained).
- Correspondence from solicitors.
- Data Protection requests.
- Financial information.
- Freedom of Information requests.
- Garda reports.
- Health & Safety forms.
- Medico-legal reports.
- Incident report forms and risk management critical incident reviews.

Documents not held in the healthcare record

- Welfare notification forms.
- This is not an exhaustive list and if in doubt, please consult the healthcare records manager or designated person for advice.
- These documents shall be stored in a safe and secure manner in accordance with local policies and procedures.

4 Managing loose information

4.1 Introduction

It is considered to be in the best interest of patients and their care that the full history of their care is available to the current multidisciplinary team. It is thus essential that all documentation relating to the patient is filed promptly in the healthcare record.

4.2 Scope

The purpose of this procedure is to provide guidelines on how to manage loose information in the event of not having prompt access to the healthcare record.

4.3 Content

Section One: General principles

4.4 Procedure

Section One: General principles

- All loose reports and other documents shall be filed in the proper location in the correct healthcare record by the end of the working day of receipt, except when the record is not available, in which case the loose reports shall be stored in a safe and secure manner until the record becomes available.
- Each hospital must clearly identify responsibility for filing of loose information.

Figure 4-1: Managing loose documents

Content of the Healthcare Record

1 Confidentiality and security of the healthcare record

1.1 Introduction

Every healthcare record (including information kept on paper and electronic format) is a confidential document of patient care and as such must be kept secure at all times. Patients have a right to expect that those working in the hospital keep these personal documents, which contain information relating to their health and welfare, confidential and secure. The healthcare records department aims to provide a secure and confidential environment in which to care for patients' records, but cannot be responsible when records are outside of their care. This recommended practice therefore applies to any member of staff when records are in their care. It also applies to information available on computer systems.

1.2 Scope

The aim of this procedure is to outline the method for which the confidentiality and security of a healthcare record is preserved.

1.3 Contents

1.4 Procedure

Section One: Responsibility

- It is the responsibility of Clinical Directors, Nurse Managers, Business Managers, and Department Heads to ensure that their staff adhere to this policy and those procedures are in place within their area of responsibility regarding the confidentiality of patients' healthcare records.
- Staff must also ensure that the privacy of patients using the services of the National Hospitals Office is maintained at all times.
- Staff must report healthcare records and/or documentation located in unsecured areas to the healthcare records manager.
- Healthcare records supervisors must maintain a list of individuals authorised to access the healthcare records library. This list is displayed prominently within the department. All healthcare records staff are required to check anyone who enters the department against this list. The healthcare records library supervisor should be responsible for control and access to the filing room library.
- If there is any doubt as to whether a person has right of access, the supervisor must be informed immediately.
- All healthcare records must be correctly tracked by using the local healthcare record tracking system.
- All healthcare records must be stored in a secure/supervised area with restricted access.
- All healthcare records to be returned to their designated storage location when not in use.
- Under no circumstances are healthcare records to be made available for unauthorised use.
- The staff member who takes a healthcare record is responsible for its safety, for ensuring its confidentiality and ensuring that it is returned to the healthcare records department or to an appropriate person. An appropriate person is one who has a professional role that requires him/her to read the healthcare record or update it.
- In some care areas, for example, midwifery, procedures have been agreed to provide patient held healthcare records, however, unless these procedures are agreed and in place, a healthcare record must not be given to a patient. Each patient has a legal right to his/her records, this right is exercised by way of a written request under the Administrative Access Policy, the Freedom of Information Acts 1997 and 2003 and Data Protection Acts 1988 and 2003.

Confidentiality and security of the healthcare record

- Care should be taken to ensure that a patient's healthcare record is not placed in any public place or where it may be viewed or accessed inappropriately.
- Healthcare records should not be placed on reception desks or on trolleys except when they are required for clinics and only then under the supervision of appropriate clinic staff.

Figure 1-1: Security of the healthcare record

- Healthcare records should not be left on desks in offices in the absence of the responsible staff. Whenever an office is left unattended it should be securely locked.

Section Two: Staff

- There should be a clause in all staff contracts regarding confidentiality of patient care and the security of patient healthcare information.
- Staff should be reminded of importance of confidentiality and security of patient healthcare information at staff meetings.
- Staff are informed of the importance of confidentiality and security of patient healthcare information at induction and training courses.
- Any HSE employee will be subject to disciplinary action if he/she breaches the confidentiality and security clause.
- Patient information will be restricted to HSE employees on a 'need-to-know' basis, as determined by their role or service responsibilities.
- In carrying out their duties, staff may have access to, or hear information concerning the personal affairs of patients and/or staff or other healthcare service business. Such records and information are strictly confidential and on no account must any information be divulged or discussed unless acting on the instructions of an authorised officer.

Section Three: Healthcare delivery associates and third parties

- Healthcare delivery associates will receive relevant, appropriate and agreed information on their patients. The National Hospitals Office expects healthcare delivery associates to handle this shared patient information confidentially and securely in adherence to the Data Protection Acts 1988 and 2003.
- If patient information is disclosed to an authorised third party, the National Hospitals Office will hold the said party to the same set of confidentiality and privacy principles that the organisation adheres to.

Confidentiality and security of the healthcare record

Section Four: Access to healthcare records or clinical information

The healthcare record or its information content shall be made available only to:

- Those medical, nursing and healthcare professionals who are responsible for providing or supervising the patient's care.
- Those hospital employees authorized to process the record within the healthcare records department, to review the record for quality assurance, clinical audit, quality improvement, risk management or infection control purposes.
- Students or trainees in medicine, nursing, a health and social care profession or another recognized clinical professional training programme, when the students are involved in the patient's care and under the supervision of named clinical staff.
- Any clinician to whom the patient is being referred or transferred.
- Other individuals with specific written authorization in accordance with the Data Protection Acts 1988 and 2003 and Freedom of Information Acts 1997 and 2003.
- Access to healthcare records may also be available for research purposes where patient details are annoyimized or where the hospital has obtained clear and unambigious consent from the patients concenred for the use of their healthcare information for these purposes.

Section Five: Sequestered records

- Healthcare records of designated individuals and records of cases under medico-legal investigation should be stored in a designated secure area as agreed with the hospital CEO/Manager.
- Provision shall be made for these records to be accessed out-of-hours if a patient whose record is sequestered requires emergency or urgent treatment.
- Certain designated healthcare records or certain designated sensitive medical documentation relating to a patient may be kept separately from the healthcare record files.
- The tracking system shall be used to indicate that these records are filed separately in the department to enable the department head or designee to retrieve the records promptly when required.

2 Communication with patients

2.1 Introduction

All information provided to patients (written or verbal) should be delivered in a form and manner which is clear, courteous and in a way that the patient can understand.

2.2 Scope

This objective of this procedure is to provide guidelines to staff regarding appropriate communications with patients.

2.3 Contents

Section One: Communication regarding the patients clinical status

Section Two: General communications

Section Three Training in communications

2.4 Procedure

Section One: Communication regarding the patients clinical status

- All communications should be delivered in a form and manner that the patient is able to understand.
- The patient should be allowed sufficient time to reflect on opinions and ask questions in relation to their treatment.
- Key information should be repeated to help the patient understand and remember it.
- A competent interpreter should be used if the patient requires this service.
- Information should only be given to the patient's next-of-kin/nominated representative with the consent of the patient.
- Where possible, written and verbal communication should avoid jargon and should be understandable to the patient.
- All relevant communications with patients/families should be documented in the relevant part of the notes.
- Communicate effectively with colleagues within and outside your own team/ department.

Section Two: General communications

When dealing with a member of the public all staff are representing the Health Service Executive and are expected to respond:

- **Promptly** and without undue delay.
- **Correctly** in accordance with the law and other rules governing entitlements.
- **Sensitively** by having regard to age, capacity to understand and any disability they may have.
- **Helpfully** by simplifying procedures and maintaining proper records.
- **Fairly** by treating people in similar circumstances in like manner, avoiding bias based on personal prejudice, colour, sex, or marital status, ethnic origin, culture, language, religion, sexual orientation, attitude reputation or because of who they are or whom they know.
- **Confidentially** with respect for patient privacy.

Section Three: Training in communications

- All relevant staff should receive formal training in providing a personalised service and in using the patient systems appropriate to their area of work.
- All staff dealing with the public should have training in customer care.

3 General requirements for all entries in the healthcare record

3.1 Introduction

The National Hospitals Office is committed to providing quality care. The quality of clinical documentation in the healthcare record is essential to:

- Ensure the continuity and delivery of safe and quality patient healthcare.
- Document and facilitate communication of care between patient, family and healthcare teams and provide evidence of same.
- Justify care delivery in the context of legislation, professional standards, guidelines, evidence, research and professional and ethical conduct. This includes demonstrating accountability and defending care delivery within the context of health-legal issues.

The healthcare record should contain sufficient information to identify the patient, support the diagnosis, justify treatment, document the treatment course and results and facilitate continuity of care among healthcare providers.

3.2 Scope

The purpose of this procedure is to provide guidelines to healthcare professionals on good practice for healthcare documentation.

3.3 Contents

Section One: Ensuring correct identification

Section Two: Legibility

Section Three: Documenting date and time

Section Four: Author identification

Section Five: Corrections

Section Six: Documenting evidence of Care

Section Seven: Retrospective entries

Section Eight: Abbreviations

Section Nine: Relevancy

Section Ten: Verbal instructions

Section Eleven: Abnormal results

Section Twelve: Medications

Section Thirteen: Language

Section Fourteen: Advice

3.4 Procedure

Section One: Ensuring correct identification

- The patient's name is on each side of each page where patient information is documented and each page has the correct unique patient identification number and/or label. This also applies to every screen on computerised systems.
- There should be no blank spaces or pages between entries.
- Before the healthcare professional makes an entry in the patient's healthcare record, s/he must establish that the record belongs to the patient being attended. This should be done by verifying with the patient and by cross-referencing the patient's wrist band with the healthcare record.

Figure 3-1: Ensure correct patient identification—verify with the patient and cross reference the patient's wrist band with the healthcare record

General requirements for all entries in the healthcare record

Section Two: Legibility

- It is the author's responsibility to ensure that writing is clear and legible.
- Always write clearly when prescribing, using un-joined lower case text or block capitals.
- All entries must be dated, timed and signed with a clear signature, printed name, title and bleep number (where relevant).
- All entries are in permanent black ink.

Section Three: Documenting date and time

- It should always be clear from the patient record what time an event occurred and what time a record was written.
- The time (24 hour clock) and date (day/month/year) are noted against each clinical entry.
- All entries must be accurate in relation to date (day/month/year) and time.

Section Four: Author identification

- Each hospital site has a signature bank of all clinical staff and non-clinical staff that may have occasion to write in the healthcare record.
- The mechanism for achieving this should be considered and progressed on each hospital site in consultation with both the Human Resource and Health Manpower departments.
- Identification stamp pens, which have the clinician's name printed on a stamp attached to the pen, are permissible.

General requirements for all entries in the healthcare record

Section Five: Corrections

- Records are not erased or destroyed but are amended if incorrect.
- Correction fluids are not used. The original entry should remain visible.
- Deletions or alterations are made by scoring out with a single line followed by:
  1. Signature (plus name in capitals) and counter signature, if appropriate.
  2. Date and time of correct entry.
  3. Reason for amendment.
- Corrections are made as close to the original record as possible.
- Alterations to prescriptions are not permissible. A prescription that is no longer appropriate should be discontinued and a new prescription should be written.

Section Six: Documenting evidence of care

- Records provide physical, psychological and social factors that may affect the patient.
- The chronology of events and reasons for any decision made are recorded in the context of a thorough assessment of the patient including relevant history taking.
- Records must provide accurate, correct, comprehensive and concise information concerning the condition and care of the patient and associated observations.
- Information is factual.
- All entries in the record by healthcare professionals should be made as soon as possible after each intervention and at least once every 24 hours during the working week for acute inpatient episodes. There should be an entry in the record at least twice a week for rehabilitative care.
- Every record entry (clinician related) should identify the most senior clinician present at the time the entry was made.
- The name of the primary clinician who is assuming overall responsibility for the patient's care is clearly identifiable in the healthcare record at all times. The name in the patient's record shall be the same clinician's name entered into the Patient Administration System (PAS). Should the primary clinician change during the course of treatment, this must be noted on the healthcare record and on the PAS.
- Input into all records is multi-disciplinary.

General requirements for all entries in the healthcare record

Section Seven: Retrospective entries

- Ensure retrospective documentation is:

i. Dated.

ii. Timed.

iii. Signed (and counter signed as appropriate).

- The reason why the retrospective entry is being made should be clearly stated.
- It should be clear that the entry is a retrospective entry.

Section Eight: Abbreviations

- Abbreviations should not be used. In the event of abbreviations being utilised, only abbreviations approved by the National Hospitals Office may be permitted.
- Other than the abbreviations approved by the National Hospitals Office, on each side of each page the full term must be used, followed by the abbreviation in brackets. Thereafter the abbreviation may be used on that page.

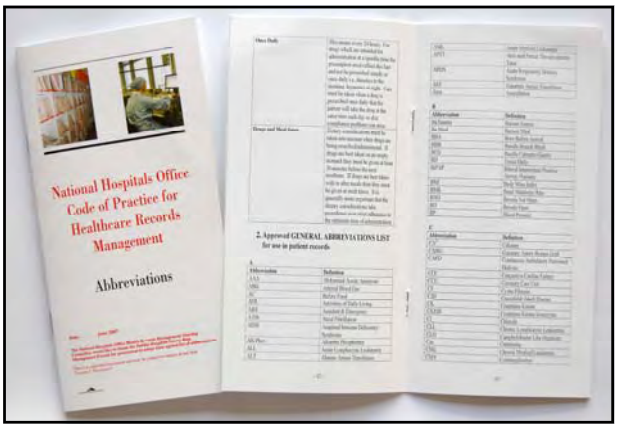


Figure 3-2: Abbreviations

- Abbreviations are not used on documentation which is used for transfer, discharge or external referral letters.
- Abbreviations are not used on consent forms, death certificates, incident reporting forms or external communications.
- Drugs names are not abbreviated.
- Any references to "the patient" must never be abbreviated, (e.g. "pt"). The patient's given name must be used.

General requirements for all entries in the healthcare record

- Any references to individual healthcare professionals should state their full name, title and pager number if applicable. Documentation stating, "seen by physio" or "reviewed by SIOC" is unacceptable.
- The following should never be used in clinical records
    i. R for Right or L for Left
    ii. Symbols e.g. ↑,↓.
    iii. "+ve" and "–ve". These can be abbreviated to Pos. and Neg.
    iv. +, ++ unless as part of an official grading e.g. urinalysis results.

Section Nine: Relevancy

- Records are objective and describe what is observed.
- If an incident has not been observed but is relevant to patient care then this is clear e.g. patient states that....

Section Ten: Verbal instructions

- Instructions regarding patient care from a healthcare professional via the telephone are documented, dated, signed and later countersigned by the healthcare professional responsible for giving the instructions.
- If no instructions were given this is also documented.

Section Eleven: Abnormal results

- There is a note in the clinical record of any significant abnormal results found or communicated to the healthcare professional. This includes a record of who has been informed e.g. healthcare professional's name. This note must be made by the appropriate healthcare professional.

General requirements for all entries in the healthcare record

Section Twelve: Medications

- Drugs are only administered and documented in the presence of clear unambiguous prescriptions and in accordance with hospital policies.
- Drug names must never be abbreviated under any circumstances.
- Generic names ONLY should be used for the drug chart.
- Prescribe medications, including intravenous fluids, by approved (generic) name, except in the case of multi-ingredient preparations and modified release formulations when the brand names must be used.
- The choice of therapeutic agents used remains the responsibility of the clinician.

Section Thirteen: Language

- Records must be written in English.
- Records are completed in terms that the patient and/or the healthcare professional can understand.
- Records are supported by explanations where this may not be possible.
- Records are phrased clearly and unambiguously.
- Records are objective, factual, devoid of jargon, witticisms or derogatory remarks.

Section Fourteen: Advice

- Healthcare professionals advice on care, in any format (e.g. verbal, leaflet), is documented in notes of advice given.

4 Alerts in the healthcare record

4.1 Introduction

There should be a method for indicating alert to risk factors, with the healthcare record containing a designated place for healthcare staff to record actual allergies/ risks.

4.2 Scope

The purpose of this procedure is to provide guidelines to relevant staff regarding alerts in the healthcare record for allergies.

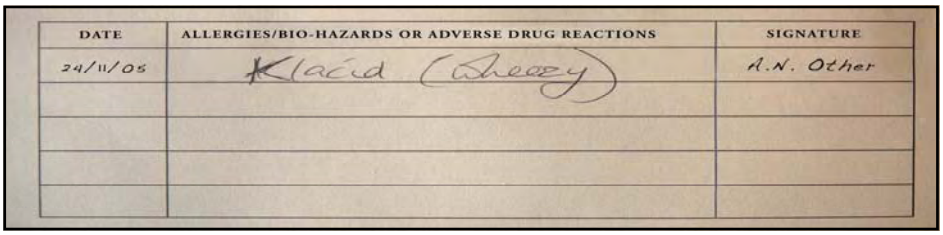
4.3 Contents

Section One: General principles

4.4 Procedure

Section One: General principles

- Alerts for allergies should be recorded on the inside of the cover of the healthcare record.
- This information should be signed and dated.
- There should be an end-date for the alert if possible.
- A clear procedure as to who should enter alerts into the patient record, when alerts should be entered and the procedure for removing alerts from the healthcare record must be drawn up by the hospital.



DATE	ALLERGIES/BIO-HAZARDS OR ADVERSE DRUG REACTIONS	SIGNATURE
24/11/05	Klacid (Sheezy)	A.N. Other

Figure 4-1: Allergies/bio-hazards or adverse drug reactions

5 Referral letters

5.1 Introduction

The GP or attending clinician should forward a referral letter for any patient they wish to have treated in hospital.

5.2 Scope

The objective of this procedure is to ensure that a record is kept of every patient referred for services in the hospital, that all patients are either placed on a waiting list for an appointment or issued with an appointment

5.3 Contents

Section One: General principles

5.4 Procedure

Section One: General principles

- Referral letters should be date stamped on receipt in every department.
- All referrals should be recorded on the appropriate ICT management system.
- All referrals are assessed by the appropriate healthcare professional and marked as routine or urgent depending on their clinical need.
- Where waiting lists exist, the patient's name is placed on the waiting list.
- Where there are no waiting lists, the patient is issued with an appointment, if appropriate.
- The GP/referral source should be notified of the outcome of the referral.

6 Admission entry

6.1 Introduction

Patient care may be affected if complete admission information is not available to aid treatment decision-making.

6.2 Scope

The purpose of this procedure is to outline the patient information that should be included in the record entry for acute health admissions.

6.3 Contents

Section One: Reason for clinical encounter

Section Two: Presenting problem/complaint

Section Three: History of presenting problem

Section Four: Current diagnoses

Section Five: Patient alerts/allergies

Section Six: Past illnesses

Section Seven: Procedures and investigations

Section Eight: Medications and diets including nutritional supplements

Section Nine: Social circumstances

Section Ten: Functional state

Section Eleven: Family history

Section Twelve: Systems review

Section Thirteen: Examination findings

Section Fourteen: Results of investigations

Section Fifteen: Problem list

Section Sixteen: Overall assessment

Section Seventeen: Management care plan

Section Eighteen: Intended outcomes

Section Nineteen: Information given to patient

Other headings may be used locally in addition to those listed.

6.4 Procedure

Section One: Reason for clinical encounter

- Reason for clinical encounter is the administrative reason for the patient's contact with the clinician. (e.g. clinical review, referred by GP etc).

Section Two: The Presenting Problem/complaint

- The presenting problem/complaint is the sign, symptom or condition that has occasioned the admission of the patient to hospital. In circumstances where this does not apply, the reason for the admission should be recorded.

Section Three: History of presenting problem

- This section includes the history of the presenting problem/complaint.

Section Four: Current diagnoses

- Current diagnoses are disorders, syndromes and diseases that the person currently suffers from, including allergies. Specific professional rules may exist for particular diseases being classified as diagnoses, even if they have potentially been resolved (e.g. treated cancer).

Section Five: Patient alerts/allergies

- Allergies include any hypersensitivity reactions or other adverse event related to medications. If the patient has no known allergies, this should also be recorded. Dates should be given.

Admission entry

Section Six: Past illnesses (where applicable)

- Past illnesses include previous disorders, syndromes and diseases that are not currently affecting the patient. Dates should be given.

Section Seven: Procedures and investigations

- Procedures include any operations, interventions or investigations that the patient has had.

Section Eight: Medications and diets including nutritional supplements

- Medications include any substance being taken by the patient on a regular or as required basis. Dose, frequency, route of administration and duration should be recorded for each medication.
- Diets include any special dietary needs or requirements.
- Nutritional status is recorded including any nutritional supplements.

Section Nine: Social circumstances

- Social circumstances should include domestic, employment and lifestyle information.

Section Ten: Functional state

- Functional state may be recorded as a validated score if appropriate.
- **This may include information on:** self-care/baseline mobility/walking aids and appliances.

Section Eleven: Family history

- The family history lists the health status of immediate family members as well as their causes of death (if known). This may include a genogram if appropriate.

Admission entry

Section Twelve: Systems review

- The review of systems is a series of questions grouped by organ system including: General/Constitutional, Skin/Breast, Eyes/Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Neurologic/Psychiatric, and Allergic/Immunologic/Lymphatic/Endocrine.

Section Thirteen: Examination findings

- Examination findings includes general observations (e.g. pulse, blood pressure) as well as specific systems (e.g. cardiovascular, respiratory, central nervous) and body areas (e.g. ear nose and throat, abdomen).

Section Fourteen: Results of investigations

- Results of investigations include test results, or results of other assessments made of the patient's condition (e.g. stairs assessment). Dates should be given.

Section Fifteen: Problem list

- Problems include any issues that require action from the clinician or team and may include the patient's presenting problem, clinical findings, test results, and diagnoses. If there is uncertainty about a diagnosis then the most appropriate problem (symptom, sign or test result) should be used until the diagnosis is confirmed.

Section Sixteen: Overall assessment

- Overall assessment is the clinician's overall assessment of the patient's condition.

Section Seventeen: Management care plan

- Management plan includes any procedures or medications that would relate to resolving the identified problems. It should also include plans for review, follow-up and discharge planning.

Admission entry

Section Eighteen: Intended outcomes

- Intended outcomes includes prognosis and 'do not resuscitate' orders.
- Proposed time-frames should also be included.

Section Nineteen: Information given to patient

- This includes any information given to the patient (both written and verbal) on any of the items listed above. A note of the information given to the patient should be documented in the patient record.

7 Follow up entries

7.1 Introduction

Every follow-up entry should clearly record what has happened to the patient since the previous entry, interventions and response to same, the assessment of the patient's condition, state the new management plan, and document any information given to the patient.

7.2 Scope

The purpose of this procedure is to outline the patient information that should be included in the follow up entries for acute health admissions.

7.3 Contents

The contents may include the following where applicable:

Section One: Reason for clinical Encounter

Section Two: Review of case

Section Three: Overall assessment

Section Four: Management care plan

Section Five: Information given to patient and carers

Section Six: Any change since previous encounter

Section Seven: Other

7.4 Procedure

Section One: Reason for clinical encounter

- Reason for clinical encounter may simply be 'clinician ward round' or 'asked to see patient'.

Follow up entries

Section Two: Review of case

- Review of case is any new information that relates to the patient's care.

Section Three: Overall assessment

- Overall assessment is the clinician's overall assessment of the patient's condition including any change since previous encounter. If there is no change then 'no change' can be recorded.

Section Four: Management care plan

- Management Care Plan - if the plan has not changed since the last entry then 'continue' can be recorded.

Section Five: Information given to patient and carers

- Information given to patient and carers includes any information the patient has been given (both written and verbal). This includes information on any of the items listed above.

Section Six: Any change since previous encounter

- Any change in the patient's condition since the previous encounter should be documented.

Section Seven: Other

- New problems, medications, examination findings, test results etc. should be recorded under the relevant headings.

8 Discharge/transfer entries

8.1 Introduction

A discharge/transfer communication must be provided for all relevant clinical staff who will be involved in the care of the patient when care is transferred out of the hospital. Patient care may be affected if complete discharge information is not available when the patient is next seen.

8.2 Scope

The discharge/transfer communication provides a clinical summary of a patient's stay in hospital.

8.3 Contents

The contents may include the following:

Section One: Transfer/discharge note

Section Two: Transfer/discharge communication

Section Three: Transfer/discharge communication written by a senior house officer

Section Four: Transfer/discharge communication when investigative results are pending

8.4 Procedure

Section One: Transfer/discharge note

At the time of discharge, a final health progress note shall be prepared that is sufficiently comprehensive to provide relevant information to a clinician who may be seeing the patient in an outpatient clinic before the discharge summary is available. The discharge note shall include at least:

- The date of discharge.
- Final diagnoses, with the principal diagnosis listed first.
- Any operations/procedures carried out.

Discharge/transfer entries

- Dosage and quantity of any take-home medications.
- Instructions to the patient or family and follow-up arrangements.

Section Two: Transfer/discharge communication

An immediate transfer or discharge communication shall be prepared. It shall be sent to the patient's general practitioner within 48 hours of the patient's discharge in order to enable the safe transfer of clinical responsibility for the patient. Where patients are being transferred to the care of another clinician; clinician to clinician (or designated registrar) communication should take place. The document shall include some or all of the following information, as appropriate:

- Hospital name.
- Patient identification information.
- Validating clinician name and contact details.
- Ward or department or specialty issuing the discharge document.
- Patient's registered GP details/referring clinician if different.
- Admission details.
- Discharge details.
- Final diagnosis.
- Current diagnoses (note if primary or secondary).
- Patient alerts/allergies.
- Procedures and investigations.
- Medications and diets including nutritional supplements.
- Functional state (Self-care/baseline mobility/walking aids and appliances).
- Systems review.
- Examination findings.
- Results of investigations.
- Relevant information on administration of medicines.
- Problem list.
- Any complications.
- Infection Status (as appropriate).

Discharge/transfer entries

- Management care plan.
- Intended outcomes.
- Information given to patient.
- The name and title of the receiving clinician in the case of a transfer.
- *Other headings may be used locally in addition to those listed.*
- **Current diagnoses** should include all adverse drug reactions and other problems that developed during the stay in hospital as well as existing diagnoses on admission.
- **Final diagnosis** should include progress in hospital and any other clinically important information.
- **Management care plan** should include specific instructions for the receiving clinician, any services provided, and follow-up requirements.
- **Transfer/discharge communication** should be multi-disciplinary where multi-disciplinary care is to be continued.
- A copy of the transfer/discharge communication or letter should be completed within 48 hours of the patients discharge and sent to the patients GP. A further copy should be retained in the record.
- Transfer/discharge communication should be authorised by the relevant, responsible healthcare professionals.
- All patients should be given information about their illness, treatment and further management. The information given should be documented in the record.
- Information about the patient's illness, treatment and further management can be given to the patient's partner, relatives or carers if consent has been obtained to do so. The information given, and to whom, should be documented in the record.

Section Three: Transfer/discharge communication written by a senior house officer

- When a senior house officer prepares a transfer/discharge communication, the supervising clinician or a specialist registrar or registrar delegated by the supervising clinician shall add his or her own relevant observations or conclusions, when necessary, and countersign the transfer/discharge communication or prepare his or her own transfer/discharge communication.

Discharge/transfer entries

Section Four: Transfer/discharge communication when investigative results are pending

- If laboratory, pathology or diagnostic imaging findings are pending at the time of a patients transfer/discharge, the responsible clinician shall prepare the transfer/discharge communication as required. The clinician should note in the transfer/discharge communication pending findings of (name of report) and should prepare an addendum to the transfer/discharge communication when such results are received, if appropriate, particularly if it is anticipated that the results will be delayed beyond a few days.

9 Patient consent

9.1 Introduction

Patients have a right to decide what happens to them and healthcare professionals have a corresponding right to provide sufficient information to ensure that such decisions are taken on an informed basis. This section gives general guidance on patient consent; more detailed information is available in '*Guidelines in relation to obtaining consent to a Clinical Treatment in an Acute Hospital setting*'. (HSE DNE, 2006)

9.2 Scope

The objective of this procedure is to provide guidelines to staff regarding patient consent.

9.3 Contents

Section One: General principles

Section Two: Documenting consent in the healthcare record

Section Three: Patient wishes

9.4 Procedure

Section One: General principles

- There are three elements to consent and they must all be present for consent to be valid. The consent must be **voluntary**, given by someone with the **capacity** and based on **sufficient** information.
- Consent may be **expressed**, i.e. affirmed orally or in writing, or it may be **implied** by the conduct or silence of the person whose consent is required. Caution should be exercised by the healthcare professional in the area of implied consent.

Patient consent

- There are two exceptions to the rule for obtaining consent; **therapeutic privilege** and in an **emergency situation**. The *therapeutic privilege* means that the healthcare professional can withhold information if s/he feels that it would be psychologically damaging to the patient to disclose. In an *emergency life-threatening situation* where the patient is unable to consent or to appreciate what is required, the healthcare professional may administer the necessary medical treatment in the absence of the expressed consent of the patient.
- If the patient chooses not to participate in the decision making process concerning their treatment or care, the patient, if willing, should be asked to sign a waiver, stating that s/he does not wish to discuss the matter following advice being offered. This should be clearly recorded in the healthcare record.
- Consent can only be secured by someone suitably qualified or experienced enough to understand the proposed treatment and risks involved.
- Consent should always be obtained prior to the proposed treatment or procedure. Under no circumstances should consent be obtained from a patient who has been pre-medicated or sedated in preparation for a procedure or if the patient is in severe pain.
- It is recommended that written consent must not be obtained more than three months before the expected procedure date. In the event of this time-frame having lapsed, the patient must be re-consented.
- If there is a change in the patient's condition between the consultation and admission resulting in a significant change in the nature, purpose or risk associated with the procedure, consent must be obtained again.
- A patient does not have to consent if s/he does not want to. Where a decision to refuse treatment appears irrational, the implications of this decision must be carefully explained. The decision, however, ultimately rests with the patient in these circumstances.
- Anyone over eighteen years old is legally an adult. Anyone less than eighteen years old is a minor/child. Minors between their sixteenth and eighteenth birthdays may give their own consent to medical, dental and surgical procedures. The minor must have the mental and intellectual capacity to understand the proposed treatment.

Patient consent

Section Two: Documenting consent in the healthcare record

Consent must:

- Be easily and clearly identifiable either on a consent form, which is retained as part of the clinical record, or in the case of verbal consent documented within the clinical record.
- Contain no abbreviations.
- Clearly state the procedure/treatment/care involved and the risks and benefits of that procedure.
- Clearly identify the patient by name and their medical record number.
- Clearly identify who has granted or refused consent and/or their relationship to the patient in the case of parent/guardian.
- Have a documented record of what appropriate patient information or relevant discussions has been provided to the patient/guardian detailing the procedure/treatment/care, risks, benefits and/or alternative.
- Have a documented record of how this information has been provided (e.g. patient information leaflets, verbally etc.).
- Be dated and signed by the healthcare professional obtaining the consent, including full name and grade.
- Verbal consent must be documented in the clinical record and must clearly identify the witness, as relevant, e.g. by name and grade.
- This standard applies to both hardcopy and electronic documentation.

Section Three: Patient wishes

- The involvement of the patient in decisions about his or her care should be documented in the record under 'patient wishes'.
- Living Wills or Advance Directives must be clearly recorded in the notes, alongside any resuscitation statements.
- The person who wishes to give Advance Directives must be over eighteen years of age and must be of sound mind at the time of making the Advance Directives.

NOTE: The Steering Committee would like to thank the Dublin Hospitals Group Risk Management Forum Documentation sub-committee for their advice and input into 'Documenting Consent in the Healthcare Record'

10 Death entries

10.1 Introduction

A patient's record on the hospital management system should always be up to date. When a patient dies or when the hospital is notified of the death of a patient, the hospital management system should be updated to reflect this.

10.2 Scope

The objective of this procedure is to set out good practice for hospital staff to follow to ensure that patient data is accurate.

10.3 Contents

Section One: Death entry

Section Two: Death notification

Section Three: Report to the coroner

10.4 Procedure

Section One: Death entry

A summary shall be completed for each patient who dies in the hospital. The summary shall include the following information:

- Date and time the patient was certified dead.
- Date and time of the entry in the record.
- Name and designation of the clinician certifying the patient's death in block capitals.
- Examination made establishing death.
- Events leading to death and cause(s) of death.
- Signature of the clinician certifying death.
- Final diagnosis (to include principal diagnosis and all procedures).

Death entries

Section Two: Death notification

When the death notification form is completed, an entry should be made in the record stating:

- The cause of death as appearing on the death notification form.
- Whether a cremation form has been completed.
- Whether and how the deceased's relatives have been or will be informed.
- Whether and how the General Practitioner has been or will be informed.

The clinician responsible for the patient's care shall ensure that the patient's general practitioner is notified of the patient's death as soon as possible following the death.

Section Three: Report to the coroner

Deaths should be reported to the coroner:

- Where death occurs within 24 hours of admission to hospital.
- Where death occurs within 24 hours of the administration of an anaesthetic, surgical procedure or any procedure.
- For certain deaths which occur in a department of a hospital, e.g. radiology department, out-patients department, physiotherapy department, etc.
- For maternal deaths.
- Where a patient dies in a hospital, having been recently transferred or discharged from a nursing home or other residential institution (including mental hospital or prison).
- Where there is any doubt as to the cause of death.
- Where organ donation is contemplated or agreed.
- At the request of the attending clinician.
- When the hospital is notified of the patient's death, then all of the patient's healthcare records should be updated and all relevant departments should be notified.

11 Post mortem entries

11.1 Introduction

A review of the clinical diagnosis and the findings of post-mortem examinations are an important part of the clinical process and should be contained within the notes.

11.2 Scope

The objective of this procedure is to set out good practice for hospital staff to follow regarding post mortem entries.

11.3 Contents

Section One: Healthcare record

Section Two: Post mortem report

11.4 Procedure

Section One: Healthcare record

- When a hospital post mortem is performed a provisional diagnosis shall be noted in the healthcare record within 72 hours and the healthcare record shall be completed within one month following the death (this does not include paediatric post mortems).
- A consent form for the hospital post-mortem is filed in the healthcare record.
- A copy of the hospital post-mortem report must be filed in the healthcare record.
- A record of all post mortem meetings with parents, social workers and the multi-disciplinary team should be documented in the healthcare record.

Post mortem entries

Section Two: Post mortem report

Should a hospital post mortem be performed, provisional anatomic diagnoses shall be available within 72 hours and the post mortem report shall be completed within 30 days. (This excludes paediatric post mortems and post mortems that require toxicology reports via state laboratories). The record of the deceased shall include the following:

- The consent form for the post mortem.
- A copy of the post-mortem examination report.

Healthcare Records Management

1 Care and maintenance of the healthcare record

1.1 Introduction

It is the aim of the National Hospitals Office to ensure that healthcare records are maintained and preserved in optimum condition to support the provision of high quality patient care.

1.2 Scope

This procedure guides all healthcare record users through the requirements for ensuring that healthcare records are held in the optimum condition in order to ensure that all information is available to all staff at all times.

1.3 Contents

Section One: Maintaining the physical state of the healthcare record chart

Section Two: Sending out healthcare records

1.4 Procedure

Section One: Maintaining the physical state of the healthcare record chart

- If a healthcare record chart requires recovering, a new identification label is produced and fixed to the new outside cover. Inside cover details must be completed.
- Healthcare records handlers outside the healthcare records department, who require recovers or additional volumes must inform the records department and return the healthcare record for amendment.
- All healthcare record handlers must ensure that the National Hospitals Office order of filing is maintained.
- Blank pages and labels to be removed from healthcare records prior to closure.

Care and maintenance of the healthcare record

- Patient name & address label to be placed on the front cover in accordance with local filing arrangements.
- In the event of the patient's death, please ensure that the authorized RIP sticker is placed on the front cover.
- Under no circumstances should anything be sellotaped, written or stapled to the healthcare record cover.
- The front sheet should be printed on A4. This is to be punched and filed in the Administrative Section.
- Patient labels for current episode only to be filed in the Administrative Section.
- Directions for entry/filing of information are provided on the divider of each section and should be adhered to.
- There should be no loose documents in the healthcare record.

Section Two: Sending out healthcare records

- Healthcare records sent within the hospital must be securely bound with the destination clearly identified.
- Healthcare records should be transported in such a way that patients' names are not visible.
- Healthcare records should never be left unattended in the course of their delivery.
- A record should be kept of all of the healthcare records sent out using an appropriate tracking system.

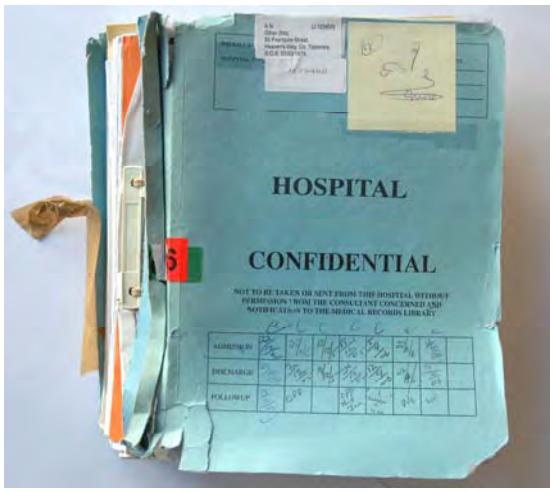


Figure 1-1: Healthcare record chart requiring re-covering

2 Patient information requests

2.1 Introduction

Patient information requests may be dealt with in a formal way in accordance with the Freedom of Information (FOI) or Data Protection (DP) legislation, or in a routine and informal way in accordance with the HSEs Administrative Access Policy. This section gives general guidance on the different access regimes, more detailed information is available in the booklet "A Practical Guide for Staff" published by the FOI/DP Liaison Group and in procedural manuals that give detailed guidelines on the legislation.

2.2 Scope

The objective of this procedure is to set out good administrative practice for hospital staff to follow when handling requests for information, within statutory requirements and health service guidelines, including Freedom of Information and Data Protection Acts.

2.3 Contents

Section One: Administrative access requests

Section Two: Freedom of Information requests

Section Three: Data Protection requests

Section Four: Legal requests

Section Five Requests for information by the Gardai

Section Six: Other healthcare providers

2.4 Procedure

Section One: Administrative access requests

- As a matter of policy the Health Service Executive supports the right of a patient to see what information is held about him or her within its service. Generally, access to an individual's own healthcare record should be provided administratively (subject to exceptions which are detailed later).
- An application for administrative access by a patient seeking access to his/her healthcare record should:

  1. Be in writing and sent to the appropriate service manager.
  2. Supply relevant information to locate records.
  3. Be accompanied by appropriate identification.

- The treating healthcare professional should, where possible, be involved in the handling of these applications to ensure that only information relevant to the application is released. Consultation with the patient is encouraged, particularly to assist in the identification of the actual documents to which access is sought or to narrow the field of inquiry, for example, to a particular admission if possible.

i. Records of deceased persons

Given the level of sensitivity of information contained in healthcare records, and the inability to consult with the deceased patient, all applications for access to deceased person's records must be processed under the Freedom of Information Acts.

ii. Exceptions to the administrative access process

Particular care must be taken when healthcare records contain sensitive matter, for example:

- Documents relating to suspected or actual child abuse.
- Documents revealing the involvement and deliberations of an investigation into alleged sexual abuse.
- Documents containing information in relation to testing for and/or treatment of HIV/AIDS (including statements regarding HIV status) or other notifiable diseases under the Health Acts.

- A deceased person's healthcare record.
- In circumstances where it is considered that access could be prejudicial to the physical or mental well being or emotional condition of the person.
- In circumstances where it is considered that the healthcare record contains matter about a third party or information received in confidence from a third party.
- Any other sensitive matter such as documents revealing confidential sources of information.

iii. Can information be released to other healthcare professionals?

- Where a patient has been transferred or discharged to another healthcare service or medical practitioner for continuing care and treatment, information from the patient's healthcare record of direct relevance to the continuing care and treatment of the patient may generally be released on written request by the healthcare service or medical practitioner. Information may also be released on confirmation by the receiving healthcare service of transfer arrangements.
- Where a request for information is received by telephone, information should be given to the treating healthcare professional or senior healthcare professional if urgently required for treatment of the patient. In these circumstances, care should be taken to establish the identity of the recipient of the information, the recipient's name and telephone number and authority to receive the information should be checked and the call returned before the information is given.

Section Two: Freedom of Information requests

The Freedom of Information Act confers on all persons the right of access to information held by public bodies, to the greatest extent possible, consistent with the public interest and the right to privacy. The concept of Freedom of Information is derived from the following principles.

i. Records

Every individual has the right

- To know what information is held in records about him or her personally (subject to certain exemptions).
- To have inaccurate material on file corrected (subject to certain exemptions designed to protect the public interest and the right to privacy).

Patient information requests

ii. Decisions

- Individuals who are affected by decisions of public bodies have the right to know the criteria used in making those decisions.
- Decisions by public bodies should be open to public scrutiny, thus providing greater knowledge of the issues involved and public ownership and acceptance of decisions. Citizens, as shareholders in public bodies, should have the right to examine and review the deliberations and processes of public bodies, subject to the exemptions provided for in the Acts.

iii. Parents, guardians and next-of kin rights

- Parents, Guardians and Next-of-Kin have been provided with rights of access to reasons for decisions in respect of certain other persons, e.g. children, deceased or disabled persons with a mental incapacity.
- Parents or Guardians have also been provided with rights to apply to have personal information of certain other persons e.g. children, deceased or disabled persons with a mental incapacity, amended if they are incomplete, incorrect or misleading.

iv. Making a Freedom of Information request

- Freedom of Information requests do have to be in a specific form. A request must:
  1. Be in writing and assistance must be provided for those who require it.
  2. Specify the records required and the manner in which access is sought.
  3. State that the request is made under the Freedom of Information Act.
- When a request for access under the Freedom of Information Acts is received in any department of the hospital, it should immediately be sent to the member of staff (Decision Maker) in your hospital who has responsibility for processing Freedom of Information requests.
- There are different forms of access to records which may be requested and granted. These are as follows:
  1. Inspect original record.
  2. Obtain copy of the record.
  3. Hear/view audiovisual record.
  4. Obtain a transcript of tape or shorthand.

5. Obtain a copy of a computer disk or other electronic device.

6. Shorthand or code must be decoded.

- It is regarded as good practice that the application is discussed with the treating healthcare professional (Medical Practitioner, Psychologist, and Social Worker etc.) for a number of reasons; e.g. the records may contain information which could, in the professional's opinion, have a detrimental effect on the patient.

- One of the grounds why a request for information may be refused is where the record is of a medical, psychiatric or social work nature relating to the requester concerned and its release, in the opinion of the Decision Maker, might be prejudicial to the physical or mental well-being of the requester. Where the Decision Maker refuses access under this provision, he/she is obliged to offer access through a registered healthcare professional, nominated by the requester, having expertise in the matter concerned.

v. Right of review

- A requester, if unhappy with a decision to release records, has the right of review. This includes:

Internal review

- In most cases the first avenue is for the patient to request an internal review. This is forwarded to the delegated Internal Reviewer (who is normally a more senior member of staff within the healthcare agency). A decision will be made within fifteen days upon receipt of request for an Internal Review.

Information Commissioner review

- If the requester is unhappy with the decision of the Internal Reviewer he/she may appeal to the Information Commissioner within six months of the date of notification of the agency's decision. There is a right of appeal to the High Court, on a point of law only, if either the requester or the Healthcare Agency is unhappy with the Commissioner's decision. The Supreme Court will in turn deal with any further appeal arising out of a High Court decision.

vi. Staff

Staff will be able to reduce the need for the public to use the Freedom of Information Acts by:

- Improving communications between staff and public.
- Drafting and publishing eligibility criteria used to determine access to schemes and services.
- Informing persons who apply for services of reasons for decisions and rights of appeal.
- Allowing access to the greatest extent possible to hospital records via administrative means.

Section Three: Data Protection requests

Data Protection (DP) is the safeguarding of the privacy rights of individuals in relation to the processing of their personal data. People supply information about themselves to healthcare organisations and to medical and healthcare professionals. Data Protection law places obligations on such healthcare providers and all staff who keep personal information.

i. Data Protection rights

Data Protection rights apply whether the information is held:

- In electronic format e.g. on computer.
- In a manual or paper based form.

ii. Personal health information should be

- Obtained and processed fairly; which means that the person providing it must know the purposes for which it will be used and the persons to whom it will be disclosed.
- Relevant and not excessive.
- Accurate, complete, up-to-date and well organised.
- Held no longer than is necessary.
- Devoid of prejudicial, derogatory, malicious, vexatious or irrelevant statements about the individual.

Patient information requests

- Purpose specific.
- Held securely.
- Accessible to the individual or person acting on his or her behalf on a reasonable basis.

iii. Request for access to records made under the Data Protection Act

- A request for access to records made under the Data Protection Acts must:

  1. Be in writing.
  2. Be accompanied by a fee (up to and no more than 6.35 Euro [2007]).
  3. Specify the records required and the manner in which access is sought e.g. inspect the original, obtain photocopies etc.
  4. State that the request is being made under the Data Protection Act.
  5. Provide proof of identity.

- When a request for access under the Data Protection Acts is received in any department of the hospital, it should immediately be sent to the member of staff in your hospital who has responsibility for processing Data Protection requests. That staff member should adhere to Data Protection procedures in dealing with the request.
- Many requests may involve the release of documents, which may be accessed without resorting to the Data Protection Acts. A non Data Protection request should usually be made to the local office of the hospital in question. If the information cannot be released routinely the requester will be advised accordingly and informed of his/her rights under the Data Protection Acts.
- If a request has already been dealt with under the Freedom of Information Acts it must still be processed separately under the Data Protection process, as if it were a new request.
- Personal health information should only be used or disclosed for the purpose for which it was collected or for another directly related purpose. It can be used or disclosed for some other purpose only where:

  1. The patient concerned has explicitly consented to the proposed use or disclosure.

2. The healthcare professional reasonably believes the use or disclosure is necessary to lessen or prevent a serious and imminent threat to an individual's life, health or safety or a serious threat to public health or public safety.

3. The use or disclosure is required or authorised by law.

4. The information concerns a patient who is incapable of giving consent, and is disclosed to a person responsible for the patient to enable appropriate care or treatment to be provided to the patient.

5. Any disclosure to a third party should be limited to that which is either authorised or required in order to achieve the desired objective.

6. Personal health information can be transferred to an individual or organisation outside the European Union only in certain specified circumstances.

iv. Refusing access to records where the request has been made under the Data Protection Act

- Access can be refused to some or all of their personal health information only if:

1. Providing access would pose a serious threat to the life or health of any individual, including the requester.

2. Providing access would have an unacceptable impact on the privacy of other individuals.

3. It is required or authorised by law.

- Many requests for information, or responses to complaints, can be made by contacting the service provider directly. If this method proves unsatisfactory to the requester, the requester may then have an option to apply for personal records under the Data Protection Acts.

Patient information requests

v. Data Protection rights

The Data Protection Rights include:

Right to be informed

The hospital that obtains personal information must ensure that the patient is informed of:

- The name of the data controller, i.e. the organisation or the individual collecting the data.
- The purpose for keeping personal data.
- Any other information which the organisation ought to provide to ensure its handling of patient's data is fair, for example, the identity of anyone to whom it will disclose the patient's personal data, and whether or not the patient is obliged to answer any of its questions.
- Data controllers who have obtained personal data from someone else, i.e. not from the patient must, in addition, inform the patient of the types of data they hold and the name of the original data controller.

Right of access

- Every individual has the right to know what information is held in records about him or her personally (subject to certain exemptions designed to protect the public interest and the right to privacy).
- This right includes access to expressions of opinion, unless these opinions were given in confidence. The right of access does not apply in specific cases, which would prejudice a particular interest e.g. the investigation of offences.
- An individual is also entitled to a full explanation of the logic used in any automated decision making process, where the decision significantly affects that person.

Right of rectification or erasure

- If information kept by a data controller is inaccurate, an individual has the right to have that information rectified or, in some cases, erased.

Patient information requests

Right to block certain issues

- In addition to an individual having the right to correct or erase data he/she can request a data controller to block his/her data i.e. prevent it from being used for certain purposes. For example, he/she might want the data blocked for research purposes.

Right to object

- Where the data controller is processing data and that individual is of the opinion that the data involves substantial and unwarranted damage or distress to him/her, he/she may request that the data controller stop using the personal data.
- This right does not apply if:
  1. Consent was obtained.
  2. The use is necessary for an agreed contractual obligation.
  3. The use is required by law.
  4. Consent has been withdrawn under Data Protection.

Section Four: Legal requests

- Authorisation from the courts, coroner or solicitors for release of information must be in writing, verbal requests are not accepted.
- Copy information is provided, never originals. Check with the healthcare records manager or designated person before this information is released.

i. Action taken against the Health Service Executive where a clinician who is an employee of the Health Service Executive is named as a co-defendant

- Where an action is taken by a patient against the Health Service Executive in circumstances where a clinician who is an employee of the Health Service Executive is named as a co-defendant, both the Health Service Executive and clinician will have the services of the one composite legal defence team.
- Patient consent is not required where the hospital transmits the patient healthcare record to its own solicitors for the defence of the claim as any such communications are fully protected by legal professional privilege.

- Where this legal team are also acting for the clinician the question of transmitting a copy of the patient healthcare record to a separate firm of solicitors and legal team does not arise.

ii. Action taken against a Ccinician who is operating in a private capacity where the Health Service Executive/hospital is named as a co-defendant

- Where an action is taken by a patient against a clinician who is operating in private capacity, in circumstances where the Health Service Executive/the hospital is named as a co-defendant and the healthcare record is held in the hospitals healthcare records department, the healthcare record is considered to be in the hospitals possession and ownership.
- Patient consent is not required where the hospital transmits the patient healthcare record to its own Solicitors for the defence of the claim as any such communications are fully protected by legal professional privilege.
- Where this legal team are also acting for the clinician the question of transmitting a copy of the patient healthcare record to a separate firm of solicitors and legal team does not arise.

iii. Action taken against a clinician who is operating in a private capacity where the HSE/hospital is not named as a co-defendant

- Where an action is taken by a patient against a clinician who is operating in private capacity, in circumstances where neither the HSE nor the hospital are named as co-defendants and the healthcare record is held in the hospitals healthcare records department, the healthcare record is considered to be in the hospitals possession and ownership.
- The healthcare record should not be released without the patient's written authorisation except on foot of an Order for Discovery from the Court.
- It is permissible to release copies of any medical reports or notes to the private clinician created by him/herself for which she/he would normally have been expected to retain a copy in his/her own possession. Any such release to a clinician at this time should make clear that the release of the information is on the basis that it is for the clinicians use only.
- Any documents created by the clinician himself/herself acting in his/her role as a private clinician to the patient could not attract any entitlement to patient confidentiality in respect of release to the clinician himself/herself.

Patient information requests

- Where documentation is given to the clinician's solicitor on foot of a Court Order for Discovery, the rules of court provide that those records may only be used by the solicitor for the purposes of the legal proceedings and for no other purposes whatsoever.
- It is the responsibility of the clinician's solicitor, as an officer of the court, to ensure that any such healthcare record is treated in a confidential matter and is appropriately destroyed on completion of the case.

Section Five: Requests for information by the Gardai

- Current practice in assisting the Garda Siochana with their general inquiries will continue. However, where the patient has authorised Gardai to have access to information from his or her health records, this may be supplied. Proof of the patient's authorisation must be obtained.
- Requests for information from the Gardai where the patient has not authorised access to information from his or her health records will be dealt with by the treating healthcare professional or senior administrator and will only be supplied in accordance with a court order on the production of a search warrant or other legal authority.
- Where the treating healthcare professional or senior healthcare professional in a hospital or any other health service becomes aware, during the clinical management of a patient, that a serious crime may have been committed the agency shall notify the Gardai. The agency, in the public interest to enable Gardai to initiate appropriate action, may provide information which will usually be given by a senior healthcare professional.

Information relating to child abuse:

- In general, requests for access to records containing information of alleged/ suspected child Abuse should be processed under the Freedom of Information Acts. However, information may be released to the HSE child protection and welfare, social work department and Garda authorities where the release of such information is necessary to promote the welfare of the child.
- Caution has to be exercised as to whether there is a breach of an obligation of confidentiality and, if so, whether there are grounds for breaching that obligation of confidentiality.
- Refer to local hospital social work department, Child Care Act 1991 and Protection for Persons reporting Child Abuse Act 1998.

Patient information requests

Section Six: Other Healthcare providers

- With regard to requests from other healthcare providers (including the National Treatment Purchase Fund), concerning patients who have now moved into their care, the source of the request must be checked to ensure that it is a valid enquiry.
- Clarify what information is required. Discharge communications can be released without the patients consent but if the other healthcare provider requires more documentation, the consent of the patient will have to be given. Send copies – if faxed through, check that it is a "safe haven" fax, and that the person requesting the information is ready to pick up the copies.
- Copy notes sent by registered post, must be double-wrapped, marked "confidential" and sent recorded delivery.

3 Requests for the healthcare record for research purposes

3.1 Introduction

In order for the release of information from a patient's healthcare records for Internal Audits/Research there has to be prior approval in accordance with local policies and procedures, to ensure that patient information is kept confidential.

3.2 Scope

The aim of this procedure is to outline the process for which healthcare records are required for research and how they are released.

3.3 Contents

Section One: General principles

3.4 Procedure

Section One: General principles

- A hospital approval form for all proposed internal audits/research activities must be completed and signed by appropriate persons (clinician, hospital CEO/ Manager, etc.).
- A complete list of all healthcare records that will be required for research to be supplied.
- Minimum of two weeks notice required for all research requests.
- Research proposals should meet the hospitals' guidelines and be accompanied by a comprehensive protocol detailing the aims, methods and reasons for the study.
- Where access to healthcare records is requested, the nature of the access requested should be clearly specified and the safeguards for privacy outlined.
- Where patients are to be contacted directly by the researcher, or potentially identifying information is requested, the written consent of the patient should be obtained by the treating healthcare professional or senior healthcare professional prior to access being allowed.

Requests for the healthcare record for research purposes

- Healthcare records will be tracked to requesting clinician, together with details of his/her supervising clinician.
- Should a healthcare record be required for an out-patient's clinic /emergency department/admission, etc. the healthcare record will need to be returned to the requestor without delay.
- Under no circumstances are hospital health records to leave the hospital grounds without approval of the hospital CEO/Manager or designated officer.

4 Tracking the healthcare record

4.1 Introduction

One of the primary reasons why records get misplaced or lost is because their movement between locations is not adequately recorded. Healthcare record tracking is the function used to change the location of any patient's healthcare record. It is compulsory that ALL staff update the healthcare record location on each occasion that a healthcare record is moved. This must be done regardless of the length of time the healthcare record is being used for. There is a dual responsibility on the part of the person who is sending the healthcare record and the person who is receiving the healthcare record to record the location of the healthcare record on the healthcare record tracking system. Each person who has occasion to retrieve a healthcare record will benefit.

4.2 Scope

To ensure that the healthcare record can be located quickly and efficiently when required and to reduce the time spent by healthcare records staff retrieving healthcare records on loan from the healthcare records library.

5.3 Contents

Section One: Computerised healthcare records tracking system

Section Two: Manual healthcare records tracking system—tracing cards

Section Three: Healthcare records library

Section Four: Accessing healthcare records out-of-hours

Section Five: Returning healthcare records for filing

Section Six: Risk management

4.4 Procedure

Section One: Computerised healthcare records tracking Function

- The healthcare records tracking functions are used to change/up-date the location of any patient's healthcare records known to the system.
- The "Base Location" for the healthcare record is the healthcare records library.
- When a healthcare record is removed from its "Base Location" the healthcare record tracking function will allow the healthcare record to be tracked from its "Base Location" to its new location. The new location is referred to as the healthcare record "Current Location".
- When a healthcare record is moved from its "Current Location" the healthcare record tracking function will allow the healthcare record to be tracked/ transferred to another location e.g. Out-Patient Clinic to medical secretariat.
- On return of the healthcare record to its "Base Location" e.g. healthcare record library, healthcare record staff will use the healthcare record tracking function to return the healthcare record from its "Current Location" to its "Base Location".

Section Two: Manual healthcare record tracking system—tracing cards

- It is the responsibility of all staff members to insert the requester's name and date on tracer cards.
- The person to whom the healthcare record is tracked, is responsible for that healthcare record until it is returned to the healthcare records department.

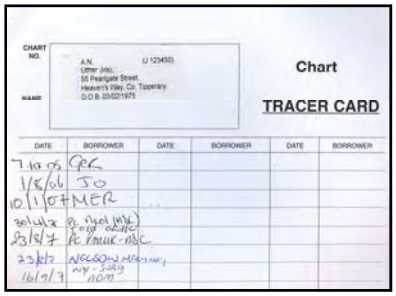


Figure 4-1: Manual tracking system

- If a healthcare record is transferred from one location to another without going through the healthcare records department then it is the responsibility of the person that the healthcare record is tracked out to, to track it to the next location.
- Healthcare records staff are responsible for ensuring that all healthcare records retrieved from filing and all healthcare records notified to them for tracking purposes are recorded on the tracer card.
- The responsibility for the whereabouts and security of a healthcare record rests with the staff member it is tracked to.

Tracking the healthcare record

- To be effective, tracking systems must at a minimum record the following information:

    i. Unique record reference number.

    ii. Description of the record (including volume/number/media type).

    iii. Person and operational area having possession of the record.

    iv. Date of transfer/movement of the record.

Section Three: Healthcare records library

- On requesting a healthcare record from the healthcare records library, it is the responsibility of the person who retrieves the healthcare record to arrange collection/transport.
- The responsibility for recording the movement of a healthcare record lies with the person who is transferring it, however, it is the responsibility of every staff member to ensure that healthcare records in their possession are tracked to them.

Section Four: Accessing healthcare records out-of-hours

- It is accepted that healthcare records will be located outside the healthcare records library e.g., out-patient clinics, discharge, etc. In these instances, it is the responsibility of every staff member to ensure that the healthcare record is tracked to his/her department/ward.
- Healthcare records should be easily accessible by administrative staff that have occasion to retrieve them out of hours e.g. Emergency Department staff. The healthcare record should be accessible, be visible and preferably filed in terminal digit order. It is the responsibility of the Department Head, Ward Manager, Staff Officer to ensure that the Emergency and Healthcare Records Department have access to offices where healthcare records are held out-of-hours.
- If a healthcare record is removed from an office or an area within the hospital 'out-of-hours', this should be notified to the healthcare records department.

Section Five: Returning healthcare records for filing

- All staff are responsible for ensuring that all healthcare records are tracked back to the healthcare records library and returned for filing.

Tracking the healthcare record

- It is the responsibility of all healthcare records users to return the healthcare record to the filing room/library when they have finished with them. Following that, it is the responsibility of healthcare record staff to update the local tracking system.

Section Six: Risk management

- The healthcare records library supervisor should be informed on each occasion that staff experience difficulty in retrieving a healthcare record. The healthcare records manager is kept informed as appropriate and determines events that need to be notified to the risk management department.

5 Training

5.1 Introduction

All line managers and supervisors must ensure that their staff, whether administrative or medical, are adequately trained and apply the appropriate recommended practices in relation to healthcare records management. The development/training needs of staff must be audited on an ongoing basis and additional training in relation to the management of healthcare records must be based on the results of these audits.

5.2 Scope

The objective of this procedure is to set out training requirements for staff who deal with healthcare records.

5.3 Contents

Section One: Healthcare records management policies and procedures

Section Two: Confidentiality

Section Three: Healthcare records management training

5.4 Procedure

Section One: Healthcare records management policies and procedures

- It is the responsibility of each head of department to ensure that new members of staff are adequately trained in the polices and procedures pertaining to healthcare records management
- Policies and procedures in relation to healthcare records management are given to all members of staff for their attention and time should be allocated to allow staff read them.
- Each head of department (where the department has an involvement in healthcare records) undertakes a staff training needs analysis and develops a prioritised action plan to address identified training needs in healthcare records management for personnel within their own department.
- Departmental records are kept of attendance of all staff who receive training in healthcare records management.

Training

- There is a regular review of the training programme content to ensure its relevance.
- The quality and effectiveness of the training programme is regularly evaluated.
- Individual competency in healthcare records management should be regularly reviewed.

Section Two: Confidentiality

- The confidentiality of information in the healthcare record is addressed on the first day a new member commences work.
- Ongoing training regarding confidentiality of patient information takes place in each local hospital.

Section Three: Healthcare records management training

- The methods of healthcare records management training that may be implemented include.

i. Implementation of a formal training programme to launch and support local policies in relation to healthcare records management.

ii. Inclusion of healthcare records management in induction training and staff handbooks.

iii. Follow-up training.

iv. Specific training in records management and archiving.

National Hospitals Office Code of Practice for Healthcare Records Management

Part 4: Recommended Practices for Healthcare Records Staff

Reader Information

Directorate:	National Hospitals Office (NHO)
Title:	NHO Code of Practice for Healthcare Records Management
Document Purpose:	Standards & Recommended Practices—Part 4
Author:	NHO Healthcare Records Management Steering Committee
Publication Date:	October 2007
Target Audience:	All staff in the NHO who work in healthcare records management
Description:	The Code of Practice is a guide to the standards of practice required in the management of healthcare records in the NHO, based on current legal requirements and professional best practice
Superseded Docs:	The retention and disposal schedule replaces the previous retention schedule on acute hospital records outlined on pages 8-9 of the 'Policy for Health Boards on Record Retention Periods' (1999). Version 2.0 replaces Version 1 of Code of Practice.
Review Date:	October 2008
Pictures:	All pictures in this document were taken with the kind assistance of the staff in South Tipperary General Hospital.
Contact Details:	Winifred Ryan, National Hospitals Office, Quality, Risk and Customer Care Directorate, Mid-Western Regional Hospital (Nenagh) Nenagh, Co. Tipperary, Ireland. **Email**: winifred.ryan1@hse.ie **Web:** www.hse.ie

Part 4

Recommended Practices for Healthcare Records Staff

Contents – Part 4

Contents

Figures—Structure of the healthcare record

Contents

Structure of the Healthcare Record

1 Unified healthcare record

1.1 Introduction

It is considered to be in the best interest of patients and their care that the full history of their care is available to the current multidisciplinary team. The healthcare record should follow the patient through every discipline in the hospital in which that patient receives care. Documents within the record should reflect the continuum of patient care.

1.2 Scope

The objective of this procedure is to ensure that all patients treated in the hospital have a unified healthcare record, in order to provide comprehensive clinical information for effective treatment.

1.3 Contents

Section One: Healthcare record chart

Section Two: Contents of the healthcare record

Section Three: Marking the healthcare record chart

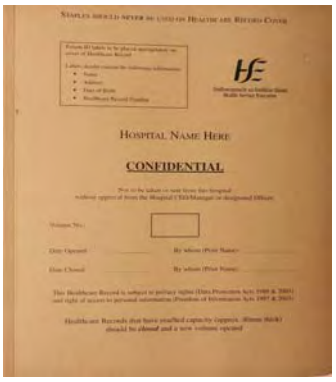


Figure 1-1: National Chart

1.4 Procedure

Section One: Healthcare record chart

- Healthcare record folders should be of 485 gsm quality manila, measure 305mm x 240mm, and have a gusset along the triple spine to allow for expansion to a maximum of 80mm as more documents are added. The dividers should be of 200gsm quality card and should have reinforced/laminated printed tabs.
- Each patient is assigned a unit number which is printed on the outside of the healthcare record chart and used as a unique identifier for that patient.

Unified healthcare record

Section Two: Contents of the healthcare record

Figure 1-2: Sections of the healthcare record

- ***Administrative Section***
- Patient labels.
- Registration Sheet.
- Relevant Billing/Private Insurance Forms (pending completion only).
- ***Correspondence Section***
- Referral Letters.
- Discharge Communication.
- Ambulance Transfer Sheets.
- Other correspondence relevant to patient care.
- ***Clinical Notes***
- Clinical Notes (inpatient and outpatient).
- Patient Emergency Department Card.
- ***Nursing Notes***
- Temperature & Observation Sheets.
- Fluid Balance Sheets.
- Nursing Care Plans.
- Intensive Care Unit Nursing Notes.
- Theatre Nursing Care Plans.
- Evaluations.
- ***Procedure***
- Procedure Forms.
- Anaesthetic Records.
- Epidural Infusion Records.
- Implants Record.
- Blood Loss Sheet.

Unified healthcare record

- Swab Count Sheet.
- Instrument Count Sheet.
- Theatre Checklist.
- Post-operative orders from the surgeon.
- **Consent**
- Consent Forms
- ***Clinical Measurement***
- Cardiovascular/Haemodynamic.
- Vascular.
- Neurophysiology.
- Pulmonary Function.
- GIT Physiology.
- Urologic Physiology.
- Audiology Reports.
- EEGs.
- ***Laboratory Results***
- Biochemistry Results.
- Haematology/Blood Group Results.
- Microbiology Results.
- Immunology Results.
- Histopathology and Hospital Post-Mortem Reports.
- Molecular Diagnostic Results.
- ***Radiology and Diagnostic Imaging Results***
- Radiology and Diagnostic Imaging Reports.
- Videofluoroscopy Reports.
- ***Prescribed Medicines***
- ***Health and Social Care Professionals***

Unified healthcare record

Section Three: Marking the healthcare record chart

- When a healthcare record chart is created, ensure that the **volume number** and the **date opened** are clearly marked, dated and signed on the front cover.
- Ensure the **patient identifier** is placed in the appropriate space on the cover of the healthcare record chart.
- In the absence of an electronic monitoring system a current **year sticker** should be applied to indicate chart activity.
- Ensure **colour sticker** is placed on the healthcare record chart to facilitate terminal digit filing in the healthcare record library.
- Ensure **RIP sticker** is placed on the front cover of the healthcare record chart in the event of patient death.
- Ensure (removable) **warning sticker** is placed on the front cover of the healthcare record chart in the event that there are two patients with the same first and second names in the same location.

Figure 1-3: RIP sticker

Figure 1-4: Warning sticker

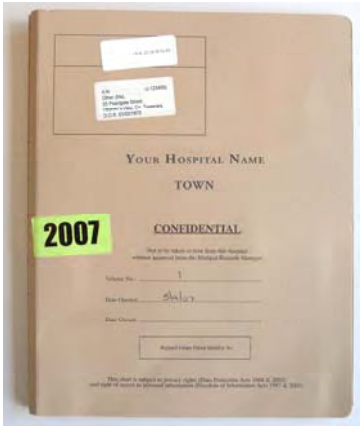


Figure 1-5: Year sticker

Figure 1-6: Terminal digit filing sticker

2 Healthcare record order of filing

2.1 Introduction

Good healthcare records are needed for good patient care. To ensure that patients are treated efficiently and effectively the current healthcare team need easy access to high quality healthcare records. All staff should be aware of their responsibilities for the upkeep, correct filing and acceptable presentation of healthcare records.

2.2 Scope

Correct filing in the healthcare record is extremely important for ease of retrieval of information and also to assist in the coding of these healthcare records.

2.3 Contents

Section One: Administrative Section

Section Two: Correspondence Section

Section Three: Clinical Notes

Section Four: Nursing Notes

Section Five: Procedures

Section Six: Consent

Section Seven: Clinical Measurement

Section Eight: Laboratory Results

Section Nine: Radiology and Diagnostic Imaging Results

Section Ten: Prescribed Medicines

Section Eleven: Health and Social Care Professionals

2.4 Procedure

Directions for entry/filing of information are provided on the divider of each section of the chart and should be adhered to.

Healthcare record order of filing

Section One: Administrative Section

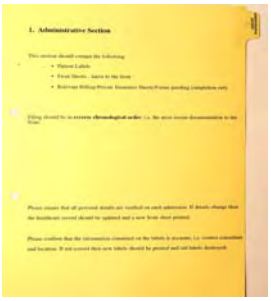


Figure 2-1: First Divider—Administrative Section

- There should be a current, dated front sheet in the front of the healthcare record chart for every patient's first point of contact with the hospital. This sheet contains the patient's personal details. Thereafter, patient details on the front sheet are checked for accuracy on each patient attendance. If there is any change in patient details the current, accurate front sheet is placed in the front of the healthcare record chart.
- Administrative staff who record or input information must be identified on the patient's front sheet.
- All details should be obtained at time of registration/admission. In the event that some details are omitted, then it becomes the responsibility of any member of staff who is dealing with the patient to obtain the missing information from the patient or the patient's relatives at the earliest opportunity and pass this on to the appropriate personnel.
- This information should be passed onto the admissions office or ward clerk for entry into hospital information system and then an updated front sheet provided.
- There should be sufficient addressographs labels in the administrative section at all times.
- All addressographs are checked for accuracy on each patient attendance. If there is any change in patient details the addressographs are to be removed from the healthcare record chart, shredded and replaced with a current, accurate set.
- The minimum data set on each patient label should include the following patient information—healthcare record number, name, address, date of birth, clinician and department.

Section Two: Correspondence Section

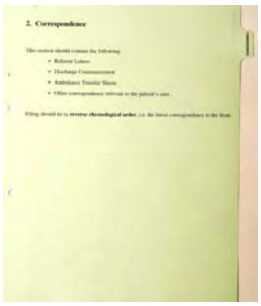


Figure 2-2: Second Divider—Correspondence

- This section contains referral letters, discharge communications and any other correspondence relevant to the patients care.
- Filing should be in reverse chronological order, i.e. the most recent documentation to the front; this includes the letters sent to and from the hospital.
- Do not store more than one copy of each letter of correspondence, unless notes have been made on both copies.

Healthcare record order of filing

Section Three: Clinical Notes

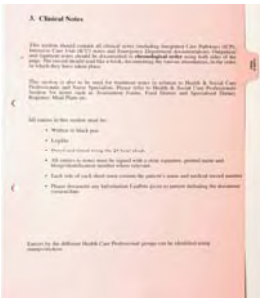


Figure 2-3: Third Divider—Clinical Notes

- Each side of each sheet where patient information is documented must have an addressograph. In the absence of addressograph labels the patient's name, healthcare record number and date of birth should be written.
- All entries must be dated, timed and signed with a clear signature, printed name, title and bleep number, where relevant.
- Filing should be in chronological order. The record should read like a book, documenting the various attendances, in the order in which they have taken place.
- Any page seen to be falling out must be reinforced and filed back into the appropriate place.
- The medical social worker should determine if it is appropriate to include certain sensitive information in this section of the healthcare record.
- Any audio-visual recordings taken by healthcare professionals should be documented in this section of the healthcare record.

Section Four: Nursing Notes

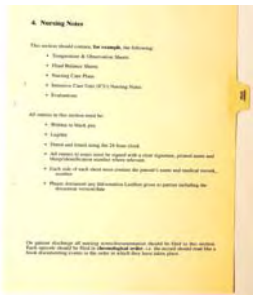


Figure 2-4: Fourth Divider—Nursing Notes

- This section is for all relevant nursing documentation.
- Each side of each sheet where patient information is documented must have an addressograph. In the absence of addressograph labels the patient's name, date of birth and healthcare record number should be written.
- All entries must be dated, timed and signed with a clear signature, printed name, title and bleep number where relevant.
- Filing should be in chronological order, i.e. the record should read like a book documenting events in the order in which they have taken place. This allows prompt and precise retrieval of data.
- Any audio-visual recordings taken by nursing staff should be documented in this section of the healthcare record.

Healthcare record order of filing

Section Five: Procedure

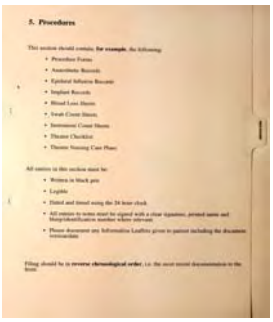


Figure 2-5: Fifth Divider—Procedures Section

- Each side of each sheet where patient information is documented must have an addressograph. In the absence of addressograph labels the patients name, healthcare record number and date of birth should be written.
- All entries must be dated, timed and signed with a clear signature, printed name and bleep number where relevant.
- The procedure note for all procedures must be held in this section, although the corresponding report may be filed elsewhere.
- Filing should be in reverse chronological order, i.e. the most recent documentation to the front.

Section Six: Consent

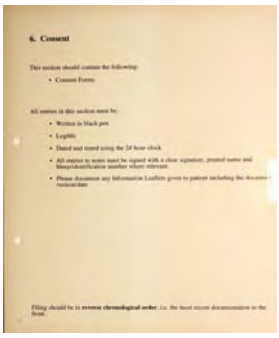


Figure 2-6: Sixth Divider—Consent Section

- Each side of each sheet where patient information is documented must have an addressograph. In the absence of addressograph labels the patients name, healthcare record number and date of birth should be written.
- Each operation/procedure record must have a corresponding consent form filed with it.
- All entries must be dated, timed and signed with a clear signature, printed name and bleep number where relevant.
- Filing should be in reverse chronological order, i.e. the most recent documentation to the front.

Section Seven: Clinical Measurement

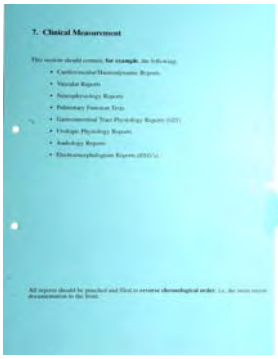


Figure 2-7: Seventh Divider—Clinical Measurement Section

- An addressograph should be placed on each sheet/report. In the absence of addressograph labels the patient's name, healthcare record number and date of birth should be written.
- All sheets/reports should be punched and filed in reverse chronological order, i.e. the most recent documentation to the front.
- Only one copy of each report to be filed in this section unless notes have been made on both copies.

Healthcare record order of filing

Section Eight: Laboratory Results

Figure 2-8: Eighth Divider—Laboratory Results

- The laboratory results section is sub-divided and has corresponding mount sheets as follows:
  - i. Biochemistry results (green)
  - ii. Haematology/Blood Group results (pink)
  - iii. Microbiology results (yellow)
  - iv. Immunology results (blue)
  - v. Histopathology results and Hospital Post Mortem reports (A4 white)
  - vi. Molecular Diagnostics (grey)
- All reports must be signed within twelve hours of the result being delivered back to the ward. This signature is placed on the results form adjacent to the results.
- All reports must be signed by a clinician before being filed. The resulting action to be taken is recorded in the healthcare record.
- Laboratory results should not be filed unless they have been signed as read and action taken by a clinician.
- Only one copy of each report to be filed.
- Each mount sheet has eleven self-adhesive strips which facilitates the filing of eleven reports on each sheet. These are numbered with number one being the first report to be filed, etc.
- While every effort is made to file reports in date order, it is advisable to check the date of the report that you are referring to.
- When a mount sheet is full, additional reports should never be sellotaped or stapled to the full mount sheet. A new mount sheet should be added in reverse chronological order with the most recent mount sheet on top for each result type.
- The mount sheet should correspond to the colour of the laboratory result forms.
- A5 (small) reports should be filed on the radiology mount sheet from the bottom of the page upwards.
- A4 (full page) reports should be punched and filed directly behind the mount sheet in reverse chronological order.

Healthcare record order of filing

Section Nine: Radiology and Diagnostic Imaging Results

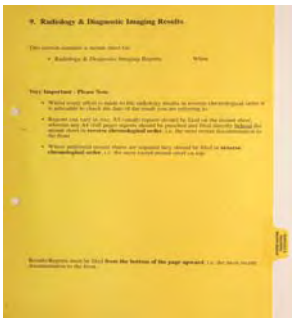


Figure 2-9: Ninth Divider—Radiology & Diagnostic Imaging Results

- This section contains radiology and diagnostic imaging reports.
- All reports must be signed within twelve hours of the result being delivered back to the ward. This signature is placed on the results form adjacent to the results.
- All reports must be signed and dated by a clinician before being filed. The resulting action to be taken is recorded in the healthcare record.
- Radiology and Diagnostic imaging results should not be filed unless they have been signed as read and action taken by a clinician.
- Only one copy of each report to be filed.
- Each mount sheet has eleven self adhesive strips which facilitate the filing of eleven reports on each sheet. These are numbered with number one being the first report to be filed etc.
- While every effort is made to file reports in date order, it is advisable to check the date of the report that you are referring to.
- When a mount sheet is full, additional reports should never be sellotaped or stapled to the full mount sheet. A new mount sheet should be added in reverse chronological order with the most recent mount sheet on top for each result type.
- A5 (small) reports should be filed on the radiology mount sheet from the bottom of the page upwards.
- A4 (full page) reports should be punched and filed directly behind the mount sheet in reverse chronological order.

Healthcare record order of filing

Section Ten: Prescribed Medicines

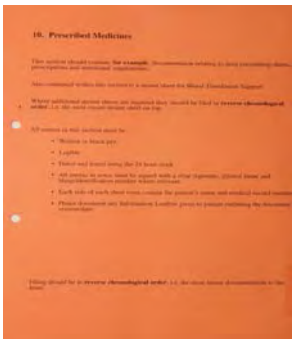


Figure 2-10: Tenth Divider—Prescribed Medicines

- This section should contain all documentation relating to prescribed medicines and nutritional supplements.
- Each side of each sheet or drug healthcare record where patient information is documented must have an addressograph. In the absence of addressograph labels the patient's name, healthcare record number and date of birth should be written.
- All entries must be dated, timed and signed with a clear signature, printed name and bleep number, where relevant.
- Filing should be in reverse chronological order, i.e. the most recent documentation to the front.

Section Eleven: Health and Social Care Professionals

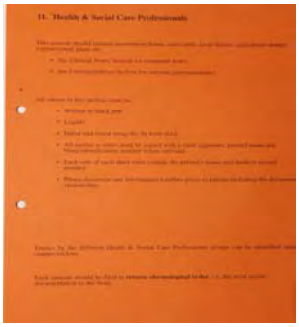


Figure 2-11: Eleventh Divider—Health & Social Care Professionals

- All health and social care professionals will use this section to file assessment forms, care cards, food diaries, specialised dietary regimes/meal plans etc.
- Each side of each sheet or drug healthcare record where patient information is documented must have an addressograph. In the absence of addressograph labels the patient's name, healthcare record number and date of birth should be written.
- All entries must be dated, timed and signed with a clear signature, printed name, title and bleep number where relevant.
- Filing should be in reverse chronological order, i.e. the most recent documentation to the front.
- Entries by the health and social care professional groups can be identified using stamps/stickers.

3 Documents not held in the healthcare record

3.1 Introduction

Due to the complexity or sensitive nature of various types of records, not all records may be suitable to be held in the main healthcare record**. However, all of these records should be identified using the patient's unique identifier.**

3.2 Scope

The purpose of this procedure is to outline the documents that should not be included in the main healthcare record.

3.3 Content

Section One: General principles

3.4 Procedure

Section One: General principles

The following documentation should not form part of the main healthcare record:

- Administrative access requests.
- Billing details.
- Child protection reports.
- Complaints.
- Coroners post-mortem reports (unless consent from the coroner is obtained).
- Correspondence from solicitors.
- Data Protection requests.
- Financial information.
- Freedom of Information requests.
- Garda reports.
- Health & Safety forms.
- Medico-legal reports.
- Incident report forms and risk management critical incident reviews.

Documents not held in the healthcare record

- Welfare notification forms.
- This is not an exhaustive list and if in doubt, please consult the healthcare records manager or designated person for advice.
- These documents shall be stored in a safe and secure manner in accordance with local policies and procedures.

4 Managing loose information

4.1 Introduction

It is considered to be in the best interest of patients and their care that the full history of their care is available to the current multidisciplinary team. It is thus essential that all paper documentation relating to the patient is filed promptly in the healthcare record.

4.2 Scope

The purpose of this procedure is to provide guidelines on how to manage loose information in the event of not having prompt access to the healthcare record.

4.3 Content

Section One: General principles

4.4 Procedure

Section One: General principles

- All loose reports and other documents shall be filed in the proper location in the correct healthcare record by the end of the working day of receipt, except when the record is not available, in which case the loose reports shall be stored in a safe and secure manner until the record becomes available.
- Each hospital must clearly identify responsibility for filing of loose information.

Figure 4-1: Managing loose documents

Healthcare Records management

1 Confidentiality and security of patient healthcare information

1.1 Introduction

Every healthcare record (including information kept on paper and electronic format) is a confidential document of patient care and as such must be kept secure at all times. Patients have a right to expect that those working in the hospital keep these personal documents, which contain information relating to their health and welfare, confidential and secure. The healthcare records department aims to provide a secure and confidential environment in which to care for patients' records, but cannot be responsible when records are outside of their care. This recommended practice therefore applies to any member of staff when records are in their care. It also applies to information available on computer systems.

1.2 Scope

The aim of this procedure is to outline the method for which the confidentiality and security of a healthcare record is preserved.

1.3 Contents

1.4 Procedure

Section One: Responsibility

- It is the responsibility of Clinical Directors, Nurse Managers, Business Managers and Department Heads to ensure that staff adhere to this policy and those procedures are in place within their area of responsibility regarding the confidentiality of patients' healthcare records.
- Staff must also ensure that the privacy of patients using the services of the National Hospitals Office is maintained at all times.
- Staff must report healthcare records and/or documentation located in unsecured areas to the healthcare records manager.
- Healthcare records supervisors must maintain a list of individuals authorised to access the healthcare records library. This list is displayed prominently within the department. All healthcare records staff are required to check anyone who enters the department against this list. The healthcare records library supervisor should be responsible for control and access to the filing room library.
- If there is any doubt as to whether a person has right of access, the supervisor must be informed immediately.
- All healthcare records must be correctly tracked by using the local healthcare record tracking system.
- All healthcare records must be stored in a secure/supervised area with restricted access.
- All healthcare records to be returned to their designated storage location when not in use.
- Under no circumstance are healthcare records to be made available for unauthorised use.
- The staff member who takes a healthcare record is responsible for its safety, for ensuring its confidentiality and ensuring that it is returned to the healthcare records department or to an appropriate person. An appropriate person is one who has a professional role that requires him/her to read the healthcare record or update it.
- In some care areas, for example, midwifery, procedures have been agreed to provide patient held healthcare records, however, unless these procedures are agreed and in place, a healthcare record must not be given to a patient. Each patient has a legal right to his/her records. This right is exercised by way of a written request under the Administrative Access Policy, the Freedom of Information Acts 1997 and 2003 and Data Protection Acts 1988 and 2003.

Confidentiality and security of patient healthcare information

- Care should be taken to ensure that a patient's healthcare record is not placed in any unsupervised public place or where it may be viewed or accessed inappropriately.
- Healthcare records should not be placed on reception desks or on trolleys except when they are required for clinics and only then under the supervision of appropriate clinic staff.

Figure 1-1: Security of the healthcare record

- Healthcare records should not be left on desks in offices in the absence of the responsible staff. Whenever an office is left unattended it should be securely locked.

Section Two: Staff

- There should be a clause in all staff contracts regarding confidentiality of patient care and the security of patient healthcare information.
- Staff should be reminded of importance of confidentiality and security of patient healthcare information at staff meetings.
- Staff are informed of the importance of confidentiality and security of patient healthcare information at induction and training courses.
- Any HSE employee will be subject to disciplinary action if he/she breaches the confidentiality and security clause.
- Patient information will be restricted to HSE employees on a 'need-to-know' basis, as determined by their role or service responsibilities.
- In carrying out their duties, staff may have access to, or hear information concerning the personal affairs of patients and/or staff or other healthcare service business. Such records and information are strictly confidential and on no account must any information be divulged or discussed unless acting on the instructions of an authorised officer.

Section Three: Healthcare delivery associates and third parties

- Healthcare delivery associates will receive relevant, appropriate and agreed information on their patients. The National Hospitals Office expects healthcare delivery associates to handle this shared patient information confidentially and securely in adherence to the Data Protection Acts 1988 and 2003.
- If patient information is disclosed to an authorised third party, the National Hospitals Office will hold the said party to the same set of confidentiality and privacy principles that the organisation adheres to.

Confidentiality and security of patient healthcare information

Section Four: Access to healthcare records or clinical information

The healthcare record or its information content shall be made available only to:

- Those medical, nursing and healthcare professionals who are responsible for providing or supervising the patient's care.
- Those hospital employees authorized to process the record within the healthcare records department, to collate medical and statistical information, to collect data for authorized clinical research projects and to review the record for quality assurance, clinical audit, quality improvement, risk management or infection control purposes.
- Students or trainees in medicine, nursing, a health and social care profession or another recognized clinical professional training programme, when the students are involved in the patient's care and under the supervision of named clinical staff.
- Any clinician to whom the patient is being referred or transferred.
- Other individuals with specific written authorization in accordance with the Data Protection Acts 1988 and 2003 and Freedom of Information Acts 1997 and 2003.
- Access to healthcare records may also be available for research purposes where patient details are annoyimized or where the hospital has obtained clear and unambigious consent from the patients concenred for the use of their healthcare information for these purposes.

Section Five: Sequestered records

- Healthcare records of designated individuals and records of cases under medico-legal investigation should be stored in a designated secure area as agreed with the hospital CEO/Manager.
- Provision shall be made for these records to be accessed out-of-hours if a patient whose record is sequestered requires emergency or urgent treatment.
- Certain designated healthcare records or certain designated sensitive medical documentation relating to a patient may be kept separately from the healthcare record files.
- The tracking system shall be used to indicate that these records are filed separately in the department to enable the department head or designee to retrieve the records promptly when required.

2 Communication with patients

2.1 Introduction

All information provided to patients (written or verbal) should be delivered in a form and manner which is clear, courteous and in a way that the patient can understand.

2.2 Scope

This objective of this procedure is to provide guidelines to staff regarding appropriate communications with patients.

2.3 Contents

Section One: General communications

Section two: Training in communications

2.4 Procedure

Section One: General communications

When dealing with a member of the public all staff are representing the Health Service Executive and are expected to respond:

- **Promptly** and without undue delay.
- **Correctly** in accordance with the law and other rules governing entitlements.
- **Sensitively** by having regard to age, capacity to understand and any disability they may have.
- **Helpfully** by simplifying procedures and maintaining proper records.
- **Fairly** by treating people in similar circumstances in like manner, avoiding bias based on personal prejudice, colour, sex, or marital status, ethnic origin, culture, language, religion, sexual orientation, attitude reputation or because of who they are or whom they know.
- **Confidentially** with respect for patient privacy.

Communication with patients

Section Two: Training in communications

- All relevant staff should receive formal training in providing a personalised service and in using the patient systems appropriate to their area of work.
- All staff dealing with the public should have training in customer care.

3 Patient registration

3.1 Introduction

Record registration is a system that allocates a unique patient identifier to each item, e.g. a file, and assigns this record in a register or index. This system provides for easy identification and retrieval of healthcare records. Accurate patient personal information details are essential for confidentiality and safety of patient care.

3.2 Scope

The purpose of this procedure is to provide guidelines to relevant staff regarding patient registration.

3.3 Contents

Section One: Patient registration information

Section Two: Record registration

Section Three: Patient identification

3.4 Procedures

Section One: Patient registration information

Registration information shall include the following:

- Title.
- Full name (forename and surname). The forename should be the name on the patient's birth certificate.
- Alias: The name by which the patient likes to be known, if different from the patient's name.
- Home address/Current address (if different).
- Two contact telephone numbers (landline and mobile, if possible).
- Next of kin/Contact in the case of an emergency (name & address).
- Two contact telephone numbers (landline and mobile, if possible).

Patient Registration

- Patient date of birth.
- Previous address.
- Gender.
- Marital status.
- Patients GP and GP contact details.
- Healthcare Record number assigned at registration.
- Admission referral source.
- Mode of arrival.
- Medical insurance.
- Mothers maiden name
- Religious preferences.
- Ethnicity.
- Spoken language (indicate if an interpreter is needed).
- Occupation.
- Accompanied by.
- Medical Card (Yes/No). Medical Card Number if yes.
- School (where relevant).
- **Identification information should be validated** at the emergency department, on every admission and on every visit to an outpatient clinic.
- The name, address and contact telephone number of the person to be contacted in case of emergency should be recorded.
- The information shall be updated as necessary and at each patient attendance.
- The 'next-of-kin'/contact in an emergency details should be checked and updated where necessary on every patient attendance to hospital, as this information is essential in the case of an emergency.

Section Two: Record registration

- The file title must be unique, (e.g. unique patient identifier).
- The reference identity assigned to each file must be unique.

- Both must be relevant and easily understood by all users.
- Only authorised personnel should have the ability to add, amend, delete and remove details from the record registration system.
- Only one record number shall be assigned to each patient.
- Each newborn shall be assigned a unique healthcare record number.
- Assignment of numbers shall be consistent with approved hospital procedures.
- Admissions staff should validate identification with any official documents (i.e. passport/driving licence/utilities bill) on first registration of a patient. Thereafter the patient information should be validated on each visit.

Section Three: Patient identification

- The patient's personal information details should be electronically recorded when a patient presents to the hospital, either for a booked appointment or for an assessment in the emergency department.
- The patient should be asked to verify their personal details to make sure that they are correct on the system.
- The patient should be asked to sign the 'patient front sheet'; if they are able to do so, in order to verify that the recorded details are correct.
- When all of the details have been verified on the system, the computer then generates a front sheet with the above details. The front sheet is printed off for the patient's healthcare record.
- Patient labels are also printed.

Figure 3-1: Patient registration

4 Care and maintenance of the healthcare record

4.1 Introduction

It is the aim of the National Hospitals Office to ensure that healthcare records are maintained and preserved in optimum condition to support the provision of high quality patient care.

4.2 Scope

This procedure guides all healthcare record users through the requirements for ensuring that healthcare records are held in the optimum condition in order to ensure that all information is available to all staff at all times.

4.3 Contents

Section One: Maintaining the physical state of the healthcare record

Section Two: Sending out healthcare records

4.4 Procedure

Section One: Maintaining the physical state of the healthcare record

- If a healthcare record chart requires recovering, a new identification label is produced and fixed to the new outside cover. Inside cover details must be completed.
- Healthcare records handlers outside the healthcare records department, who require recovers or additional volumes must inform the records department and return the healthcare record for amendment.
- All healthcare record handlers must ensure that the National Hospitals Office order of filing is maintained.
- Blank pages and labels to be removed from healthcare records prior to closure.
- Patient name & address label to be placed on the front cover in accordance with local filing arrangements.
- In the event of the patient's death, please ensure that the authorized RIP sticker is placed on the front cover.

Care and maintenance of the healthcare record

- Under no circumstances should anything be sellotaped, written or stapled to the healthcare record cover.
- The front sheet should be printed on an A4 sheet. This is to be punched and filed in the Administrative Section.
- Patient labels for current episode only to be filed in the Administrative Section.
- Directions for entry/filing of information are provided on the divider of each section and should be adhered to.
- There should be no loose documents in the healthcare record.

Section Two: Sending out healthcare records

- Healthcare records sent within the hospital must be securely bound with the destination clearly identified.
- Healthcare records should be transported in such a way that patients' names are not visible.
- Healthcare records should never be left unattended in the course of their delivery.
- A record should be kept of all of the healthcare records sent out using an appropriate tracking system.

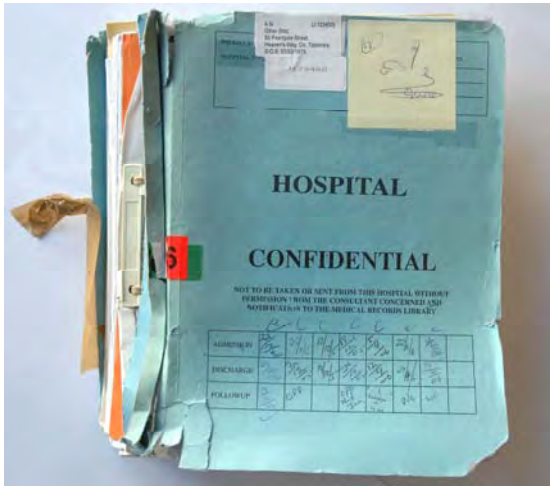


Figure 4-1: Healthcare record chart requiring re-covering

5 Tracking the healthcare record

5.1 Introduction

One of the primary reasons why records get misplaced or lost is because their movement between locations is not adequately recorded. Healthcare record tracking is the function used to change the location of any patient's healthcare record. It is compulsory that ALL staff update the healthcare record location on each occasion that a healthcare record is moved. This must be done regardless of the length of time the healthcare record is being used for. There is a dual responsibility on the part of the person who is sending the healthcare record and the person who is receiving the healthcare record to record the location of the healthcare record on the healthcare record tracking system. Each person who has occasion to retrieve a healthcare record will benefit.

5.2 Scope

To ensure that the healthcare record can be located quickly and efficiently when required and to reduce the time spent by healthcare records staff retrieving healthcare records on loan from the healthcare records library.

5.3 Contents

Section One: Computerised healthcare records tracking system

Section Two: Manual healthcare records tracking system—tracing cards

Section Three: Healthcare records library

Section Four: Accessing healthcare records out-of-hours

Section Five: Returning healthcare records for filing

Section Six: Risk management

5.4 Procedure

Section One: Computerised healthcare records tracking function

- The healthcare records tracking functions are used to change/up-date the location of any patient's healthcare records known to the system.
- The "Base Location" for the healthcare record is the healthcare records library.
- When a healthcare record is removed from its "Base Location" the healthcare record tracking function will allow the healthcare record to be tracked from its "Base Location" to its new location. The new location is referred to as the healthcare record "Current Location".
- When a healthcare record is moved from its "Current Location" the healthcare record tracking function will allow the healthcare record to be tracked/ transferred to another location e.g. Out-Patient Clinic to medical secretariat.
- On return of the healthcare record to its "Base Location" e.g. healthcare record library, healthcare record staff will use the healthcare record tracking function to return the healthcare record from its "Current Location" to its "Base Location".

Section Two: Manual healthcare record tracking system—tracing cards

- It is the responsibility of all staff members to insert the requester's name and date on tracer cards.
- The person to whom the healthcare record is tracked to is responsible for that healthcare record until it is returned to the healthcare records department.

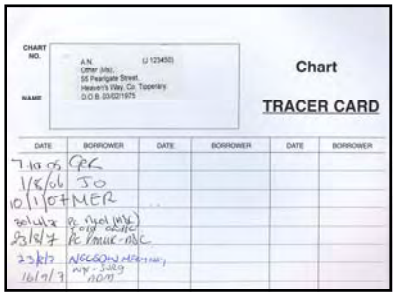


Figure 5-1: Manual tracking system

- If a healthcare record is transferred from one location to another without going through the healthcare records department then it is the responsibility of the person that the healthcare record is tracked out to, to track it to the next location.
- Healthcare records staff are responsible for ensuring that all healthcare records retrieved from filing and all healthcare records notified to them for tracking purposes are recorded on the tracer card.
- The responsibility for the whereabouts and security of a healthcare record rests with the staff member it is tracked to.

Tracking the healthcare record

- To be effective, tracking systems must at a minimum record the following information:

    i. Unique record reference number.

    ii. Description of the record (including volume/number/media type).

    iii. Person and operational area having possession of the record.

    iv. Date of transfer/movement of the record.

Section Three: Healthcare records library

- On requesting a healthcare record from the healthcare records library, it is the responsibility of the person who retrieves the healthcare record to arrange collection/transport.
- The responsibility for recording the movement of a healthcare record lies with the person who is transferring it, however, it is the responsibility of every staff member to ensure that healthcare records in their possession are tracked to them.

Section Four: Accessing healthcare records out-of-hours

- It is accepted that healthcare records will be located outside the healthcare records library e.g., out-patient clinics, discharge, etc. In these instances, it is the responsibility of every staff member to ensure that the healthcare record is tracked to his/her department/ward.
- Healthcare records should be easily accessible by administrative staff that have occasion to retrieve them out of hours e.g. Emergency Department staff. The healthcare record should be accessible, be visible and preferably filed in terminal digit order. It is the responsibility of the Department Head, Ward Manager, Staff Officer to ensure that the Emergency and Healthcare Records Department have access to offices where healthcare records are held out-of-hours.
- If a healthcare record is removed from an office or an area within the hospital 'out-of-hours', this should be notified to the healthcare records department.

Tracking the healthcare record

Section Five: Returning healthcare records for filing

- All staff are responsible for ensuring that all healthcare records are tracked back to the healthcare records library and returned for filing.
- It is the responsibility of all healthcare records users to return the healthcare record to the filing room/library when they have finished with them. Following that, it is the responsibility of healthcare record staff to update the local tracking system.

Section Six: Risk management

- The healthcare records library supervisor should be informed on each occasion that staff experience difficulty in retrieving a healthcare record. The healthcare records manager is kept informed as appropriate and determines events that need to be notified to the risk management department.

6 Filing the healthcare record

6.1 Introduction

When healthcare records are returned to the healthcare records department it is essential that they are filed in the correct location.

6.2 Scope

This procedure guides all healthcare records staff through the requirements for ensuring that healthcare records are filed correctly in the healthcare records department.

6.3 Contents

Section One: Unit record system

Section Two: Terminal digit

Section Three: Sequential numerical

Section Four: Alphabetical

Section Five: Staff responsibilities

Section Six: Filing of reports

6.4 Procedure

Section One: Unit record system

- All inpatient, outpatient and emergency care records of an individual patient shall bear the same record number, and all such records should be combined into a single unit record, to the extent feasible.

Filing the healthcare record

Section Two: Terminal digit (recommended system)

- The library is divided into 100 primary sections, numbered 00 to 99.
- This method spreads growth throughout the library.

Figure 6-1: Terminal digit filing system

Section Three: Sequential numerical

- Healthcare records are filed in straight number order.
- This produces constant end growth in the library.

Section Four: Alphabetical

- Healthcare records are filed in alphabetical order.
- This system is used rarely nowadays because of the large numbers of healthcare records involved.

Section Five: Staff responsibilities

- Healthcare records should be filed within forty-eight hours of return.
- Staff must ensure the healthcare record number and name corresponds with the tracer card.

Filing the healthcare record

- Staff are to ensure that healthcare records and tracer cards are returned to the appropriate space and that filing shelves are kept tidy.
- Healthcare records staff are responsible for the upkeep and maintenance of filing shelves assigned to them.
- Healthcare records staff are responsible for ensuring that healthcare records are filed in the correct sequence. The healthcare record numbers either side of the healthcare record being filed should be checked.

Section Six: Filing of reports

- All reports are returned to locations as agreed at local level.
- All reports must by signed by a clinician prior to filing.
- All available reports should be filed in healthcare records prior to a patient's attendance at the out-patients department.
- Reports should be filed in the healthcare record or stored in a secure area if the healthcare record is not available.

7 Storing the healthcare record

7.1 Introduction

The storage of healthcare records should take place in well designed, secure areas. This optimises the retrieval of records when required and provides a safe working environment.

7.2 Scope

The purpose of this policy is to outline the procedure by which patients' healthcare records are stored.

7.3 Contents

Section One: General principles

Section Two: Storage facilities for non-current healthcare records

7.4 Procedure

All Healthcare Records are stored in secure locations with limited & restricted access. The healthcare records facility should conform to the principles of good building design and the environmental conditions as outlined in the National Hospitals Office healthcare records management standard – 'Suitability of Physical Facilities'.

Section One: General principles

- The safety and quality of healthcare records is of prime importance. Knowing how long the records will need to be kept (refer to National Hospitals Office retention and disposal schedule) and maintained will affect decisions on storage media.
- Equipment used to store current records on all types of media should provide storage that is safe and secure with restricted access and which meets health and safety and fire regulations, but which also allow maximum accessibility of the information commensurate with its frequency of use.
- Healthcare records must be stored in such a way as to minimise the potential for deterioration and loss.

Storing the healthcare record

- Healthcare records must be stored away from and protected from the hazards of fire, flooding, humidity, atmospheric pollution, noise and vandalism.
- Healthcare records must be stored in such a way that ensures that the record remains intact and is usable throughout its lifetime.
- Healthcare records must be stored in buildings that are suitable for the storage of records and must comply with health and safety regulations.
- Buildings or rooms that house healthcare records must have the following features.
    i. Secure Windows.
    ii. Secure doors.
    iii. Controlled access system.
    iv. Sturdy construction.
    v. Secure transport mechanisms.
    vi. Allow protection, recovery and access to data and information in the event of a disaster such as flood, fire and loss of power.
- The healthcare records system should address disaster preparedness to ensure that risks are identified and appropriately addressed.

Section Two: Storage facilities for non-current healthcare records

- Any archival records, or records used on a very infrequent basis, that are still within the recommended retention period, may be stored in non-current facilities.
- The non-current storage facilities must facilitate easy and rapid retrieval when required so that the health of the patient is not compromised due to the untimely receipt of their records from non-current facilities.
- The non-current storage facilities must guarantee the integrity, security and confidentiality of all records.

Preparation of records for submission to the non-current store

- When files have been identified for transfer to the non-current store, such files must then be filtered. Blank pages and patient labels should be removed to ensure that only those documents considered vital to patient care are kept in the file.

Storing the healthcare record

- The healthcare record should be checked to see if all activity has been coded
- If the healthcare record has activity which must be coded send it to the coding department.
- The tracking system in use in the hospital should be updated.
- A record must be kept of healthcare records that have been sent to non-current/ long-term storage.

8 Managing the large healthcare record (opening and closing additional volumes)

8.1 Introduction

A second volume or subsequent volume should be created when the contents become un-manageable and there may be a risk of information becoming misplaced in the healthcare record.

8.2 Scope

The aim of this procedure is to outline the process for which a second or subsequent volume is created.

8.3 Contents

Section One: Opening and closing additional volumes

8.4 Procedure

- The following should only be applied when it becomes necessary to create a second or subsequent volume for a healthcare record.
- Additional volumes are created when a file has reached approx 80mm in width or contains approx 250 pages.

Section One: Opening and closing additional volumes

- The creator of the successor volume must be familiar with local procedures for opening and closing additional volumes.
- Check the patient's name, address, date of birth and healthcare record number on each volume to ensure the records relate to the same person.
- Blank pages and labels are to be removed from healthcare records prior to closure.
- Check that the healthcare record being closed does not contain loose pages or any form of documentation stapled or sellotaped on the front or back cover.
- The healthcare record being closed is then marked 'closed', dated and signed.

Managing the large healthcare record

- When an additional volume is created, the volume number (e.g. volume 2) and date opened must be clearly displayed on the chart cover.
- Information regarding patient alerts on the inside cover of the healthcare record must be transferred by the appropriate healthcare professional.
- The number of volumes should be recorded on the Patient Administration System.
- The date the last volume was closed should be recorded on the Patient Administration System.
- The user who creates the additional volume must record the additional volume details on the healthcare record tracking system, where appropriate.
- Current patient information must only be added to the latest volume. Current documentation must not be added to a closed volume.

9 Dealing with duplicate healthcare records and merging healthcare records

9.1 Introduction

Accurate and comprehensive recording of information and accessibility to this information are essential for effective patient care, and continuity of care between different healthcare professionals. One of the basic principles of the provision of such care is that there should be one comprehensive set of healthcare records for each patient which is available to clinicians for treatment of the patient when required.

9.2 Scope

This procedure ensures that if more than one set exists, robust and effective systems are in place to bring the sets together quickly and effectively.

9.3 Contents

Section One: Merging duplicate healthcare records

Section Two: Responsibility for correct patient identification

9.4 Procedure

Section One: Merging duplicate healthcare records

- Duplicate healthcare records may exist for a number of reasons:
  - i. Old specialty records which were originally held separately.
  - ii. Error made in the registration process.
- All patients coming to clinic or for admission have their details checked on Patient Administration System for any duplicate healthcare record numbers.
- Whatever the cause of the duplication, duplicate sets of healthcare records need to be brought together for merging as soon as practically possible.
- Obtain all existing sets of healthcare records, and physically merge using National Hospitals Office healthcare record order of filing.
- Ensure all documentation held under the deleted healthcare record number is transferred to the original number. Discard labels that refer to the deleted number.

Dealing with duplicate healthcare records and merging healthcare records

- Records should only be merged on Patient Administration System after the physical healthcare records have been merged.
- Merged numbers are held in the Patient Administration System, as an alias and not deleted from the patient history. Merged numbers can be found in the patient history when searched for correctly.
- When merging patient records, notification of other departments should form part of the process.
- Inform HIPE department that the records have been merged.

Section Two: Responsibility for correct patient identification

- All staff that have any kind of patient contact have a responsibility to ensure that the Patient Administration System (PAS) is kept up to date and accurate.
- If any member of staff finds duplicate numbers on the system for a patient, they are responsible for ensuring that the healthcare records department is notified as soon as possible.
- The healthcare records department will obtain all existing sets of healthcare records, and undertake a healthcare record merger.
- This will ensure that all healthcare records are made available for the patient's treatment and that healthcare records and Patient Administration System are merged promptly.

Figure 9-1: Duplicate Charts

10 Dealing with the missing healthcare record

10.1 Introduction

Information is only valuable if it can be accessed when it is required – this is particularly true for healthcare records. It is essential that policies and procedures are in place in each hospital to ensure successful, timely location of the missing record.

10.2 Scope

The objective of this procedure is to set out good practice for hospital staff to follow when dealing with the missing healthcare record.

10.3 Contents

Section One: Notification and recording of missing records

Section Two: When the missing record is tracked to the healthcare records department

Section Three: When the missing record is tracked to another holder

Section Four: Staff responsibility

10.4 Procedure

Section One: Notification and recording of missing records

- The healthcare records supervisor is notified of any 'missing' healthcare records, i.e. (where the records are not with the person they are tracked out to).
- The healthcare records supervisor keeps a written record of missing healthcare records, and initiates a search following normal protocols.
- When the missing set is found, the supervisor logs this, and a monthly report is provided to the healthcare records manager.

Dealing with the missing healthcare record

Section Two: When the missing record is tracked to the healthcare records department

- Make a thorough search of the healthcare records department, e.g.

  i. Check if tracer card is filed in the healthcare record space/check computerised tracking system.

  ii. Check other combinations of the healthcare record number.

  iii. Check the tracking system for any imminent clinic attendance or recent admission, to ensure they have not just been removed for that purpose and tracking has not been updated.

  iv. Check the shelf above and below.

  v. Check the transposed numbers.

  vi. Check 50 healthcare records either side of the space.

  vii. Check 50 healthcare records either side of number on opposite shelves.

  viii. Check whole shelf – taking healthcare records off and checking each one for notes slipped inside, or at the back of the shelf.

  ix. Check who has responsibility for that shelf, and check their other shelves for mis-file.

  x. Check the area where healthcare records are waiting to be filed.

  xi. Check the healthcare records of patients who were discharged on the same day from the same area.

- If the healthcare record is still not located check the following areas:

  i. Shelving where healthcare records are stored for coding.

  ii. HIPE coding offices.

  iii. Accounts.

  iv. Risk managers office.

  v. Secretary and ward clerk's location.

  vi. Medico-legal co-ordinators office.

  vii. Clinicians rooms.

  viii. Freedom of Information department.

Dealing with the missing healthcare record

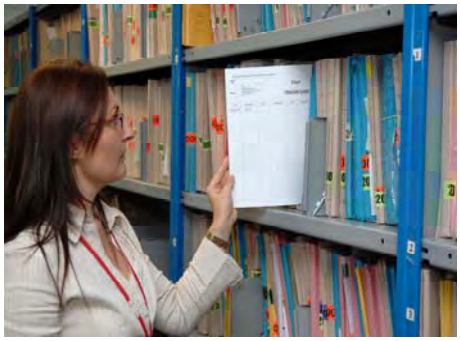


Figure 10-1: Check chart tracking system

Figure 10-2: Check shelves above and below and on either side of the space

Figure 10-3: Take charts off the shelf and check each one for notes slipped inside and check for charts which may have slipped down at the back of the shelf

Figure 10-4: Check area where charts are waiting to be filed

Figure 10-5: Check shelving where charts are stored for coding.

Dealing with the missing healthcare record

Section Three: When the missing record is tracked to another holder

- Request records from the holder again, asking for a more thorough search. If they cannot locate the records, check the healthcare records shelves as in section two.
- Check the tracking system for previous admissions and clinics, and ask relevant secretaries if they still hold the healthcare records. Ask for copy correspondence from latest hospital attendance in order to identify any other Clinicians/ departments currently involved in patient care that might have healthcare records.

Section Four: Staff responsibility (healthcare records department)

- Create a temporary healthcare record, using copy letters.
- Log 'missing' healthcare record in the system kept for this purpose in the healthcare records department.
- Check the 'missing' log on a daily basis, and search healthcare records areas as detailed above. Update log with details of where healthcare record is located when eventually found.
- Merge the temporary healthcare record with the healthcare record when found.
- If records are missing for clinics, staff may have to contact the GP for a copy of the relevant reports.
- Outpatient's staff should be informed of a missing healthcare record before the patient arrives to the clinic.

11 Creating a temporary healthcare record

11.1 Introduction

It is the policy of the National Hospitals Office that, only in exceptional circumstances and following a thorough and comprehensive search for the original record, **or in the case of a patient when their identity cannot be confirmed**, will a temporary healthcare record be created.

11.2 Scope

This procedure details the steps to be taken to create a temporary healthcare record to be used where the original healthcare record cannot be located or where it is impossible to retrieve the original healthcare record.

11.3 Contents

Section One: Request to open a temporary healthcare record

Section Two: Creation of the temporary healthcare record

Section Three: Ward clerk or designated person

Section Four: Filing of the temporary healthcare record

Section Five: Merging the original healthcare record and temporary healthcare record

11.4 Procedure

Section One: Request to open a temporary healthcare record

- When a record cannot be located a comprehensive search must be carried out.
- If, following a comprehensive search, the record still cannot be located, a request to create a temporary healthcare record is made to the healthcare records officer/designated officer.
- The healthcare records officer undertakes a further search for the healthcare record prior to approving the opening of a temporary healthcare record.

Creating a temporary healthcare record

- It is the responsibility of the healthcare records officer to ensure a search continues, on a daily basis, for the original record (in line with procedure for following up missing healthcare records).
- A list of missing records should be produced and retained in the healthcare records area to help staff stay alert to missing record status.
- When the original record is recovered the temporary healthcare record should be merged, in line with standard procedure, by healthcare records staff.

Section Two: Creation of the temporary healthcare record

- Staff should only create a temporary healthcare record when the original healthcare record cannot be located.
- Only designated personnel should have the authority to create temporary healthcare records.
- As much of the healthcare record as possible to be reconstructed by printing all available relevant reports and letters from the computer system and placing in the temporary healthcare record.
- The current status of temporary charts should be recorded, i.e. creation and closing (when merging with the original chart or a new chart is created)
- Appropriate follow-up action should be taken once the location of the original chart is established, i.e. who/what location was holding the chart and for what reason.
- If the original chart is not located, the patient healthcare information should be retained in the temporary chart as a 'flag' that the original chart is missing.
- If the temporary chart reaches capacity, a second volume of the temporary chart should be created.
- A log should be maintained of all temporary healthcare records.

Section Three: Ward clerk or designated person

- It is the responsibility of the Ward Clerk or designated person to request the original healthcare record of those patients who are admitted with a temporary healthcare record during office hours.

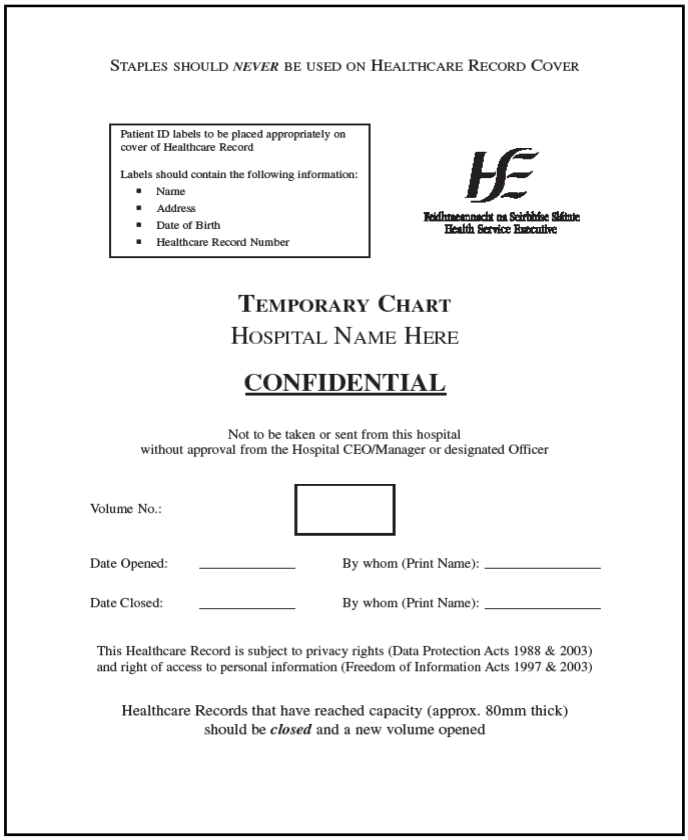
Creating a temporary healthcare record

Section Four: Filing of the temporary healthcare record

- A temporary healthcare record is filed in the healthcare records library pending follow up on the original healthcare record.
- Temporary healthcare records should be filed separately within the healthcare records department until they are merged with their original healthcare record.

Section Five: Merging the original healthcare record and the temporary healthcare record

- Where administrative personnel are holding a temporary healthcare record and the original healthcare record is received, it is their responsibility to merge both the healthcare records (eliminating any duplication) and this should be done in accordance with the National Hospitals Office order of healthcare record filing.



STAPLES SHOULD *NEVER* BE USED ON HEALTHCARE RECORD COVER

Patient ID labels to be placed appropriately on cover of Healthcare Record

Labels should contain the following information:
- Name
- Address
- Date of Birth
- Healthcare Record Number

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

TEMPORARY CHART
HOSPITAL NAME HERE

CONFIDENTIAL

Not to be taken or sent from this hospital
without approval from the Hospital CEO/Manager or designated Officer

Volume No.:

Date Opened: _____ By whom (Print Name): _____

Date Closed: _____ By whom (Print Name): _____

This Healthcare Record is subject to privacy rights (Data Protection Acts 1988 & 2003) and right of access to personal information (Freedom of Information Acts 1997 & 2003)

Healthcare Records that have reached capacity (approx. 80mm thick) should be ***closed*** and a new volume opened

Figure 11-1: Temporary chart cover (red)

12 Transporting the healthcare record off site

12.1 Introduction

On occasion, it may be necessary to transport a healthcare record to other locations

12.2 Scope

The objective of this procedure is to outline good practice for transporting the healthcare record.

12.3 Contents

Section One: General principles

12.4 Procedure

Section One: General principles

- An authorised employee or agent of the hospital must conduct the transportation of the healthcare record.
- The employee conducting the transfer is responsible for the healthcare record whilst in their charge and is responsible for the safe delivery of the record.
- Transported healthcare records must be carried in a storage case, box file or sealed confidential pouch where the name on the record(s) cannot be identified. There should be a signed chain of custody.
- Healthcare records must not be left unattended in an ambulance or staff member's car/taxi, etc.
- On arrival at the appropriate location, the healthcare record should be delivered directly to the appropriate person. There should be written confirmation of the delivery of the record.
- The movement and location of healthcare records should be controlled to ensure that a record can be easily retrieved at any time, that any outstanding issues can be dealt with, and that there is an auditable trail of record transactions.

Transporting the healthcare record off site

- When transporting a healthcare record, only a photocopy of the healthcare record should be sent, unless the hospital CEO/Manager or designated person has authorised that the original healthcare record may be sent.

13 Requests for the healthcare record

13.1 Introduction

When a patient attends another healthcare facility for treatment, that facility may need access to the patient's history in order to deliver the best possible treatment to that patient.

13.2 Scope

The aim of this procedure is to outline the process for which information from a patient's healthcare record is transferred to other healthcare facility.

13.3 Contents

Section One: Transfer of information from the healthcare record

Section Two: Transfer of the healthcare record

Section Three: Removing the healthcare record (outside office hours)

Section Four: Retrieval of the healthcare record from non-current storage which is managed in-house (within office hours)

Section Five: Retrieval of the healthcare record from third party non-current storage (within office hours)

Section Six: Retrieval of the healthcare record from non-current storage (outside office hours)

Section Seven: Returning the healthcare record

Section Eight: Returning RIP healthcare records

13.4 Procedure

Section One: Transfer of information from the healthcare record

- All telephone calls received from external medical institutions (e.g. other hospitals, nursing homes, etc) who are requesting hospital notes must be routed through the appropriate clinician's secretary.

Requests for the healthcare record

- The clinician's secretary should satisfy themselves as to the identity of the requester, e.g. using a blank transfer of patient information form/telephoning the requester back, etc).
- The secretary should then retrieve the patient healthcare record and ONLY the DISCHARGE SUMMARY and any TYPED CORRESPONDENCE should be forwarded to the requesting Medical Institution.
- It is unacceptable to transfer any other document from the healthcare record without obtaining permission from the healthcare records manager. This transfer (in whatever form) must be carried out in a secure environment.
- If there is an agreement in place for healthcare records to be sent from one institution to another, these records should be tracked through the tracking system.
- Any request forms are to be filed in the patient's healthcare record.

Section Two: Transfer of the healthcare record

- Healthcare Records must be carried in a storage case, box file or sealed confidential pouch where the name on the record cannot be identified.
- The healthcare record must be sent recorded delivery to a named individual, with a request for them to be returned securely also. A "return slip" is included with the healthcare records with address for return.
- The healthcare records supervisor keeps a record of any notes that are sent out. This record is periodically checked, and healthcare records are requested for return when appropriate.

Section Three: Removing the healthcare record (outside office hours)

- Healthcare records should not, unless absolutely necessary, be removed from any office outside office hours. However, if a healthcare record is urgently required, local policies and procedures for removing the health record must be adhered to.

Requests for the healthcare record

Section Four: Retrieval of the healthcare record from non-current storage which is managed in-house (within office hours)

- Requests for healthcare records filed in non-current storage are to be recorded and retained by the healthcare records department.
- The following details should be recorded:
    i. Date.
    ii. Healthcare Record Number.
    iii. Requester.
    iv. Retrieved by (name).
    v. Sent to.
- Healthcare records supervisor should ensure that healthcare records are retrieved from the non-current store.
- Healthcare records supervisor/nominated staff member should retrieve **urgent** healthcare records as required.
- Where healthcare records are tracked to the non-current store, this should be noted on the relevant tracking system.

Section Five: Retrieval of the healthcare record from third-party non-current storage (within office hours) - this will differ between hospitals

- When it has been identified that the healthcare record is stored off site, the filing room clerk must inform the healthcare records manager.
- The healthcare records manager or designated person contacts the non-current storage company, for retrieval of records, stating the urgency.
- The non-current storage company will operate express delivery or next day delivery as required.
- All healthcare records are delivered to the filing room.
- The filing room clerk signs for the records and then informs the person who requested them that they have arrived and are ready for collection.
- The filing room clerk will keep a copy of the signed form on file.
- The filing room clerk and the appropriate ward clerks must ensure that the healthcare records are tracked at all stages

Requests for the healthcare record

Section Six: Retrieval of the healthcare record from non-current storage (outside office hours)

- When it has been identified that the record is stored off site, local policies and procedures must be adhered to for retrieval of the healthcare record from non-current storage stating its urgency.

Section Seven: Returning the healthcare record

- All relevant staff are responsible for organising the return of healthcare records to the main library.
- The healthcare records staff or other authorised staff member is responsible for the collection of healthcare records throughout the hospital, and for the safe return of healthcare records to the healthcare records department.
- HIPE staff ensure that HIPE coding is completed.

Section Eight: Returning RIP healthcare records

- Healthcare records staff to place label marked RIP and year on spine of all healthcare record volumes.
- Where notification is received that a former patient of the hospital has died, the date of death should be recorded on the Patient Master Index/Patient Administration System.
- Healthcare records staff must ensure that the HIPE coding label is completed, and the Cancer Registry Nurse's code is inserted (where appropriate) on relevant RIP healthcare records before assigning them to archives.
- The Hospital may send a copy of a patient's discharge summary to the clinician who has referred the patient for care.
- A HIPE coding sticker is placed on the front of each closed/RIP healthcare record that has been completely coded.

14 Patient information requests

14.1 Introduction

Patient information requests may be dealt with in a formal way in accordance with the Freedom of Information (FOI) or Data Protection (DP) legislation, or in a routine and informal way in accordance with the HSEs Administrative Access Policy. This section gives general guidance on the different access regimes, more detailed information is available in the booklet "A Practical Guide for Staff" published by the FOI/DP Liaison Group and in procedural manuals that give detailed guidelines on the legislation.

14.2 Scope

The objective of this procedure is to set out good administrative practice for hospital staff to follow when handling requests for information, within statutory requirements and healthcare service guidelines, including Freedom of Information and Data Protection Acts.

14.3 Contents

Section One: Administrative access requests

Section Two: Freedom of Information requests

Section Three: Data Protection requests

Section Four: Legal requests

Section Five Requests for Information by the Gardai

Section Six: Other healthcare providers

14.4 Procedure

Section One: Administrative access requests

- As a matter of policy the Health Service Executive supports the right of a patient to see what information is held about him or her within its service. Generally, access to an individual's own healthcare record should be provided administratively (subject to exceptions which are detailed later).
- An application for administrative access by a patient seeking access to his/her healthcare record should:
    1. Be in writing and sent to the appropriate service manager.
    2. Supply relevant information to locate records.
    3. Be accompanied by appropriate identification.
- The treating healthcare professional should, where possible, be involved in the handling of these applications to ensure that only information relevant to the application is released. Consultation with the patient is encouraged, particularly to assist in the identification of the actual documents to which access is sought or to narrow the field of inquiry, for example, to a particular admission if possible.

i. Records of deceased persons:

Given the level of sensitivity of information contained in healthcare records, and the inability to consult with the deceased patient, all applications for access to deceased person's records must be processed under the Freedom of Information Acts.

ii. Exceptions to the administrative access process:

Particular care must be taken when healthcare records contain sensitive matter, for example:

- Documents relating to suspected or actual child abuse.
- Documents revealing the involvement and deliberations of an investigation into alleged sexual abuse.
- Documents containing information in relation to testing for and/or treatment of HIV/AIDS (including statements regarding HIV status) or other notifiable diseases under the Health Acts.
- A deceased person's healthcare record.

- In circumstances where it is considered that access could be prejudicial to the physical or mental well being or emotional condition of the person.
- In circumstances where it is considered that the healthcare record contains matter about a third party or information received in confidence from a third party.
- Any other sensitive matter such as documents revealing confidential sources of information.

iii. Can information be released to other healthcare professionals?

- Where a patient has been transferred or discharged to another healthcare service or medical practitioner for continuing care and treatment, information from the patient's healthcare record of direct relevance to the continuing care and treatment of the patient may generally be released on written request by the healthcare service or medical practitioner. Information may also be released on confirmation by the receiving healthcare service of transfer arrangements.
- Where a request for information is received by telephone, information should be given to the treating healthcare professional or senior healthcare professional if urgently required for treatment of the patient. In these circumstances, care should be taken to establish the identity of the recipient of the information, the recipient's name and telephone number and authority to receive the information should be checked and the call returned before the information is given.

Section Two: Freedom of Information requests

The Freedom of Information Act confers on all persons the right of access to information held by public bodies, to the greatest extent possible, consistent with the public interest and the right to privacy. The concept of Freedom of Information is derived from the following principles.

i. Records

Every individual has the right

- To know what information is held in records about him or her personally (subject to certain exemptions).
- To have inaccurate material on file corrected (subject to certain exemptions designed to protect the public interest and the right to privacy).

Patient information requests

ii. Decisions

- Individuals who are affected by decisions of public bodies have the right to know the criteria used in making those decisions.
- Decisions by public bodies should be open to public scrutiny, thus providing greater knowledge of the issues involved and public ownership and acceptance of decisions. Citizens, as shareholders in public bodies, should have the right to examine and review the deliberations and processes of public bodies, subject to the exemptions provided for in the Acts.

iii. Parents, guardians and next-of kin-rights

- Parents, guardians and next-of-kin have been provided with rights of access to reasons for decisions in respect of certain other persons, e.g. children, deceased or disabled persons with a mental incapacity.
- Parents or guardians have also been provided with rights to apply to have personal information of certain other persons e.g. children, deceased or disabled persons with a mental incapacity, amended if they are incomplete, incorrect or misleading.

iv. Making a Freedom of Information request

- Freedom of Information requests do have to be in a specific form. A request must:
  1. Be in writing and assistance must be provided for those who require it.
  2. Specify the records required and the manner in which access is sought.
  3. State that the request is made under the Freedom of Information Act.
- When a request for access under the Freedom of Information Acts is received in any department of the hospital, it should immediately be sent to the member of staff (Decision Maker) in your hospital who has responsibility for processing Freedom of Information requests. That staff member should adhere to Freedom of Information procedures in dealing with the request.
- There are different forms of access to records which may be requested and granted. These are as follows:
  1. Inspect original record.
  2. Obtain copy of the record.
  3. Hear/view audiovisual record.

4. Obtain a transcript of tape or shorthand.
5. Obtain a copy of a computer disk or other electronic device.
6. Shorthand or code must be decoded.

- It is regarded as good practice that the application is discussed with the treating healthcare professional (Medical Practitioner, Psychologist, and Social Worker etc.) for a number of reasons; e.g. the records may contain information which could, in the professional's opinion, have a detrimental effect on the patient.
- One of the grounds why a request for information may be refused is where the record is of a medical, psychiatric or social work nature relating to the requester concerned and its release, in the opinion of the Decision Maker, might be prejudicial to the physical or mental well-being of the requester. Where the Decision Maker refuses access under this provision, he/she is obliged to offer access through a registered healthcare professional, nominated by the requester, having expertise in the matter concerned.

v. Right of review

- A requester, if unhappy with a decision to release records, has the right of review. This includes:

Internal review

- In most cases the first avenue is for the patient to request an internal review. This is forwarded to the delegated Internal Reviewer (who is a normally a more senior member of staff within the healthcare agency). A decision will be made within fifteen days upon receipt of request for an internal review.

Information Commissioner review

- If the requester is unhappy with the decision of the Internal Reviewer he/she may appeal to the Information Commissioner within six months of the date of notification of the agency's decision. There is a right of appeal to the High Court, on a point of law only, if either the requester or the healthcare agency is unhappy with the Commissioner's decision. The Supreme Court will in turn deal with any further appeal arising out of a High Court decision.

vi. Staff

Staff will be able to reduce the need for the public to use the Freedom of Information Acts by:

- Improving communications between staff and public.
- Drafting and publishing eligibility criteria used to determine access to schemes and services.
- Informing persons who apply for services of reasons for decisions and rights of appeal.
- Allowing access to the greatest extent possible to hospital records via administrative means.

Section Three: Data Protection requests

Data Protection (DP) is the safeguarding of the privacy rights of individuals in relation to the processing of their personal data. People supply information about themselves to healthcare organisations and to medical and healthcare professionals. Data Protection law places obligations on such healthcare providers and all staff who keep personal information.

i. Data Protection rights

Data Protection rights apply whether the information is held:

- In electronic format e.g. on computer.
- In a manual or paper based form.

ii. Personal healthcare information should be

- Obtained and processed fairly; which means that the person providing it must know the purposes for which it will be used and the persons to whom it will be disclosed.
- Relevant and not excessive.
- Accurate, complete, up-to-date and well organised.
- Held no longer than is necessary.
- Devoid of prejudicial, derogatory, malicious, vexatious or irrelevant statements about the individual.

Patient information requests

- Purpose specific.
- Held securely.
- Accessible to the individual or person acting on his or her behalf on a reasonable basis.

iii. Request for access to records made under the Data Protection Act

- A request for access to records made under the Data Protection Acts must:

1. Be in writing.
2. Be accompanied by a fee (up to and no more than 6.35 Euro [2007]).
3. Specify the records required and the manner in which access is sought e.g. inspect the original, obtain photocopies etc.
4. State that the request is being made under the Data Protection Act.
5. Provide proof of identity.

- When a request for access under the Data Protection Acts is received in any department of the hospital, it should immediately be sent to the member of staff in your hospital who has responsibility for processing Data Protection requests. That staff member should adhere to Data Protection procedures in dealing with the request.
- Many requests may involve the release of documents, which may be accessed without resorting to the Data Protection Acts. A non Data Protection request should usually be made to the local office of the hospital in question. If the information cannot be released routinely the requester will be advised accordingly and informed of his/her rights under the Data Protection Acts.
- If a request has already been dealt with under the Freedom of Information Acts it must still be processed separately under the Data Protection process, as if it were a new request.
- Personal healthcare information should only be used or disclosed for the purpose for which it was collected or for another directly related purpose. It can be used or disclosed for some other purpose only where:

1. The patient concerned has explicitly consented to the proposed use or disclosure.

2. The healthcare professional reasonably believes the use or disclosure is necessary to lessen or prevent a serious and imminent threat to an individual's life, health or safety or a serious threat to public health or public safety.

3. The use or disclosure is required or authorised by law.

4. The information concerns a patient who is incapable of giving consent, and is disclosed to a person responsible for the patient to enable appropriate care or treatment to be provided to the patient.

5. Any disclosure to a third party should be limited to that which is either authorised or required in order to achieve the desired objective.

6. Personal health information can be transferred to an individual or organisation outside the European Union only in certain specified circumstances.

iv. Refusing access to records where the request has been made under the Data Protection Act

- Access can be refused to some or all of their personal health information only if:

1. Providing access would pose a serious threat to the life or health of any individual, including the requester.

2. Providing access would have an unacceptable impact on the privacy of other individuals.

3. It is required or authorised by law.

- Many requests for information, or responses to complaints, can be made by contacting the service provider directly. If this method proves unsatisfactory to the requester, the requester may then have an option to apply for personal records under the Data Protection Acts.

Patient information requests

v. Data Protection rights

The Data Protection Rights include:

Right to be informed

The hospital that obtains personal information must ensure that the patient is informed of:

- The name of the data controller, i.e. the organisation or the individual collecting the data.
- The purpose for keeping personal data.
- Any other information which the organisation ought to provide to ensure its handling of patient's data is fair, for example, the identity of anyone to whom it will disclose the patient's personal data, and whether or not the patient is obliged to answer any of its questions.
- Data controllers who have obtained personal data from someone else, i.e. not from the patient must, in addition, inform the patient of the types of data they hold and the name of the original data controller.

Right of access

- Every individual has the right to know what information is held in records about him or her personally (subject to certain exemptions designed to protect the public interest and the right to privacy).
- This right includes access to expressions of opinion, unless these opinions were given in confidence. The right of access does not apply in specific cases, which would prejudice a particular interest e.g. the investigation of offences.
- An individual is also entitled to a full explanation of the logic used in any automated decision making process, where the decision significantly affects that person.

Right of rectification or erasure

- If information kept by a data controller is inaccurate, an individual has the right to have that information rectified or, in some cases, erased.

Patient information requests

Right to block certain issues

- In addition to an individual having the right to correct or erase data he/she can request a data controller to block his/her data i.e. prevent it from being used for certain purposes. For example, he/she might want the data blocked for research purposes.

Right to object

- Where the data controller is processing data and that individual is of the opinion that the data involves substantial and unwarranted damage or distress to him/her, he/she may request that the data controller stop using the personal data.
- This right does not apply if:
    1. Consent was obtained.
    2. The use is necessary for an agreed contractual obligation.
    3. The use is required by law.
    4. Consent has been withdrawn under Data Protection.

Section Four: Legal requests

- Authorisation from the courts, coroner or solicitors for release of information must be in writing, verbal requests are not accepted.
- Copy information is provided, never originals. Check with the healthcare records manager or designated person before this information is released.

i. Action taken against the Health Service Executive where a clinician who is an employee of the Health Service Executive is named as a co-defendant

- Where an action is taken by a patient against the Health Service Executive in circumstances where a clinician who is an employee of the Health Service Executive is named as a co-defendant, both the Health Service Executive and clinician will have the services of the one composite legal defence team.
- Patient consent is not required where the hospital transmits the patient healthcare record to its own solicitors for the defence of the claim as any such communications are fully protected by legal professional privilege.

- Where this legal team are also acting for the clinician the question of transmitting a copy of the patient healthcare record to a separate firm of solicitors and legal team does not arise.

ii. Action taken against a clinician who is operating in a private capacity where the Health Service Executive /hospital is named as a co-defendant

- Where an action is taken by a patient against a clinician who is operating in private capacity, in circumstances where the Health Service Executive /the hospital is named as a co-defendant and the healthcare record is held in the hospitals healthcare records department, the healthcare record is considered to be in the hospitals possession and ownership.
- Patient consent is not required where the hospital transmits the patient healthcare record to its own solicitors for the defence of the claim as any such communications are fully protected by legal professional privilege.
- Where this legal team are also acting for the clinician the question of transmitting a copy of the patient healthcare record to a separate firm of solicitors and legal team does not arise.

iii. Action taken against a clinician who is operating in a private capacity where the Health Service Executive /hospital is not named as a co-defendant

- Where an action is taken by a patient against a clinician who is operating in private capacity, in circumstances where neither the HSE nor the hospital are named as co-defendants and the healthcare record is held in the hospitals healthcare records department, the healthcare record is considered to be in the hospitals possession and ownership.
- The healthcare record should not be released without the patient's written authorisation except on foot of an order for discovery from the court.
- It is permissible to release copies of any medical reports or notes to the private clinician created by him/herself for which she/he would normally have been expected to retain a copy in his/her own possession. Any such release to a clinician at this time should make clear that the release of the information is on the basis that it is for the clinicians use only.
- Any documents created by the clinician himself/herself acting in his/her role as a private clinician to the patient could not attract any entitlement to patient confidentiality in respect of release to the clinician himself/herself.

- Where documentation is given to the clinician's Solicitor on foot of a court order for discovery, the rules of court provide that those records may only be used by the Solicitor for the purposes of the legal proceedings and for no other purposes whatsoever.
- It is the responsibility of the clinician's solicitor, as an officer of the court, to ensure that any such healthcare record is treated in a confidential matter and is appropriately destroyed on completion of the case.

Section Five: Requests for information by the Gardai

- Current practice in assisting the Garda Siochana with their general inquiries will continue. However, where the patient has authorised Gardai to have access to information from his or her healthcare records, this may be supplied. Proof of the patient's authorisation must be obtained.
- Requests for information from the Gardai where the patient has not authorised access to information from his or her healthcare records will be dealt with by the treating healthcare professional or senior administrator and will only be supplied in accordance with a court order on the production of a search warrant or other legal authority.
- Where the treating healthcare professional or senior healthcare professional in a hospital or any other healthcare service becomes aware, during the clinical management of a patient, that a serious crime may have been committed the agency shall notify the Gardai. The agency, in the public interest to enable Gardai to initiate appropriate action, may provide information which will usually be given by a senior healthcare professional.

Information relating to child abuse:

- In general, requests for access to records containing information of alleged/ suspected child abuse should be processed under the Freedom of Information Acts. However, information may be released to the HSE Child Protection and Welfare, Social Work Department and Garda authorities where the release of such information is necessary to promote the welfare of the child.
- Caution has to be exercised as to whether there is a breach of an obligation of confidentiality and, if so, whether there are grounds for breaching that obligation of confidentiality.
- Refer to local hospital social work department, Child Care Act 1991 and Protection for Persons Reporting Child Abuse Act 1998.

Patient information requests

Section Six: Other healthcare providers

- With regard to requests from other healthcare providers (including the National Treatment Purchase Fund), concerning patients who have now moved into their care, the source of the request must be checked to ensure that it is a valid enquiry.
- Clarify what information is required. Discharge communications can be released without the patients consent but if the other healthcare provider requires more documentation, the consent of the patient will have to be given. Send copies – if faxed through, check that it is a "safe haven" fax, and that the person requesting the information is ready to pick up the copies.
- Copy notes sent by registered post, must be double-wrapped, marked "confidential" and sent recorded delivery.

15 Requests for the healthcare record for research purposes

15.1 Introduction

In order for the release of information from a patient's healthcare records for Internal Audits/Research there has to be prior approval in accordance with local policies and procedures, to ensure that patient information is kept confidential.

15.2 Scope

The aim of this procedure is to outline the process for which healthcare records are required for research and how they are released.

15.3 Contents

Section One: General principles

15.4 Procedure

Section One: General principles

- A hospital approval form for all proposed internal audits/research activities must be completed and signed by appropriate persons (clinician, hospital CEO/ manager, etc.).
- A complete list of all healthcare records that will be required for research to be supplied.
- Minimum of two weeks notice required for all research requests.
- Research proposals should meet the hospitals' guidelines and be accompanied by a comprehensive protocol detailing the aims, methods and reasons for the study.
- Where access to healthcare records is requested, the nature of the access requested should be clearly specified and the safeguards for privacy outlined.
- Where patients are to be contacted directly by the researcher, or potentially identifying information is requested, the written consent of the patient should be obtained by the treating healthcare professional or senior healthcare professional prior to access being allowed.

Requests for the healthcare record for research purposes

- Healthcare records will be tracked to requesting clinician, together with details of his/her supervising clinician.
- Should a healthcare record be required for the out-patients department/ emergency department/admission, etc. the healthcare record will need to be returned to the requestor without delay.
- Under no circumstances are hospital healthcare records to leave the hospital grounds without approval of the hospital CEO/manager or designated officer.

16 Clinic preparation

16.1 Introduction

The timely provision of healthcare records is essential to good patient care. Clinic preparation is the process carried out by healthcare records staff/library secretary to ensure healthcare records are delivered on time, in good condition, and hold all relevant information necessary for consultation.

16.2 Scope

This procedure guides staff through the process of ensuring patient information is available when and where it is required for that care.

16.3 Contents

Section One: General principles

16.4 Procedure

Section One: General principles

- Clinic lists are produced from the patient administration system and delivered to appropriate personnel to pull healthcare records.
- Healthcare records are obtained from healthcare records library.
- Healthcare records not filed in the library are requested from the person/area that is recorded as currently holding the healthcare records.
- Clinic list is updated with location of records, and the date that the healthcare record was requested from other holder.
- Healthcare record location is updated in the tracking system.
- Each healthcare record for the clinic is checked for completeness and results are found if not on the healthcare record. Outside covers are checked and replaced where necessary.
- Healthcare records are closed if necessary and a new volume opened.

Clinic preparation

- Healthcare records for clinics are bundled and clearly labelled. A complete clinic list is attached to the top of the healthcare records. They are stored on the appropriate shelves until time for delivery to the clinic areas.
- The day before clinic date, new clinic list is printed from patient administration system and any amendments (additions/removals from clinic) are dealt with appropriately. Any healthcare records still to come from other areas are noted, and person holding the healthcare record requested to provide urgent return to the healthcare records department.
- Notes are delivered to appropriate clinic areas in accordance with local policies and procedures. They include an up-to-date clinic list, and note for clinic staff regarding any outstanding notes waiting for delivery from other holders.
- Complete clinic lists are produced and provided to clinic reception area(s).
- At the end of the clinic session, the healthcare records are delivered to the relevant secretary who updates the patient administration system.

Figure 16-1: Produce clinic lists

Figure 16-2: Pull charts

Figure 16-3: File results in chart

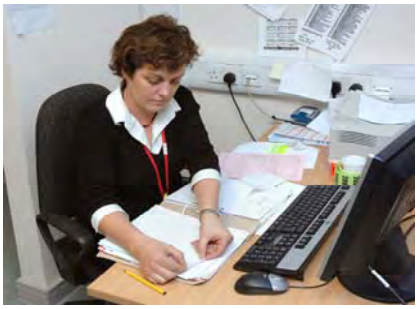


Figure 16-4: Patient labels filed on each side of each page

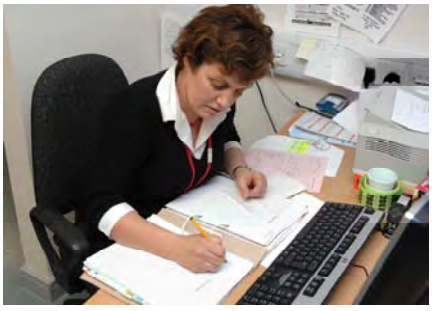


Figure 16-5: Continuation sheets dated

Figure 16-6: Bundle and label charts for clinics

17 Booking appointments

17.1 Introduction

For many years problems have arisen with long queues and waiting times in hospital out patient clinics. There are three main points to consider when designing an appointments scheme:

- The time of the first appointment.
- The number of appointments given in the clinic.
- How appointments are distributed through the clinic.

Arranging appointments with these three points in mind can result in a significant reduction in patient waiting times

17.2 Scope

To ensure an appropriate appointments scheme is in place to minimise patient queuing and deliver an efficient, effective service to patients.

17.3 Contents

Section One: General principles

Section Two: New appointments

Section Three: Review appointments

Section Four: Cancellation of appointments

17.4 Procedure

Section One: General principles

Patients can be issued with an out-patient appointment following:

- A previous out-patient visit.
- Discharge from hospital.
- A letter sent by their GP.

Booking appointments

- A telephone call from their GP (in urgent cases).
- A visit to the emergency department.

Section Two: New appointments

- If a waiting list exists, the patient referral is registered on the Patient Administration System, an acknowledgement letter is sent and an appointment follows in due course.

All new appointments should receive postal notification by means of a standard appointment card which should contain sufficient information as follows:

- Name of clinic.
- Time of appointment.
- Date of appointment.
- Advice on any necessary documentation to bring.
- A number to contact in the event of cancellation.
- Appropriate charges as necessary.

Section Three: Review appointments

Review patients should normally receive their appointment on exit from the clinic which should have the appropriate information above updated.

Section Four: Cancellation of appointments

There should be a local policy to deal with cancellation of appointments and confirmation of appointments.

18 Patient admission and follow-up

18.1 Introduction

Healthcare records are essential for the provision of quality, safe patient care. The National Hospitals Office is committed to ensuring that healthcare records are available when a patient is admitted. This procedure details the duties of the healthcare records staff in providing healthcare records for patient admissions and patient follow-up.

18.2 Scope

This procedure details the processes involved in ensuring that a patient's healthcare records are made available upon admission and follow-up, to support effective patient care through the provision of the patient's previous medical history.

18.3 Contents

18.4 Procedure

Section One: General principles

- When a patient is admitted to the hospital, admission staff/ward clerk/ emergency staff are responsible for ensuring that information in the Patient Administration System (PAS) is updated and the healthcare records department is notified of the admission either manually (on an admission form), or through PAS.
- Any changes to patient demographics are made by admission staff at time of admission, and new labels requested/produced for the healthcare record folder as appropriate.

Patient admission and follow-up

- It is the responsibility of admissions/library staff to ensure that they have the healthcare records for elective admissions prior to the admissions taking place.
- Requests for healthcare records for emergency admissions are notified to the healthcare records department as soon as possible, in order to facilitate records retrieval.
- Healthcare records that are located out of the hospital must be obtained and returned for the patient's admission within a maximum of 24 hours. When clinical need dictates, faxed information may be required from the healthcare record holder until the healthcare record can be obtained.

Section Two: Emergency admissions

- When a patient requires treatment or admission on an emergency basis outside normal working hours, arrangements for registration and admission of such a patient shall be made by staff in the emergency department in accordance with approved procedures for such registrations and admissions.

Section Three: Transfers

- Patient transfer arrangements shall be made by the staff responsible, when required, in accordance with approved hospital policies and procedures.

Section Four: Appointments for admissions

- Every patient who is given an appointment for admission should be admitted on the day of the appointment, or if it is known that a bed will not be available, the patient should be contacted by telephone prior to coming to the Hospital. In certain defined circumstances the responsible clinician will be consulted before an alternative admission date is given. To the extent possible, a patient who is being admitted for a routine admission should be given a choice of admission dates.
- Parents/patients may be advised to phone the admissions office on the morning of admission to confirm bed availability.
- Day ward patients should be requested to confirm their attendance on the day prior to admission.
- Rebooking of cancelled patients will usually be carried out by the specialists involved and is dependent on the next available space on the theatre list.
- If possible, this alternative appointment should be confirmed by telephone.

Patient admission and follow-up

Section Five: Patient follow-up

- Patient advice sheet given to patients on discharge from the day ward and followed up the next day by a telephone call (where necessary) from the relevant healthcare professional.
- Telephone calls from patients/parents may be taken by healthcare professionals. Any advice given to be documented in the patient's healthcare record.
- On discharge, patients are given a follow-up appointment when necessary.
- Out-patient department follow-up: When a patient is finished an out-patient's appointment, they should present to the desk and should be given the next appointment as per the clinician's instructions. Any tests, blood tests and X-Rays should be done during the visit if possible. Out-patient letters are dictated to the GP informing them of the out-patient visit and of the follow-up planned.
- Did not attend follow-up: Did not attend is recorded in the healthcare record and patient administration system (if appropriate). The referrer should be made aware of the fact that the patient did not attend.

19 Patient discharge and transfer

19.1 Introduction

Patients who have been medically discharged and are leaving the hospital should be discharged from the patient management system using the proper procedure.

19.2 Scope

The aim of this procedure is to outline the process for keeping the healthcare record up to date following patient discharge and transfer from the hospital.

19.3 Contents

Section One: General principles

19.4 Procedure

Section One: General principles

- Reports and test results should be filed at ward level prior to healthcare record being returned.
- As soon as possible following the discharge of the patient, the patient's healthcare record must be returned to the clinician's secretary for transcription of the discharge letter.
- Upon discharge, the healthcare record is sent to HIPE for coding before being sent back for filing.
- Outstanding reports to be filed by the appropriate designated person.
- On return to the healthcare records library the healthcare record is retraced and filed.

20 Training

20.1 Introduction

All line managers and supervisors must ensure that their staff, whether administrative or medical, are adequately trained and apply the appropriate recommended practices in relation to healthcare records management. The development/training needs of staff must be audited on an ongoing basis and additional training in relation to the management of healthcare records must be based on the results of these audits.

20.2 Scope

The objective of this procedure is to set out training requirements for staff who deal with healthcare records.

20.3 Contents

Section One: Healthcare records management policies and procedures

Section Two: Confidentiality and security of patient healthcare information

Section Three: New staff members

Section Four: Manual handling

Section Five: Healthcare records management training

20.4 Procedure

Section One: Healthcare records management policies and procedures

- Each head of department (where the department has an involvement in healthcare records) undertakes a staff training needs analysis and develops a prioritised action plan to address identified training needs in healthcare records management for personnel within their own department.
- Departmental records are kept of attendance of all staff who receive training in healthcare records management.
- There is a regular review of the training programme content to ensure its relevance.

Training

- The quality and effectiveness of the training programme is regularly evaluated.
- Individual competency in healthcare records management should be regularly reviewed.

Section Two: Confidentiality and security of patient healthcare information

- The confidentiality and security of information in the healthcare record is addressed on the first day a new member commences work.
- Ongoing training regarding confidentiality and security of patient healthcare information takes place in each local hospital.

Section Three: New staff members

- The new member should be accompanied by the healthcare records manager or designated staff member to the wards and all other departments within the hospital and introduced. The work of each area should be explained to the new member of staff.
- If a new member of staff has not previously worked in a hospital and is not familiar with medical terminology, they are advised to keep a record of medical words they are not familiar with. It is suggested that they write down medical words in a note book in alphabetical order so that they can refer to it when typing letters.
- All work is checked by the healthcare records manager or experienced member of staff until the new member is competent in his/her work.
- It is stressed to the new member of staff the importance of asking questions regarding their work to either the healthcare records manager or another member of staff.
- All staff to be reminded that their personal belongings are their own responsibility and they should be securely locked away during office hours.

Section Four: Manual handling

- All employees, including permanent, temporary, full-time, part-time, students, agency, contract staff etc. who carry out manual handling activities as part of their work must complete manual handling training—manual handling of materials and fire safety training course/session at the commencement of their employment and annually thereafter.

Training

Section Five: Healthcare records management training

- The methods of records management training that may be implemented include.

i. Implementation of a formal training programme to launch and support local policies in relation to records management.

ii. Inclusion of records management in induction training and staff handbooks.

iii. Follow-up training.

National Hospitals Office Code of Practice for Healthcare Records Management

Part 5: Retention and Disposal Schedule

Reader Information

Directorate:	National Hospitals Office (NHO)
Title:	NHO Code of Practice for Healthcare Records Management
Document Purpose:	Standards & Recommended Practices—Part 5
Author:	NHO Healthcare Records Management Steering Committee
Publication Date:	October 2007
Target Audience:	All staff in the NHO who work in healthcare records management
Description:	The Code of Practice is a guide to the standards of practice required in the management of healthcare records in the NHO, based on current legal requirements and professional best practice
Superseded Docs:	The retention and disposal schedule replaces the previous retention schedule on acute hospital records outlined on pages 8-9 of the 'Policy for Health Boards on Record Retention Periods' (1999). Version 2.0 replaces Version 1 of Code of Practice.
Review Date:	October 2008
Contact Details:	Winifred Ryan, National Hospitals Office, Quality, Risk and Customer Care Directorate, Mid-Western Regional Hospital (Nenagh) Nenagh, Co. Tipperary, Ireland. **Email**: winifred.ryan1@hse.ie **Web:** www.hse.ie

Part 5

Retention and Disposal Schedule

Contents

1. Introduction

- Part 5 of the National Hospitals Office (NHO) Code of Practice for Healthcare Records Management sets out the schedules for retention and disposal of healthcare records in publicly funded acute hospitals in the National Hospitals Office. Part 5:
    1. Lists the minimum retention periods for healthcare records in the NHO.
    2. Provides a clear policy in order that hospitals can operate a healthcare records retention and disposal practice in a consistent manner across the Health Service Executive.
- The schedule replaces the previous retention schedule on acute hospital records outlined on pages 8-9 of the '*Policy for Health Boards on Record Retention Periods*' (1999).

2. Types of healthcare record covered by this schedule

- This retention policy applies to healthcare records of all types regardless of the medium on which they are held.
- These may consist of:
    1. Patient healthcare records (electronic or paper based, including those concerning all specialties).
    2. Emergency Department, birth, theatre, minor operations and other related registers.
    3. X-ray and imaging reports, output and images.
    4. Photographs, slides, and other images.
    5. Microform (i.e. microfiche/microfilm).
    6. Audio and video tapes, cassettes, CD-ROM etc.
    7. Computerised records.
    8. Scanned records.

3. Legal obligation and good practice

- The Health Service Executive must comply with the provisions of section 2(1)(c) of the Data Protection Acts 1988 and 2003. The Acts set out the principle that personal data shall not be kept for longer than is necessary for the purpose or purposes for which it was obtained. This requirement places a responsibility on the Health Service Executive to be clear about the length of time personal data will be kept and the reasons why the information is being retained.
- To comply with this rule the Health Service Executive **must have** a policy on retention periods for personal data that is retained. This policy must include defined retention periods for healthcare records and systematic disposal of healthcare records immediately after the retention period expires.
- Since 2003, Data Protection legislation also applies to electronic and hard copy records.

4. Basis for the National Hospitals Office healthcare records retention and disposal schedule

- The following criteria were taken into consideration in determining the retention periods:
- **Medical Criteria**—records are maintained primarily for the treatment of patients during current and subsequent periods of medical attention. The retention period should allow the retention of the record for a sufficient period of time after the duration of treatment.
- **Legal Criteria**—the limitation period may run from the date on which the alleged malpractice or negligence became apparent, rather than from the date on which the medical treatment was terminated.
- **Legislative Criteria**—the retention schedule must comply with relevant legislation.

5. Responsibilities

- Each Department Head is responsible for making sure that all healthcare records retained in the department are periodically and routinely reviewed to ensure systematic implementation of the National Hospitals Office Healthcare Records Retention and Disposal Schedule.

6. Retention and disposal schedule:

- A retention and disposal schedule is a key document in a healthcare records management system which outlines:
    1. The types of healthcare records held within an organisation.
    2. The minimum period for which such records should be retained.
    3. The action required when the minimum retention period has been reached.
- The retention and disposal schedule lists all of the healthcare records for which predetermined periods of retention have been agreed.

Why is a retention and disposal schedule needed?

- For the storage of healthcare records that must be retained for the appropriate retention period after the patient has been discharged from hospital.
- For the extended preservation of healthcare records which are of long-term value.
- For the prompt disposal of healthcare records whose retention period has ended.

Decisions regarding the retention and disposal of healthcare records

- Healthcare records that have reached their offical retention period, should be reviewed under the following criteria, so that ill-considered disposal is avoided. Whenever the schedule is used, the guidelines listed below should be followed.
- Recommended retention periods should be calculated from the end of the calendar month following the last entry on the document.
- The healthcare records manager or designated person should carry out healthcare record reviews in line with the National Hospitals Office retention and disposal schedule.
- It is recommended that a multidisciplinary healthcare records users group should be established to provide advice on the retention and disposal of healthcare records. Input from local healthcare professionals should be a key element of the hospital's healthcare records management strategy.
- Where a set of healthcare records have reached their final date for retention, the Healthcare records manager shall confirm the implementation of the National Hospitals Office healthcare records retention and disposal schedule with the healthcare records users committee in the hospital.

Retention and disposal schedule

- If a record due for disposal is known to be the subject of an **access request** for records, then this contact will be regarded at the latest contact date and the relevant retention period will apply.
- Where an **adverse outcome** has been advised to the risk management personnel then these healthcare records should be retained for an additional period as advised by the hospital risk management committee.
- Hospital healthcare records **should not be kept any longer than** the appropriate retention period. Hospitals who wish to retain healthcare records for longer than the appropriate retention period for research or statistical purposes must obtain clear and unambigious consent from the patients concerned for the retention of their records for these purposes.

Retention and disposal policy

- When original healthcare records are selected for disposal in accordance with this policy, a clear disposal policy must be applied.
- It is vital that the process of disposal safeguards and maintains the confidentiality of patient records. This can be done onsite or via an approved contractor, but it is the responsibility of the hospital to satisfy itself that the methods used provide adequate safeguards against accidental loss or disclosure of the records.
- Disposal of healthcare records should be carried out in accordance with environmental health regulations.
- Where a contractor is used to destroy records they should be required to sign confidential undertakings and to produce written certification as proof of disposal.
- Please note that optical and magnetic media require special disposal facilities.
- A record should be kept in perpetuity of all healthcare records destroyed. The register should contain the persons name, address, date of birth, file number, dates covered by the file (i.e. dates of first and last contact), date of disposal and by whom the authority was given to destroy the records. If agreement is reached at a later date to the use of a unique healthcare identifier, then this identifier should also be recorded.
- This record should be signed by the staff member supervising the removal and disposal of the records.
- The record should be filed and stored in a secure location in accordance with local policies and procedures.

7. Alternative media

- In order to address problems of storage space or for reasons of business efficiency, the hospital may consider transferral of hospital healthcare records to alternative media at any time during the life of the healthcare record within the retention period.
- It should be noted that effective management of digital records requires systematic procedures for transferring them to new media before the old media becomes unusable.
- Where transfer to alternative media is proposed the costs of the conversion to the requested medium should bear in mind the length of the retention period for which the records are required to be kept.

8. Interpretation and use of the schedule

- This retention and disposal schedule details a **Minimum Retention Period** for the types of healthcare record listed in the schedule. The recommended minimum retention period should be calculated from the end of the calendar month following the last entry on the document.
- The Schedule has five columns:

1.	Reference	This is to facilitate reference to the schedule
2.	Type of healthcare record	This column identifies the type of healthcare record created in the National Hospitals Office.
3.	Retention period	The retention period is calculated from the time the healthcare record was closed.
4.	Derivation	Notes the details of legislation and any other references of relevance to the recommended retention period.
5.	Final Action	There are two possibilities: • Destroy under confidential conditions. • Likely to be of archival value. Contact the National Archives (records acquisition division).

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR1	A&E (Emergency Department) records (where these are stored separately from the main patient record)	Retain for the period of time appropriate to the patient/ specialty, e.g. children's A&E records should be retained as per the retention period for the records of children and young people shown below		Destroy under confidential conditions
HCR2	A&E (Emergency Department) registers (where they exist in paper format)	8 years after the year to which they relate		Likely to have archival value. Contact the National Archives (Records Acquisition Division)
HCR3	Admission Books (where they exist in paper format)	8 years after the last entry		Likely to have archival value. Contact the National Archives (Records Acquisition Division)
HCR4	Ambulance records - patient identifiable component (including paramedic records made on behalf of the Ambulance Service)	10 years		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR5	Audiology Records	Retain for the period of time appropriate to the patient/ speciality, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if the patient died while in the care of the organisation		Destroy under confidential conditions
HCR6	Birth Registers (i.e. Register of births kept by the hospital)	10 years		Likely to have archival value. Contact the National Archives (Records Acquisition Division)
HCR7	Blood Transfusion Records (see pathology records)			
HCR8	Breast screening X-Rays	8 years		Destroy under confidential conditions
HCR9	Cervical Screening Slides	10 years		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR10	Children and young people (all types of records relating to children and young people)	Retain until the patient's 25th birthday or 26th if young person was 17 at the conclusion of treatment, or 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period		Destroy under confidential conditions
HCR11	Clinical Audit Records	5 years		Destroy under confidential conditions
HCR12a	Clinical trials of investigational medicinal products – healthcare records of participants that are the source data for the trial	For trials to be included in regulatory submissions: 20 years. It is the responsibility of the Sponsor/someone on behalf of the Sponsor to inform the investigator/institution as to when these documents no longer need to be retained	European Commission Directive 2005/28/EC of 8 April 2005 laying down principles and detailed guidelines for good clinical practice as regards investigational medicinal products for human use, as well as the requirements for authorisation of the manufacturing or importation of such products: http:/ pharmacos.eudra.org/F2/. harmacos/dir200120ec.htm	

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR12b	Clinical trials of investigational medicinal products – healthcare records of participants that are the source data for the trial	For trials which are not to be to be used in regulatory submissions: 20 years	Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use Directive 2001/20/EC: The Medicines for Human Use (Clinical Trials) Regulations 2004. ENTR/F/2 D(2002) – detailed guidelines on the trial master file and archiving ICH Harmonised Tripartite Guideline, guidance for good clinical practice, CPMP/ICH/135/95: http://www.emea.eu.int.pdfs/human/ich/013595en.pdf	Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR13	Creutzfeldt-Jakob Disease (hospital and GP)	30 years from date of diagnosis including deceased patients		Destroy under confidential conditions
HCR14	Death - Cause of, Certificate counterfoils	2 years		Destroy under confidential conditions
HCR15	Death registers – i.e. register of deaths kept by the hospital, where they exist in paper format	10 years		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR16	Dental, ophthalmic and auditory screening records	11 years for adults For children 11 years or up to their 25th birthday, which ever is the longer		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR17	Dietetic and Nutrition	Retain for the period of time appropriate to the patient/ speciality, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if the patient died while in the care of the organisation		Destroy under confidential conditions
HCR18	Discharge Books (where they exist in paper format)	8 years after the last entry		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR19	Donor records (blood and tissue)	25 years post transplantation		Destroy under confidential conditions
HCR20	Drug trials, records (see clinical trials)			

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR21	Forensic medicine records (including pathology, toxicology, haematology, dentistry, DNA testing, post mortems forming part of the Coroner's report, and human tissue kept as part of the forensic record). See also Human tissue, Post mortem registers	For post-mortem records which form part of the Coroner's report, approval should be sought from the coroner for a copy of the report to be incorporated in the patient's notes, which should then be kept in line with the specialty, and then reviewed. All other records retain for 30 years		Destroy under confidential conditions
HCR22	Genetic records	30 years from date of last attendance		Destroy under confidential conditions
HCR23	Healthcare records (excluding records not specified elsewhere in this schedule)	8 years after conclusion of treatment or Death		Destroy under confidential conditions
HCR24	Homicide / "Serious untoward incident" records	30 years		Destroy under confidential conditions
HCR25	Hospital acquired infection records	6 years		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR26	Human Tissue	For post-mortem records which form part of the Coroner's report, approval should be sought from the Coroner for a copy of the report to be incorporated in the patient's notes, which should then be kept in line with the specialty and then reviewed. All other records retain for 30 years		Destroy under confidential conditions
HCR27	Intensive Care Unit Charts	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions
HCR28	Joint replacement records	For joint replacement surgery the revision of a primary replacement may be required after 10 years to identify which prosthesis was used. Only need to retain minimum of notes with specific information about the prosthesis		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR29	Maternity (all obstetric and midwifery records, including those of episodes of maternity care that end in stillbirth or where the child later dies)	25 years after the birth of the last child		Destroy under confidential conditions
HCR30	Medical illustrations (see Photographs (HCR 43 below)			
HCR31	Mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001)	20 years after the date of last contact between the patient/client/service user and any healthcare professional employed by the mental health provider, or 8 years after the death of the patient/client/service user if sooner	Mental Health Acts 1945 to 2001	Destroy under confidential conditions
HCR32	Microfilm/microfiche records relating to patient care	Retain for the period of time appropriate to the patient/specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR33	Midwifery records	25 years after the birth of the last child		Destroy under confidential conditions
HCR34	Mortuary Registers (where they exist in paper format)	10 years		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR35	Notifiable Diseases Book	6 years		Destroy under confidential conditions
HCR36	Occupational therapy records	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001). 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR37	Oncology (including radiotherapy)	25 years. NB Records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes		Destroy under confidential conditions
HCR38	Operating Theatre Registers	8 years after the year to which they relate		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR39	Orthoptic records	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while		Destroy under confidential conditions
HCR40	Outpatient lists (where they exist in paper format)	2 years after the year to which they relate		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR41	Paediatric records (see Children and young people above)			
PATH1	Pathology Records *Documents, electronic and paper records* Accreditation documents; records of inspections	10 years or until superseded	http://www.rcpath.org/resources/pdf/retention - SEPT05.pdf–Applies to records PATH1 to PATH45.	Destroy under confidential conditions–Applies to records PATH1 to PATH45
PATH2	Batch Records Results	10 years		
PATH3	Bound copies of reports / records if made	30 years		
PATH4	Day Books and other Records of Specimens received by a laboratory	2 calendar years		
PATH5	Equipment / instruments maintenance logs, records of service inspections	Lifetime of equipment		
PATH6	Procurement, use, modification and supply records relevant to production of products (diagnostics) or equipment	11 years		

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
PATH7	External Quality Control records	2 years		
PATH8	Internal Quality Control Records	10 years		
PATH9	Lab File Cards or other working records of test results for named patients	2 calendar years		
PATH10	Near-patient Test Data	Result in patient record, log retained for lifetime of instrument		
PATH11	Pathological Archive / Museum Catalogues	30 years, subject to consent		
PATH12	Photographic Records	30 years where images present the primary source of information for the diagnostic process		
PATH13	Records of Telephoned Reports	2 calendar years		

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
PATH14	Records relating to investigation or storage of specimens relevant to organ transplantation, semen or ova	30 years if not held with health-care record		
PATH15	Reports, copies Post Mortem Reports	6 months Held in the patient's healthcare record for 8 years after the patients death		
PATH16	Request forms that are not a unique record	1 week after report received by requestor		
PATH17	Request forms that contain clinical information not readily available in the healthcare record	30 years		
PATH18	Standard operating procedures (current and old)	30 years		
PATH19	*Specimens and Preparations* Blocks for electron microscopy	30 years		
PATH20	Electrophoretic strips and immunofixation plates	5 years unless digital images taken, in which case 2 years and stored as a photographic record		

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
PATH21	Frozen Tissue for immediate histological assessment (frozen section)	Stained microscope slides - 10 years. Residual tissue - kept as fixed specimen once frozen section complete		
PATH22	Frozen Tissue or cells for histochemical or molecular genetic analysis	10 years		
PATH23	Grids for electron microscopy	10 years		
PATH24	Human DNA	4 weeks after final report for diagnostic specimens. 30 years for family studies for genetic disorders (consent required)		
PATH25	Microbiological Cultures	Most positive cultures can be discarded within 24 - 48 hours of issuing a final authorised report. Specified cultures of clinical importance (Blood Culture isolates, Cerebro spinal Fluid (CSF) isolates, enteric pathogens, multiple resistant or methicillin resistant Staph. Aureus, 'outbreak strains, M. tuberculosis, Group A streptococci, and unusual pathogens of clinical significance) should be retained for at least 7 days. Where isolates have been referred to external laboratories they should be retained for at least 7 days after the issue of their final report.		

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
PATH26	Museum specimens (teaching collections)	Permanently. Consent of the relative is required if it is tissue obtained through post mortem	http://www.rcpath.org/resources/pdf/Retention-SEPT05.pdf	
PATH27	Stained Slides	Depends on the purpose of the slide - see RCPath document for further details		
PATH28	Newborn Blood Spot screening cards	5 years - parents should be alerted to the possibility of contact from researchers after this period and a record kept of their 'consent to contact' response		
PATH29	Body fluids / aspirates / swabs	48 hours after the final report issued by lab		
PATH30	Paraffin Blocks	30 years and then appraise for archival value		
PATH31	Records relating to donor or recipient sera	11 years post transplant		
PATH32	Serum following needlestick injury or hazardous exposure	2 years		

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
PATH33	Serum from first pregnancy booking visit	1 year		
PATH34	Wet Tissue (representative aliquot or whole tissue or organ)	4 weeks after final report for surgical specimens.		
PATH35	Whole blood specimens for full blood count	24 hours		
PATH36	*Transfusion Labaratories* Annual reports (where required by EU directive)	15 years		
PATH37	Autopsy reports, specimens, archive material and other where the deceased has been the subject of a Coroner's autopsy	These are Coroner's records - copies may only be lodged on the healthcare record with the Coroner's permission		
PATH38	Blood Bank Register, blood component audit trial and fates	30 years to allow full traceability of all blood products used	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)	
PATH39	Blood for grouping, antibody screening and saving and/or cross-matching	1 week at 4°C		

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
PATH40	Forensic Material - criminal cases	Permanently, not part of the healthcare record		
PATH41	Refrigeration and Freezer Charts	11 years		
PATH42	Request forms for grouping, antibody screening and cross-matching	1 month	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50	
PATH43	Results of grouping, antibody screening and other blood transfusion related tests	30 years to allow full traceability of all blood products used	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)	
PATH44	Separated serum / plasma stored for transfusion purposes	Up to 6 months		
PATH45	Storage of material following analyses of nucleic acids	30 years See RCPath document for further guidance	http://www.cepath.org/resources/pdf/Retention-SEPT05.pdf	
PATH46	Worksheets	30 years to allow full traceability of all blood products used	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)	

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR42	Patient-held records	At the end of an episode of care the hospital organisation responsible for delivering that care and compiling the record of the care must make appropriate arrangements to retrieve patient-held records. The records should then be retained for the period appropriate to the specialty		Destroy under confidential conditions
HCR43	Photographs (where the photograph refers to a particular patient it should be treated as part of the healthcare record)	Retain for the period of time appropriate to the patient/specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions
HCR44	Physiotherapy records	Retain for the period of time appropriate to the patient/specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR45	Podiatry records	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions
HCR46	Post mortem records (see Pathology records)			
HCR47	Post mortem registers (where they exist in paper format)	30 years		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR48	Psychology records	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR49	Records/documents related to any litigation	As advised by the organisation's legal advisor. All records to be reviewed. Normal review 10 years after the file is closed		Destroy under confidential conditions
HCR50	Records of Destruction of Individual Healthcare records (case notes) and other health related records contained in this retention schedule (in manual or computer format)	Permanently		
HCR51	Scanned Records relating to patient care	Retain for the period of time appropriate to the patient/ specialty e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR52	Social Work records	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation Note: Records created under the Child Care legislation – hold in perpetuity.		Destroy under confidential conditions
HCR53	Speech and Language Therapy records	Retain for the period of time appropriate to the patient/ specialty e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions
HCR54	Suicide – notes of patients havingcommitted suicide	10 years		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR55	Telemedicine records (see also Video records)	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions
HCR56	Transplantation records	Records not otherwise kept or issued to patient records that relate to investigations or storage of specimens relevant to organ transplantation should be kept for 3 years	The Retention and Storage of Pathological Records and Archives (3rd edition 2005) Addendum 1	Destroy under confidential conditions
HCR57	Ultrasound records (e.g. vascular, obstetric	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR58	Video records/ voice recordings relating to patient care/ videoconferencing records	8 years subject to the following exceptions: Children and young people: Records must be kept until the patient's 25th birthday, or if the patient was 17 at the conclusion of treatment, until their 26th birthday, or until 8 years after the patient's death if sooner Maternity: 25 years Mentally disordered persons: Records should be kept for 20 years after the date of last contact between patient/client/service user and any healthcare professional or 8 years after the patient's death if sooner Cancer patients: Records should be kept until 8 years after the conclusion of treatment, especially if surgery was involved.		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR59	Ward registers, including daily bed returns (where they exist in paper format	2 years after the year to which they relate		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR60	X-ray films (including other image formats for all imaging modalities/diagnostics)	7 years (if there is an accompanying X-Ray report which is retained for the appropriate period of time as part of the patient record). If there is no accompanying X-Ray report the X-ray films (including other image formats for all imaging modalities/ diagnostics) are considered as a part of the patient record and should be retained for the appropriate period of time		Destroy under confidential conditions
HCR61	X-ray registers (where they exist in paper format)	30 years		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR62	X-ray reports (including reports for all imaging modalities)	To be considered as a part of the patient record and should be retained for the appropriate period of time		Destroy under confidential conditions

National Hospitals Office Code of Practice for Healthcare Records Management

Part 6: Audit Tool

Reader Information

Directorate:	National Hospitals Office (NHO)
Title:	NHO Code of Practice for Healthcare Records Management
Document Purpose:	Standards & Recommended Practices—Part 6
Author:	NHO Healthcare Records Management Steering Committee
Publication Date:	October 2007
Target Audience:	All staff in the NHO who work in healthcare records management
Description:	The Code of Practice is a guide to the standards of practice required in the management of healthcare records in the NHO, based on current legal requirements and professional best practice
Superseded Docs:	The retention and disposal schedule replaces the previous retention schedule on acute hospital records outlined on pages 8-9 of the 'Policy for Health Boards on Record Retention Periods' (1999). Version 2.0 replaces Version 1 of the Code of Practice.
Review Date:	October 2008
Contact Details:	Winifred Ryan, National Hospitals Office, Quality, Risk and Customer Care Directorate, Mid-Western Regional Hospital (Nenagh) Nenagh, Co. Tipperary, Ireland. **Email**: winifred.ryan1@hse.ie **Web:** www.hse.ie

Part 6
Audit Tool

Contents

1 Introduction

1.1 Standards for healthcare records management in acute hospitals

During 2006, standards for healthcare records management in acute care hospitals in the National Hospitals Office were developed using a consistent methodology. A literature review was undertaken which included a search for all relevant guidance and evidence. Expert opinion was also sought for the standards. A national consultation process was undertaken and feedback where appropriate was incorporated into the final version of the standards. An audit tool (based on the 'Safety and Health Audit Tool for the Healthcare Sector) was then developed to assist in the monitoring for the standards.

1.2 Audit

Audit is a function of all developing and progressive organisations. The outcome from an audit can facilitate an organisation to be knowledgeable about its areas of non-conformance and to identify and implement corrective action where necessary.

1.3 Audit tool

This audit tool in this document relates to the principles of healthcare records management and includes: organisational structure and accountability, structure and content of the healthcare records and communication with patients. The audit tool can be used to provide objective data on conformance with the standards within the National Hospitals Office. Year-on-year data can assist in monitoring the effectiveness of healthcare records management programmes and assist in strategic planning to meet long term healthcare records management objectives.

1.4 Levels of audit

There are two levels of audit against the NHO healthcare records management standards: self-assessment and external review.

Self assessment is a process whereby the hospital measures its conformance against national standards. Each hospital will be asked to undertake a self-assessment exercise for its service against the standards. This will be completed annually, signed by the hospital manager and sent to the Network Manager in the hospital network.

External review uses the same national standards to independently measure the hospital through an on-site audit. The findings from the audit will be summarised in a written report and hospitals will be supported in the development of quality improvement action plans.

2 Guidelines for using the audit tool

2.1 Healthcare records management audit tool

The audit tool is intended for use by the healthcare records department, staff with a demonstrated interest in healthcare records management and trained audit personnel.

2.2 Planning the audit programme

It is envisaged that the healthcare records committee will plan and prioritise the use of the audit tool based on a review of specific policies or in response to specific clinical incidents.

2.3 Time required

The time required to complete a specific audit will vary according to the tool, the size of the hospital, the type of procedures audited and the experience of the auditor.

2.4 Conformance

A conformance categorisation has been incorporated into the scoring system to provide a clear indication of conformance. The allocation of conformance levels is based on the scores obtained. For the purpose of these audits the categories will be allocated as follows: minimal conformance 75% or less, partial conformance 76-84% and conforming 85% or above.

2.5 Feedback of information and report findings

It is advised that the auditor should verbally report any areas of concern and of good practice to the head of department in charge of the area being audited prior to leaving. A written report should also be developed by the auditor and should be given to the relevant head of department for action. The report should clearly identify areas requiring action. The head of department is responsible for developing an action plan to address the issues identified within a given timescale.

The audit team may decide to re-audit the ward/department if there are concerns or a minimal conformance rating is observed. A system of feedback to the healthcare records committee on the action taken by wards/departments should be in place. This may involve feedback meetings or the return of completed action plans to the healthcare records manager.

Guidelines for using the audit tool

2.6 Scoring

Eleven standards for audit of healthcare records management are described in the following sections. Each standard is stated and followed by questions based on the standard criteria. Below is an explanation of the abbreviation used under each criterion.

I = Interview

O = Observation

D = Documentation

Y = Yes

P = Partial

N = No

Instructions on the completion of a standard worksheet

In order to effectively audit healthcare records management it is necessary that all standards are audited as part of the audit process. The auditor can repeat a full audit of all standards at regular intervals in order to measure the level of improvement in the effectiveness of healthcare records management.

There are eleven standards in this audit tool and for each standard there is a worksheet, which details a list of questions to be answered. There is specific information to be completed in the worksheet and this is explained below:

Step 1:

For each question the auditor can use an "X" to indicate the appropriate answer, which is "Yes", "Partial" or "No". In this example we will assume the answer is "No"

	1		Y	P	N
I O D	☐ ☐ ☐	**Does the hospital have a specific budget for the healthcare records service?** Supporting Evidence/Comments			X

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Guidelines for using the audit tool

Step 2

For each question the auditor can use an "X" to indicate the method of verification used in trying to get an answer to the question. The auditor may have interviewed (**I**) an employee, observed (**O**) a particular work practice or reviewed a particular document (**D**). The auditor may have used all three methods. For this example the auditor interviewed an employee and used an "X" to indicate this on the worksheet.

	1		Y	P	N
I	X	**Does the hospital have a specific budget for the healthcare records service?**			X
O					
D					

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

Step 3

The auditor can then detail some supporting evidence or comments to explain the reason for the relevant answer. In this example the answer to the question was "No" because the organisation did not have a specific budget for the healthcare records service.

	1		Y	P	N
I	X	**Does the hospital have a specific budget for the healthcare records service?**			X
O					
D					

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

No specific cost centre or budget allocated to the healthcare records department.

Guidelines for using the audit tool

Step 4

The auditor can use an "X" to indicate the appropriate answer for each question, which will be "Yes", "Partial" or "No".

The different scoring options are as set out below:

If the auditor selects "Yes" as his/her answer to the question, then the auditor uses an "X" to select "Yes" in the score table and enters a total score of "10" in the score table. An answer of "Yes" means there is full evidence of conformance and this is allocated a score of 10.

YES X
Score 10

If the auditor selects "No" as his/her answer to the question, then the auditor uses an "X" to select "No" in the score table and enters a total score of "0" in the score table. An answer of "No" means there is no evidence of conformance and this will be allocated a score of "0.

NO X
Score 0

If the auditor selects "Partial" as his/her answer to the question, then the auditor must choose from one of three options. A, B and C. The categories have the meaning as follows:

A: Evidence of significant level of conformance

B: Evidence of a reasonable level of conformance

C: Very little evidence of conformance

The auditor uses an "X" to select the appropriate option A, B or C.

A	B	C
Score 8	Score 5	Score 2

Guidelines for using the audit tool

Step 5

The auditor should check that he/she has entered the appropriate total score in the score table for each question.

Yes	No X	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	*0*

Step 6

The auditor should calculate the criterion score as a percentage. This is explained by a worked example below:

Number of Questions in Standard:	13
Maximum Standard Score (**MS**)	
(Total Number of Questions x Maximum Score (10)):	130 (13 x 10)
Actual Standard Score (AS) (Sum of the total scores for each question)	100

Note: In this example the actual score used was 100, however the actual score will vary depending on the scores allocated to each question.

Standard Score as a percentage = **AS/MS x 100/1**

In this example Standard Score as a percentage = 100/130 x 100/1 = 76.92%

Note: Where a question in a standard is not applicable, it will not be given a score.

Example:

In the above case; if there were only 12 questions applicable then the maximum criterion score (MS) would be 120 (12 x 10).

Guidelines for using the audit tool

Step 7

The auditor repeats Step 1-6 for each question in the standard worksheet.

Step 8

When a standard has been fully audited, the auditor can detail a summary of the results in the standard report form. This information can be taken from the worksheet or the auditor may use his/her own notes taken during the audit. This report form should be completed for each standard. An example of what information can be included in this report form is detailed below.

Standard 1: Organisational structure and accountability
Responsibility for healthcare records management in acute hospitals shall be clearly defined and there shall be clear lines of responsibility throughout each hospital.
Summary of documentation audited and referenced
Summary of main findings of the audit
Conformance in the area *Managers are aware of responsibilities* **Non-conformance in the area**
Standard Score: *100/130 76.92%*

Guidelines for using the audit tool

Step 9

The areas of non-conformance in each standard report form should be transferred to a quality improvement action plan. An example of a blank quality improvement action plan is detailed in section 5 of this document. Below is an example of the type of information that would be documented in this quality improvement action plan by the auditor.

Standard	*Area of Non Conformance*	*Corrective Action*	*Responsible Person*	*Time-frame*	*Review*
1	*No specific budget allocated for the healthcare records service*	*Discuss with Finance Manager. Include in Service Plan for following year*	*Hospital CEO/ Manager*	*Dec 2007*	*Feb 2008*

The auditor may have a number of areas of non-conformance for each standard. The quality improvement action plan will need to be agreed in consultation with the hospital management committee (or appropriate committee). The action plan is used to summarise the main findings of the audit and it is used as a tool for continuous improvement.

Note: The auditor may use the auditors note section in section 7 of this document to compile further relevant information.

Guidelines for using the audit tool

STANDARD SCORING SUMMARY SHEET

Step 10:

The auditor should detail the scoring for each Standard in a Standard Scoring Summary Sheet. A completed Standard Scoring Summary sheet is detailed below and a blank Standard Scoring Summary sheet is detailed in section 6 of this document.

Standard	Actual Standard Score (AS)	Maximum Standard Score (MS) Total Number of Question x Maximum Score (10)	Standard Score as a percentage (AS/MS x 100/1)
1	100	130	76.9
2	90	210	42.85
3	40	50	80
4	50	60	83.3
5	125	130	96.15
6	90	110	81.81
7	650	840	77.38
8	110	110	100
9	30	60	50
10	30	90	33.33
11	50	50	100
Overall Audit Score	1365	1,840	74.18

Guidelines for using the audit tool

Step 11:

Using the example above the auditor needs to calculate the overall audit score.

Overall

audit score = Sum of all actual standard scores (AS)/Sum of all maximum standard Scores (MS) x 100/1

Overall audit score = 1365/1740 x 100/1 = 78.44%

This overall audit score can be used to benchmark performance from year to year and the individual standard score allows the auditor to identify areas where most attention is needed.

A summary sheet with Standard and overall audit score could be attached to the quality improvement action plan as a full audit report.

3 Risk level categories

A response is categorised as non-conforming if it does not meet the criteria identified in the National Hospitals Office Standards for healthcare records management. An indication of the seriousness of the non-conformance is given by a risk category that is attached to each non-conformance statement. The categorisation of risk should provide some assistance in prioritising remedial actions.

On the right hand side of each statement is a risk level categorisation. These are organised as shown in Table 1.

Table 1: Definition of risk levels used in non-conformance statements

Level	Category	Description
1	Observation	This category includes reported facts which, although not necessarily non-conformances, should be considered when any remedial action is planned.
2	Low Risk	The reported fact(s) indicate a minor hazard with a low likelihood of the hazard occurring.
3	Medium Risk	The reported fact(s) indicate either a minor hazard with a significant likelihood of the hazard occurring or a significant hazard with a low likelihood of the hazard occurring.
4	High Risk	The reported fact(s) indicate a significant hazard with a significant likelihood of the hazard occurring.

4 Standards for healthcare records management system

Standard 1: Organisational structure and accountability

Responsibility for healthcare records management in acute hospitals shall be clearly defined and there shall be clear lines of responsibility throughout the hospital

Standard 2: Suitability of physical facilities

The storage of healthcare records shall take place in a well designed, secure area, which shall be free of obvious hazards, shall be protected from fire and flooding, and shall have stable levels of temperature and relative humidity. The facility shall be designed so that it is a secure department with **limited and restricted access** .

Standard 3: Management and key personnel

Appropriately qualified key personnel shall be in place to ensure that the healthcare records management service is provided efficiently and cost-effectively.

Standard 4: Education and training

Education and training in relevant aspects of healthcare records management shall be provided to all new, temporary and existing staff members.

Standard 5: Operational policies and procedures

Written policies, procedures and guidelines for the structure and content of the healthcare record and for the healthcare records service shall be based on National Hospitals Office guidelines for healthcare records management, shall be available, implemented and shall reflect relevant legislation and published professional guidance.

Standard 6: Structure of the healthcare record

All records relating to the patient shall be kept in a unified healthcare record file which is structured using the National Hospitals Office healthcare record order of filing. The structure shall facilitate documentation of the chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes. The structure shall also facilitate the monitoring of standards, audit, quality assurance and the investigation of complaints.

Standard 7: Content of the healthcare record

The content of the healthcare record shall provide an accurate chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes. The content of each record shall comply with clinical guidance provided by professional bodies and legal guidance provided by the Clinical Indemnity Scheme. This standard shall apply to both hardcopy and electronic documentation.

Standard 8: Audit and monitoring

Audits shall be carried out to ensure that the procedures for healthcare records management conform to the required standards and that the processes undertaken conform to the procedures. The audit results shall be used to identify opportunities for improvement.

Standard 9: Key performance indicators

Key performance indicators that are capable of showing improvements in the efficacy of healthcare records management in the hospital shall be used.

Standard 10: Communication and consultation

Appropriate and effective mechanisms shall be in place for communication and consultation on matters relating to healthcare records management, with key stakeholders within and outside the organization.

Standard 11: Clinical coding

The hospital shall use HIPE (Hospital In-Patient Enquiry System), a computer based health information system which collects clinical and administrative data on discharges, day cases and deaths from acute hospitals.

Organisational structure and accountability

Standard 1: Organisational structure and accountability

Responsibility for healthcare records management in acute hospitals shall be clearly defined and there shall be clear lines of responsibility throughout each hospital

	1.3.1		Y	P	N
I O D	☐ ☐ ☐	**Is individual responsibility for healthcare records management clearly defined? Are there clear lines of accountability throughout the hospital from hospital management to healthcare records staff and all healthcare records users, including clinical staff?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments Risk Category_____			

	1.3.2		Y	P	N
I O D	☐ ☐ ☐	**Does the scope of responsibility include the competence of contractors where the hospital buys in services and professional liability where the hospital sells services to other organisations?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments Risk Category_____			

	1.3.3		Y	P	N
I O D	☐ ☐ ☐	**Is healthcare records management a standard item on the agenda of the quality and risk management committee (or appropriate committee) in the hospital? Does the healthcare records manager (or designated manager) submit regular reports on healthcare records management to the committee?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments Risk Category_____			

Organisational structure and accountability

	1.3.4		Y	P	N
I O D	☐ ☐ ☐	**Is the twice yearly report on the effectiveness of HRM submitted to the quality & risk management committee (or appropriate committee for review)? Does this committee, which includes in its membership the hospital CEO/Manager or CEO/Manager nominee, present the report to the hospital management team?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	1.3.5		Y	P	N
I O D	☐ ☐ ☐	**Has the hospital identified a healthcare records manager (or designated manager)? Do the duties of the manager encompass all healthcare records processes wherever they occur within the hospital? (See Note, Part 2, p8)** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	1.3.6		Y	P	N
I O D	☐ ☐ ☐	**Does the healthcare records manager (or designated manager) have responsibility and authority for developing and monitoring policies, continuous quality improvement and/or strategies for HRM for approval by the quality and risk committee (or appropriate committee)?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Organisational structure and accountability

	1.3.7		Y	P	N
I O D	☐ ☐ ☐	**Does the healthcare records manager (or designated manager) attend appropriate meetings/conferences, local and national relevant to healthcare records management?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / / Score 8 / Score 5 / Score 2 / Supporting Evidence/Comments **Risk Category_____**			

	1.3.8		Y	P	N
I O D	☐ ☐ ☐	**Does the healthcare records manager (or designated manager) undertake the dissemination of all information received from the NHO/relevant agencies relating to healthcare records management within the hospital?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / / Score 8 / Score 5 / Score 2 / Supporting Evidence/Comments **Risk Category_____**			

	1.3.9		Y	P	N
I O D	☐ ☐ ☐	**Does the healthcare records manager (or designated manager) work with clinicians and departmental/ line managers to develop and improve the systematic approach to healthcare records management?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / / Score 8 / Score 5 / Score 2 / Supporting Evidence/Comments **Risk Category_____**			

Organisational structure and accountability

	1.3.10		Y	P	N
I O D	☐ ☐ ☐	**Is the healthcare records manager (or designated manager) responsible for ensuring that the healthcare record audit activity, under the responsibility of each relevant head of department has been completed?** Yes / Score 10 · No / Score 0 · Partial · A / Score 8 · B / Score 5 · C / Score 2 · Total score Supporting Evidence/Comments **Risk Category_____**			

	1.3.11		Y	P	N
I O D	☐ ☐ ☐	**Is the quality and risk committee (or appropriate committee) responsible for the implementation and monitoring of a healthcare records audit and monitoring programme in the hospital?** Yes / Score 10 · No / Score 0 · Partial · A / Score 8 · B / Score 5 · C / Score 2 · Total score Supporting Evidence/Comments **Risk Category_____**			

	1.3.12		Y	P	N
I O D	☐ ☐ ☐	**Is each relevant member of staff made aware of their responsibility in relation to the healthcare record?** Yes / Score 10 · No / Score 0 · Partial · A / Score 8 · B / Score 5 · C / Score 2 · Total score Supporting Evidence/Comments **Risk Category_____**			

Organisational structure and accountability

	1.3.13		Y	P	N
I O D	☐ ☐ ☐	**Does the hospital have a specific and appropriate resource provision for the healthcare records service?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Organisational structure and accountability

Standard 1: Report Form

Standard 1: Organisational structure and accountability
Responsibility for healthcare records management in acute hospitals shall be clearly defined and there shall be clear lines of responsibility throughout the hospital.
Summary of documentation audited and referenced
Summary of main findings of the audit
Conformance in the area **Non-conformance in the area**
Standard Score:

Suitability of physical facilities

Standard 2: Suitability of physical facilities

The storage of healthcare records shall take place in a well designed, secure area, which shall be free of obvious hazards, shall be protected from fire and flooding, and shall have stable levels of temperature and relative humidity. The facility shall be designed so that it is a secure department with **limited and restricted access.**

	2.3.1		Y	P	N
I O D	☐ ☐ ☐	**Is the area maintained in a good condition and cleaned regularly?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 **Supporting Evidence/Comments** **Risk Category_____**			

	2.3.2		Y	P	N
I O D	☐ ☐ ☐	**Is there lighting over each gangway, including gangways that will exist when mobile units are in operation? Is the interior light and pleasant with an adequate level of illumination that can be varied to suit functional activities? Are the healthcare records protected from the damaging effects of sunlight?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 **Supporting Evidence/Comments** **Risk Category_____**			

	2.3.3		Y	P	N
I O D	☐ ☐ ☐	**Is there sufficient electricity supply, computer terminal points and work stations within the facility to allow optimum use of Information Technology (IT), Management Information System (MIS) and on-line training?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Suitability of physical facilities

	2.3.4		Y	P	N
I O D	☐ ☐ ☐	**Is the ventilation system appropriate to provide a comfortable working environment?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	2.3.5		Y	P	N
I O D	☐ ☐ ☐	**Is the temperature maintained as close as possible to 18◦ C?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	2.3.6		Y	P	N
I O D	☐ ☐ ☐	**Does the floor covering contribute towards the creation of an attractive environment? Is the floor covering safe for people with a disability or the movement of wheeled equipment?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Suitability of physical facilities

	2.3.7		Y	P	N
I O D	☐ ☐ ☐	**Is confidentiality and security of healthcare records maintained at all times?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	2.3.8		Y	P	N
I O D	☐ ☐ ☐	**Are the doors, floors and wall surfaces and furniture of HRD's capable of withstanding the constant traffic of healthcare record trolleys and supply trolleys?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	2.3.9		Y	P	N
I O D	☐ ☐ ☐	**Are healthcare records stored on fixed and/or mobile shelving units?** **Are appropriate items of equipment available to access and transport healthcare records?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

Suitability of physical facilities

	2.3.10		Y	P	N
I ☐ O ☐ D ☐		**Is there suitable access and facilities for people with a disability who have problems of mobility or orientation?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	2.3.11		Y	P	N
I ☐ O ☐ D ☐		**Are doors wide enough to allow a clear space for people using a walking aid and for the passage of wheelchairs and trolleys?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	2.3.12		Y	P	N
I ☐ O ☐ D ☐		**Is fire safety training part of induction and orientation of staff and is reinforced through their term of employment?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Suitability of physical facilities

	2.3.13		Y	P	N
I O D	☐ ☐ ☐	**Are staff aware of location of fire extinguishers in their work area?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	2.3.14		Y	P	N
I O D	☐ ☐ ☐	**Are healthcare records filed on metal shelves?** **Are shelves in 900mm runs with side pieces and backing sheets?** **Are mobile units approx. 5.4m in length?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	2.3.15		Y	P	N
I O D	☐ ☐ ☐	**Are shelves 300mm deep and set with 300mm centres between shelves and divided by supports at 300mm intervals?** **Are the edges of shelving and side pieces rolled?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Suitability of physical facilities

	2.3.16		Y	P	N
I O D		**Is there an adequate amount of space to store all records?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	2.3.17		Y	P	N
I O D	☐ ☐ ☐	**Is the highest shelf accessible by all staff using a kick stool?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	2.3.18		Y	P	N
I O D	☐ ☐ ☐	**Are gangways 900mm wide provided between the rows of shelving to allow for trolleys and kick stools?** **Are the main access aisles at least 1.5m wide?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Suitability of physical facilities

	2.3.19		Y	P	N
I O D		**If mobile units are used, are sufficient gangways and fixed units allowed so that access is not impeded?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	2.3.20		Y	P	N
I O D	☐ ☐ ☐	**Are records retrievable on a 24-hour/7 day arrangement?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	2.3.21		Y	P	N
I O D	☐ ☐ ☐	**Has a health & safety statement been completed for the area?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Suitability of physical facilities

<table>
<tr><td></td><td>2.3.22</td><td></td><td>Y</td><td>P</td><td>N</td></tr>
<tr><td>I

O

D</td><td>☐

☐

☐</td><td>Where hazards have been identified, have risks been assessed and have appropriate control measures been put in place?

<table>
<tr><td>Yes</td><td>No</td><td rowspan="2">Partial</td><td>A</td><td>B</td><td>C</td><td>Total score</td></tr>
<tr><td>Score 10</td><td>Score 0</td><td>Score 8</td><td>Score 5</td><td>Score 2</td><td></td></tr>
</table>
Supporting Evidence/Comments

Risk Category_____</td><td></td><td></td><td></td></tr>
</table>

Suitability of physical facilities

Standard 2 Report Form

Standard 2: Suitability of physical facilities
The storage of healthcare records shall take place in a well designed, secure area, which shall be free of obvious hazards, shall be protected from fire and flooding, and shall have stable levels of temperature and relative humidity. The facility shall be designed so that it is a secure department with **limited and restricted access.**
Summary of documentation audited and referenced
Summary of main findings of the audit
Conformance in the area **Non-conformance in the area**
Standard Score:

Management and key personnel

Standard 3: Management and key personnel

Appropriately qualified key personnel shall be in place to ensure that the healthcare records management service is provided efficiently and cost-effectively.

	3.3.1		Y	P	N
I O D	☐ ☐ ☐	**Has the Hospital CEO/Manager put in place arrangements to ensure effective and efficient management of healthcare records?** Yes / Score 10 · No / Score 0 · Partial · A / Score 8 · B / Score 5 · C / Score 2 · Total score Supporting Evidence/Comments **Risk Category_____**			

	3.3.2		Y	P	N
I O D	☐ ☐ ☐	**Has a healthcare records manager (or designated manager) been appointed? Does s/he have formally defined responsibilities in accordance with these Standards? Has s/he been provided with the necessary resources to discharge these responsibilities?** Yes / Score 10 · No / Score 0 · Partial · A / Score 8 · B / Score 5 · C / Score 2 · Total score Supporting Evidence/Comments **Risk Category_____**			

	3.3.3		Y	P	N
I O D	☐ ☐ ☐	**Does the healthcare records manager (or designated manager) have an appropriate combination of experience and qualifications to undertake his/her role?** Yes / Score 10 · No / Score 0 · Partial · A / Score 8 · B / Score 5 · C / Score 2 · Total score Supporting Evidence/Comments **Risk Category_____**			

Management and key personnel

	3.3.4		Y	P	N
I O D	☐ ☐ ☐	**Does the healthcare records manager (or designated manager) have designated healthcare records staff for the hospital healthcare records service? Has the HRM or designated manager ensured that these personnel have been trained to the necessary standard of competence?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	3.3.5		Y	P	N
I O D	☐ ☐ ☐	**Do healthcare professionals have appropriate training on the principles of good record keeping and a good knowledge of the NHO recommended practices in relation to the structure and content of the healthcare record?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	3.3.6		Y	P	N
I O D	☐ ☐ ☐	**Is appropriate ICT expertise and support available for healthcare records management?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Management and key personnel

Standard 3 Report Form

Standard 3: Management and key personnel
Appropriately qualified key personnel are in place to ensure that the healthcare records management service is provided efficiently and cost-effectively.
Summary of documentation audited and referenced
Summary of main findings of the audit
Conformance in the area **Non-conformance in the area**
Standard Score:

Education and training

Standard 4: Education and training

Education and training in relevant aspects of healthcare records management shall be provided to all new, temporary and existing staff members.

	4.3.1		Y	P	N
I O D	☐ ☐ ☐	**Is there a structured healthcare records management foundation training programme for relevant managers and staff commensurate with their work activity/responsibility?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	4.3.2		Y	P	N
I O D	☐ ☐ ☐	**Is induction training in healthcare records management provided to each staff member (where relevant)? Is this recorded in the individuals training record?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	4.3.3		Y	P	N
I O D	☐ ☐ ☐	**Is there a continuing programme of training and education for staff in healthcare records management? Are departmental records kept of staff attendance at further training in HRM?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Education and training

	4.3.4		Y	P	N
I ☐ O ☐ D ☐		**Is training in healthcare records management supported with adequate resources and facilities?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	4.3.5		Y	P	N
I ☐ O ☐ D ☐		**Are competencies in healthcare records management across the hospital assessed and are records kept?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	4.3.6		Y	P	N
I ☐ O ☐ D ☐		**Is there a formal appraisal system in place to monitor staff performance and to identify individual training records?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Education and training

	4.3.7		Y	P	N
I O D	☐ ☐ ☐	**Does the hospital undertake an annual training needs analysis for healthcare records management? Does the hospital develop a training plan to support the needs identified?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Education and training

Standard 4 Report Form

Standard 4: Education and training
Education and training in relevant aspects of healthcare records management shall be provided to all new, temporary and existing staff members
Summary of documentation audited and referenced
Summary of main Findings of the audit
Conformance in the area **Non-conformance in the area**
Standard Score:

Operational policies and procedures

Standard 5: Operational policies and procedures

Written policies, procedures and guidelines for the structure and content of the healthcare record and for the healthcare records service shall be based on National Hospitals Office recommended practices for healthcare records management, shall be available, implemented and shall reflect relevant legislation and published professional guidance.

	5.3.1		Y	P	N
I O D	☐ ☐ ☐	**Does the hospital have documented policies, procedures and guidelines (where assessed as relevant) for all of the key elements of healthcare records management as outlined in the recommended practices section of the NHO Code of Practice?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	5.3.2		Y	P	N
I O D	☐ ☐ ☐	**Do all policies and procedures associated with healthcare records management comply with current legislation and NHO guidance?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	5.3.3		Y	P	N
I O D	☐ ☐ ☐	**Does the quality and risk management committee (or appropriate committee) approve policies, procedures and guidelines for health-care records management in the hospital?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Operational policies and procedures

	5.3.4		Y	P	N
I O D	☐ ☐ ☐	**Is there a system to ensure that each department or service has a current copy of the approved healthcare records management policies, procedures and guidelines pertinent to its activities?** Yes / Score 10 · No / Score 0 · Partial · A / Score 8 · B / Score 5 · C / Score 2 · Total score Supporting Evidence/Comments **Risk Category_____**			

	5.3.5		Y	P	N
I O D	☐ ☐ ☐	**Are all relevant hospital staff required to read the healthcare records policies and procedures relevant to their area of work and to sign a statement to indicate that they have read, understood and will comply with same?** Yes / Score 10 · No / Score 0 · Partial · A / Score 8 · B / Score 5 · C / Score 2 · Total score Supporting Evidence/Comments **Risk Category_____**			

	5.3.6		Y	P	N
I O D	☐ ☐ ☐	**Are all policy and procedure documents associated with healthcare records management controlled showing the date of issue and revision number?** Yes / Score 10 · No / Score 0 · Partial · A / Score 8 · B / Score 5 · C / Score 2 · Total score Supporting Evidence/Comments **Risk Category_____**			

Operational policies and procedures

	5.3.7		Y	P	N
I O D	☐ ☐ ☐	**Are master copies kept in a secure location?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	5.3.8		Y	P	N
I O D	☐ ☐ ☐	**Are obsolete documents removed from all points of use?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	5.3.9		Y	P	N
I O D	☐ ☐ ☐	**Is a biennial review undertaken of all policies, procedures and documents associated with healthcare records management to check their relevance and issue status?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

Operational policies and procedures

	5.3.10		Y	P	N
I O D	☐ ☐ ☐	**Is there a document management system for the control and management of healthcare records policies and procedures available within the hospital?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / / Score 8 / Score 5 / Score 2 / Supporting Evidence/Comments **Risk Category_____**			

	5.3.11		Y	P	N
I O D	☐ ☐ ☐	**Is all electronic data stored securely and backed up and audited regularly?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / / Score 8 / Score 5 / Score 2 / Supporting Evidence/Comments **Risk Category_____**			

	5.3.12		Y	P	N
I O D	☐ ☐ ☐	**Is access to data/records restricted to authorised named persons? Is specified information maintained in line with the Data Protection Acts?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / / Score 8 / Score 5 / Score 2 / Supporting Evidence/Comments **Risk Category_____**			

Operational policies and procedures

	5.3.13		Y	P	N
I O D	☐ ☐ ☐	Do staff have Intranet access? Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Operational policies and procedures

Standard 5 Report Form

Standard 5: Operational policies and procedures
Written policies, procedures and guidelines for the structure and content of the healthcare record and for the healthcare records service shall be based on National Hospitals Office recommended practices for healthcare records management, shall be available, implemented and shall reflect relevant legislation and published professional guidance.
Summary of documentation audited and referenced
Summary of main findings of the audit
Conformance in the area **Non-conformance in the area**
Standard Score:

Structure of the healthcare record

Standard 6: Structure of the healthcare record

All records relating to the patient shall be kept in a unified healthcare record which shall be structured using the NHO healthcare record order of filing. The structure shall facilitate documentation of the chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes. The structure shall also facilitate the monitoring of standards, audit, quality assurance and the investigation of complaints.

	6.3.1		Y	P	N
I O D	☐ ☐ ☐	**Is there a unified healthcare record that all healthcare professionals use?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	6.3.2		Y	P	N
I O D	☐ ☐ ☐	**Is each patient assigned a unit number which is printed on the outside of the patient healthcare record chart and used as a unique identifier for that patient?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	6.3.3		Y	P	N
I O D	☐ ☐ ☐	**Does the hospital follow the NHO agreed format for filing of information within the healthcare record?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

Structure of the healthcare record

	6.3.4		Y	P	N
I O D	☐ ☐ ☐	**Are the healthcare records folders 485gsm quality manila, measuring 312mm x 240mm? Do they have a gusset along the triple spine to allow for expansion to a maximum of 80mm as more documents are added? Are the dividers 200gsm quality card and do they have reinforced/ laminated printed tabs?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	6.3.5		Y	P	N
I O D	☐ ☐ ☐	**Does the healthcare record contain a designated place for healthcare professionals to record actual allergies/alerts? Is there a designated place for signing and dating these allergies/alerts?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	6.3.6		Y	P	N
I O D	☐ ☐ ☐	**If healthcare records have become too full (approx. 80mm thick), are they closed and a new volume opened?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Structure of the healthcare record

	6.3.7		Y	P	N
I O D	☐ ☐ ☐	**Is there a designated place to indicate the volume number, the date for opening and closing the new volume and the name(s) of the staff member who has opened/closed the healthcare record volume?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	6.3.8		Y	P	N
I O D	☐ ☐ ☐	**Is the tracking system updated to include the new volume with any alerts being reproduced on the inside cover?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	6.3.9		Y	P	N
I O D	☐ ☐ ☐	**Is there an appropriate procedure in place to identify duplicate and temporary charts?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Structure of the healthcare record

	6.3.10		Y	P	N
I O D	☐ ☐ ☐	**If more than one set of patients' charts exists, are there robust and effective systems in place to bring the sets together quickly and effectively?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	6.3.11		Y	P	N
I O D	☐ ☐ ☐	**Where there is more than one patient identifier, is there a cross-referencing system in place on the Patient Administration System (PAS)?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	6.3.12		Y	P	N
I O D		**Are there *no loose documents* in the healthcare record?** **No—score (10) Yes—score (0)** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Structure of the healthcare record

	6.3.13		Y	P	N
I O D	☐ ☐ ☐	**Are documents not held in the patient's healthcare record chart, stored securely and linked by the patient's unique identifier?** Yes / Score 10 · No / Score 0 · Partial · A / Score 8 · B / Score 5 · C / Score 2 · Total score Supporting Evidence/Comments **Risk Category_____**			

Structure of the healthcare record

Standard 6: Report Form

Standard 6: Structure of the healthcare record
All records relating to the patient are kept in a single unified healthcare record which shall be structured using the NHO healthcare record order of filing. The structure shall facilitate documentation of the chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes. The structure shall also facilitate the monitoring of standards, audit, quality assurance and the investigation of complaints.
Summary of documentation audited and referenced
Summary of main findings of the audit
Conformance in the area **Non-conformance in the area**
Standard Score:

Content of the healthcare record

Standard 7: Content of the healthcare record

The content of the healthcare record shall provide an accurate chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes. The content of each record shall comply with clinical guidance provided by professional bodies and legal guidance provided by the Clinical Indemnity Scheme. This standard shall apply to both hardcopy and electronic documentation.

	7.3.1		Y	P	N
I O D	☐ ☐ ☐	**Does the hospital have policies and procedures for the content of the healthcare record?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.2		Y	P	N
I O D		**Do these policies and procedures take account of national guidelines on legal and clinical practice requirements?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.3		Y	P	N
I O D	☐ ☐ ☐	**Is there a written agreed programme for the audit of conformance with healthcare records content policies and procedures?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.4		Y	P	N
I O D	☐ ☐ ☐	**Does this programme apply to each clinical specialty and department?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	7.3.5		Y	P	N
I O D	☐ ☐ ☐	**Are audit results fed back to staff and used to help inform and improve healthcare records content practices?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	7.3.6		Y	P	N
I O D	☐ ☐ ☐	**Is the patient's name on each side of each page where patient information is documented and does each page have the correct unique patient identification number and/or addressograph? Does this also apply to every screen on computerised systems?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.7		Y	P	N
I O D	☐ ☐ ☐	Are there *no blank spaces* or pages between entries? No—score (10) Yes—score (0) Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.8		Y	P	N
I O D	☐ ☐ ☐	Before the healthcare professional makes an entry in the patient's healthcare record, does s/he establish that the record belongs to the patient being attended? Is this done by verifying with the patient and by cross-referencing the patients' wrist band with the healthcare record? Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.9		Y	P	N
I O D	☐ ☐ ☐	Is all documentation clear and legible? Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Content of the healthcare record

	7.3.10		Y	P	N
I O D	☐ ☐ ☐	**When prescribing, is writing in un-joined lower case text or block capitals?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	7.3.11		Y	P	N
I O D	☐ ☐ ☐	**Are all entries dated, timed and signed with a clear signature, printed name, title and bleep number (where relevant)?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	7.3.12		Y	P	N
I O D	☐ ☐ ☐	**Are all entries in permanent black ink?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.13		Y	P	N
I O D	☐ ☐ ☐	**Is it clear from the patient record the time that an event occurred and the time that a record was made?** Yes / Score 10 — No / Score 0 — Partial — A / Score 8 — B / Score 5 — C / Score 2 — Total score Supporting Evidence/Comments **Risk Category_____**			

	7.3.14		Y	P	N
I O D	☐ ☐ ☐	**Are the time (24 hour clock) and date (day/month/year) noted against each clinical entry?** Yes / Score 10 — No / Score 0 — Partial — A / Score 8 — B / Score 5 — C / Score 2 — Total score Supporting Evidence/Comments **Risk Category_____**			

	7.3.15		Y	P	N
I O D	☐ ☐ ☐	**Are all entries accurate in relation to date (day/month)/year and time?** Yes / Score 10 — No / Score 0 — Partial — A / Score 8 — B / Score 5 — C / Score 2 — Total score Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.16		Y	P	N
I ☐ O ☐ D ☐		**Does the hospital site have a signature bank of all clinical staff and non-clinical staff who may have occasion to write in the healthcare record?** Yes: Score 10 | No: Score 0 | Partial | A: Score 8 | B: Score 5 | C: Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	7.3.17		Y	P	N
I ☐ O ☐ D ☐		**Are identification stamp pens, which have the clinician's name printed on a stamp attached to the pen, used in the hospital?** Yes: Score 10 | No: Score 0 | Partial | A: Score 8 | B: Score 5 | C: Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	7.3.19		Y	P	N
I ☐ O ☐ D ☐		**Are records amended if incorrect?** Yes: Score 10 | No: Score 0 | Partial | A: Score 8 | B: Score 5 | C: Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.20		Y	P	N
I O D	☐ ☐ ☐	**Are correction fluids used? Does the original entry remain visible?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.21		Y	P	N
I O D	☐ ☐ ☐	**Are deletions or alterations made by scoring out with a single line followed by:** • **Signature (plus name in capitals) and counter signature, if appropriate?** • **Date and time of correct entry?** • **Reason for amendment?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.22		Y	P	N
I O D	☐ ☐ ☐	**Are corrections made as close to the original recording as possible?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.23		Y	P	N
I O D	☐ ☐ ☐	If a prescription is no longer appropriate, is the prescription discontinued and a new prescription written? (No alterations) Yes / Score 10 — No / Score 0 — Partial — A / Score 8 — B / Score 5 — C / Score 2 — Total score Supporting Evidence/Comments Risk Category_____			

	7.3.24		Y	P	N
I O D	☐ ☐ ☐	Do records provide physical, psychological and social factors that appear to affect the patient? Yes / Score 10 — No / Score 0 — Partial — A / Score 8 — B / Score 5 — C / Score 2 — Total score Supporting Evidence/Comments Risk Category_____			

	7.3.25		Y	P	N
I O D	☐ ☐ ☐	Are the chronology of events and reasons for any decision made recorded in the context of a thorough assessment of the patient including relevant history taking? Yes / Score 10 — No / Score 0 — Partial — A / Score 8 — B / Score 5 — C / Score 2 — Total score Supporting Evidence/Comments Risk Category_____			

Content of the healthcare record

	7.3.26		Y	P	N
I O D	☐ ☐ ☐	**Do records provide accurate, correct, comprehensive and concise information concerning the condition and care of the patient or client and associated observations?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.27		Y	P	N
I O D	☐ ☐ ☐	**Is the information factual? (Documenting evidence of care)** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.28		Y	P	N
I O D	☐ ☐ ☐	**Are all entries in the record by healthcare professionals made as soon as possible after each intervention and at least once every 24 hours during the working week for acute inpatient episodes?** **Is there an entry in the record at least twice a week for rehabilitative care?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.29		Y	P	N
I	☐	Does every record entry (clinician related) identify the most senior clinician present at the time the entry was made?			
O	☐				
D	☐				

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

Risk Category_____

	7.3.30		Y	P	N
I	☐	Is the name of the primary clinician who is assuming overall responsibility for the patient's care clearly identifiable in the healthcare record at all times?			
O	☐	Is the name in the healthcare record the same clinician name entered into the Patient Administration System (PAS)?			
D	☐	If the primary clinician changes during the course of treatment, is this noted on the healthcare record and on the PAS?			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

Risk Category_____

	7.3.31		Y	P	N
I	☐	Is input into all records multidisciplinary?			
O	☐				
D	☐				

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

Risk Category_____

Content of the healthcare record

	7.3.32		Y	P	N
I O D	☐ ☐ ☐	Is retrospective documentation • Dated? • Timed? • Signed and countersigned as appropriate? Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.33		Y	P	N
I O D	☐ ☐ ☐	Is the reason why the retrospective entry is being made clearly stated? Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.34		Y	P	N
I O D	☐ ☐ ☐	Is it clear that the entry is a retrospective entry? Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Content of the healthcare record

	7.3.35		Y	P	N
I O D	☐ ☐ ☐	**Are the abbreviations used, on the list of abbreviations approved by the NHO?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.36		Y	P	N
I O D	☐ ☐ ☐	**Are all approved abbreviations written in higher care BLOCK letters?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.37		Y	P	N
I O D	☐ ☐ ☐	**Other than this list, on each side of each page, is the full term used, followed by the abbreviation in brackets?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.38		Y	P	N
I ☐ O ☐ D ☐		Are abbreviations *not used* on documentation which is used for transfer, discharge or external referral letters? No—score (10) Yes—score (0) Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.39		Y	P	N
I ☐ O ☐ D ☐		Are abbreviations *not used on* • Consent forms? • Death certificates? • Incident report forms? • Communications sent from the hospital? No—score (10) Yes—score (0) Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.40		Y	P	N
I ☐ O ☐ D ☐		Are records objective and do they describe what is observed? Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Content of the healthcare record

	7.3.41		Y	P	N
I O D	☐ ☐ ☐	**If an incident has not been observed but is relevant to client care then is this clear? e.g. patient states...** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.42		Y	P	N
I O D	☐ ☐ ☐	**Are instructions regarding patient care from a healthcare professional via the telephone documented, dated, signed and later countersigned by the healthcare professional responsible for giving the instructions?** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.43		Y	P	N
I O D	☐ ☐ ☐	**If no instructions are given is this also documented?** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Content of the healthcare record

	7.3.44		Y	P	N
I O D	☐ ☐ ☐	**Is there a note in the clinical record of any significant abnormal results found or communicated to the healthcare professional?** **Does this includes a record of who has been informed e.g. healthcare professionals' name?** **Is this note made by the appropriate healthcare professional?** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.45		Y	P	N
I O D	☐ ☐ ☐	**Are drugs only administered and documented in the presence of clear unambiguous prescriptions and in accordance with hospital policies?** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.46		Y	P	N
I O D		**Are drug names *not abbreviated* under any circumstances?** **No—score (10) Yes—score (0)** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Content of the healthcare record

	7.3.47		Y	P	N
I O D	☐ ☐ ☐	**Are generic names ONLY used for the drug chart?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.49		Y	P	N
I O D	☐ ☐ ☐	**Are all records written in English?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.50		Y	P	N
I O D	☐ ☐ ☐	**Are records completed in terms that the patient and/or the health-care professional can understand?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.51		Y	P	N
I ☐ O ☐ D ☐		**Are records supported by explanations where this may not be possible?** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.52		Y	P	N
I ☐ O ☐ D ☐		**Are records phrased clearly and unambiguously?** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.53		Y	P	N
I ☐ O ☐ D ☐		**Are records objective, factual, devoid of jargon, witticisms or derogatory remarks?** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Content of the healthcare record

	7.3.54		Y	P	N
I O D	☐ ☐ ☐	**Is healthcare professionals advice on care, in any format documented in notes of advice given?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.55		Y	P	N
I O D	☐ ☐ ☐	**Does the patient registration information comply with NHO guidelines?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.56		Y	P	N
I O D	☐ ☐ ☐	**Are alerts and allergies recorded on the inside of the cover of the healthcare record chart?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.57		Y	P	N
I	☐	**Is this information signed and dated? Is there an end date for the alert if appropriate?**			
O	☐				
D	☐				

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

Risk Category_____

	7.3.58		Y	P	N
I	☐	**Does the hospital have a clear procedure regarding who should enter alerts into the healthcare record, when alerts should be entered and the procedure for removing alerts from the healthcare record? Are these procedures adhered to?**			
O	☐				
D	☐				

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

Risk Category_____

	7.3.59		Y	P	N
I	☐	**Are referral letters date stamped on receipt in every department?**			
O	☐				
D	☐				

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

Risk Category_____

Content of the healthcare record

	7.3.60		Y	P	N
I	☐	**Are referrals recorded on the appropriate ICT management system?**			
O	☐				
D	☐				

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

Risk Category_____

	7.3.61		Y	P	N
I	☐	**Are referrals assessed by the appropriate healthcare professional and marked as routine or urgent depending on their clinical need?**			
O	☐				
D	☐				

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

Risk Category_____

	7.3.62		Y	P	N
I	☐	**Where waiting lists exist, is the patient's name then placed on the waiting list?**			
O	☐				
D	☐				

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

Risk Category_____

Content of the healthcare record

	7.3.63		Y	P	N
I O D	☐ ☐ ☐	**Where there are no waiting lists, is the patient issued with an appointment, if appropriate?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	7.3.64		Y	P	N
I O D	☐ ☐ ☐	**Is the GP/referral source notified of the outcome of the referral?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

	7.3.65		Y	P	N
I O D	☐ ☐ ☐	**Does the Admission Entry include the minimum, general patient information as outlined in the NHO guidelines?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.66		Y	P	N
I ☐ O ☐ D ☐		**Does the Follow-Up Entry include the minimum, general patient information as outlined in the NHO guidelines?**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

Risk Category_____

	7.3.67		Y	P	N
I ☐ O ☐ D ☐		**Does the Transfer/Discharge Communication include the minimum, general patient information as outlined in the NHO guidelines?**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

Risk Category_____

	7.3.68		Y	P	N
I ☐ O ☐ D ☐		**Is the transfer/discharge communications multi-disciplinary where multi-disciplinary care is to be continued?**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Supporting Evidence/Comments

Risk Category_____

Content of the healthcare record

	7.3.69		Y	P	N
I O D	☐ ☐ ☐	**Is the transfer/discharge communication completed within 48 hours of the patients discharge?** **Is a copy of the transfer/discharge communication sent to the patient's GP and a further copy retained in the record?** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.70		Y	P	N
I O D	☐ ☐ ☐	**Is the transfer/discharge communication authorised by the relevant responsible healthcare professionals?** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	7.3.71		Y	P	N
I O D	☐ ☐ ☐	**Is all relevant communication with patients and families documented in the relevant part of the healthcare record?** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Content of the healthcare record

	7.3.72		Y	P	N
I O D	☐ ☐ ☐	**Does the documentation regarding consent comply with the NHO guidelines?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.73		Y	P	N
I O D	☐ ☐ ☐	**If verbal consent is given is this documented in the record? Is the witness clearly identified?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.74		Y	P	N
I O D	☐ ☐ ☐	**Does this Standard apply to both hardcopy and electronic documentation?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.75		Y	P	N
I O D	☐ ☐ ☐	**Is the involvement of the patient in decisions about his or her care documented in the record under 'patient wishes'?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.76		Y	P	N
I O D	☐ ☐ ☐	**Are Living Wills or Advance Directives clearly recorded in the notes alongside any resuscitation statements?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.77		Y	P	N
I O D	☐ ☐ ☐	**Does the Death Entry include the minimum general patient information as outlined in the NHO guidelines?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.78		Y	P	N
I O D	☐ ☐ ☐	**When the death notification form is completed, is an entry made in the record as outlined in the NHO guidelines?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.79		Y	P	N
I O D	☐ ☐ ☐	**Is a discharge summary form completed in the event of death?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.80		Y	P	N
I O D	☐ ☐ ☐	**When a hospital post mortem is performed is a provisional diagnosis noted in the healthcare record within 72 hours of confirmation of death?** **Is the healthcare record completed within one month following the death? (this does not include paediatric post mortems)** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.81		Y	P	N
I O D	☐ ☐ ☐	**Is a copy of the consent for the hospital post-mortem report filed in the healthcare record?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.82		Y	P	N
I O D	☐ ☐ ☐	**Is there a record of all post mortem meetings with parents, social workers and the multidisciplinary team documented in the health-care record?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.83		Y	P	N
I O D	☐ ☐ ☐	**Is a copy of the hospital post-mortem report filed in the healthcare record?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

	7.3.84		Y	P	N
I O D	☐ ☐ ☐	**Are there procedures in place within the hospital regarding the confidentiality and security of patients' healthcare records?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.85		Y	P	N
I O D	☐ ☐ ☐	**Is there a clause in all staff contracts regarding confidentiality of patient care?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	7.3.86		Y	P	N
I O D	☐ ☐ ☐	**Does ongoing training regarding confidentiality take place at local level?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Content of the healthcare record

Standard 7 Report Form

Standard 7: Content of the healthcare record
The content of the healthcare record shall provide an accurate chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes. The content of each record shall comply with clinical guidance provided by professional bodies and legal guidance provided by the Clinical Indemnity Scheme. This standard shall apply to both hardcopy and electronic documentation.
Summary of documentation audited and referenced
Summary of main findings of the audit
Conformance in the area **Non-conformance in the area**
Standard Score:

Audit and monitoring

Standard 8: Audit and monitoring

Audits shall be carried out to ensure that the procedures for healthcare records management conform to the required Standards and that the processes undertaken conform to the procedures. The audit results shall be used to identify opportunities for improvement.

	8.3.1		Y	P	N
I O D	☐ ☐ ☐	**Does audit of healthcare records management include:** • **Accountability arrangements?** • **Staff knowledge, expertise and resources?** • **Processes, including risk management arrangements?** • **Policies, procedures and guidelines?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category**_____			

	8.3.2		Y	P	N
I O D	☐ ☐ ☐	**Is each relevant head of department responsible for preparing a written agreed programme which ensures that all aspects of healthcare records management within their department are audited at least once a year?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category**_____			

	8.3.3		Y	P	N
I O D	☐ ☐ ☐	**Is each relevant head of department responsible for ensuring that the audit is conducted in accordance with this programme?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category**_____			

Audit and monitoring

	8.3.4		Y	P	N
I O D	☐ ☐ ☐	**Is each relevant head of department responsible for ensuring that remedial actions are carried out for any deficiencies found and for verifying the efficacy of remedial actions undertaken?** Yes / Score 10 · No / Score 0 · Partial · A / Score 8 · B / Score 5 · C / Score 2 · Total score Supporting Evidence/Comments **Risk Category**_____			

	8.3.5		Y	P	N
I O D	☐ ☐ ☐	**Is the healthcare records manager (or designated manager) responsible for ensuring that the audit activity, under the responsibility of each relevant head of department has been completed?** Yes / Score 10 · No / Score 0 · Partial · A / Score 8 · B / Score 5 · C / Score 2 · Total score Supporting Evidence/Comments **Risk Category**_____			

	8.3.6		Y	P	N
I O D	☐ ☐ ☐	**Is the quality and risk (or appropriate) committee responsible for the implementation and monitoring of a healthcare records audit and monitoring programme in each hospital?** Yes / Score 10 · No / Score 0 · Partial · A / Score 8 · B / Score 5 · C / Score 2 · Total score Supporting Evidence/Comments **Risk Category**_____			

Audit and monitoring

	8.3.7		Y	P	N
I O D	☐ ☐ ☐	**Are audit results fed back to the healthcare records manager (or designated manager) , the healthcare records committee, staff and the hospital management team?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	8.3.8		Y	P	N
I O D	☐ ☐ ☐	**Are audit results included in the quality and risk management annual (or appropriate) annual report?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	8.3.9		Y	P	N
I O D	☐ ☐ ☐	**Are audit results used to help to inform and improve healthcare records management practices?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Audit and monitoring

	8.3.10		Y	P	N
I O D	☐ ☐ ☐	**Are the audits carried out by appropriately trained auditors?** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	8.3.11		Y	P	N
I O D	☐ ☐ ☐	**Does the hospital management team submit an annual assurance statement on audit findings for consideration and approval by the Network Manager?** Supporting Evidence/Comments **Risk Category_____**			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Audit and monitoring

Standard 8 Report Form

Standard 8: Audit and monitoring
Audits shall be carried out to ensure that the procedures for healthcare records management conform to the required standards and that the processes undertaken conform to the procedures. The audit results shall be used to identify opportunities for improvement.
Summary of documentation audited and referenced
Summary of main findings of the audit
Conformance in the area **Non-conformance in the area**
Standard Score:

Key performance indicators

Standard 9: Key performance indicators

Key performance indicators that are capable of showing improvements in the efficacy of healthcare records management in the hospital shall be used.

	9.3.1-9.3.3		Y	P	N
I O D	☐ ☐ ☐	**Does the hospital meet the key performance indicators in relation to the *Environment* and healthcare records management?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category**_____			

	9.3.4-9.3.9		Y	P	N
I O D	☐ ☐ ☐	**Does the hospital meet the key performance indicators in relation to the *Healthcare Record*?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category**_____			

	9.3.10-9.3.12		Y	P	N
I O D	☐ ☐ ☐	**Does the hospital meet the key performance indicators in relation to *Management and Personnel* for healthcare records management?** Yes / Score 10 | No / Score 0 | Partial | A / Score 8 | B / Score 5 | C / Score 2 | Total score Supporting Evidence/Comments **Risk Category**_____			

Key performance indicators

	9.3.13-9.3.14		Y	P	N
I O D	☐ ☐ ☐	Does the hospital meet the key performance indicators in relation to *Education and Training* and healthcare records management? Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	9.3.15-9.3.16		Y	P	N
I O D		Does the hospital meet the key performance indicators in relation to *Audit and Monitoring* and healthcare records management? Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	9.3.17-9.3.19		Y	P	N
I O D		Does the hospital meet the key performance indicators in relation to *Service Quality* and healthcare records management? Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Key performance indicators

Standard 9 Report Form

Standard 9: Key performance indicators
Key performance indicators that are capable of showing improvements in the efficacy of healthcare records management in the hospital shall be used.
Summary of documentation audited and referenced
Summary of main findings of the audit
Conformance in the area **Non-conformance in the area**
Standard Score:

Communication and consultation

Standard 10: Communication and consultation

Appropriate and effective mechanisms shall be in place for communication and consultation with key stakeholders, within and outside the organization, on matters relating to healthcare records management.

	10.3.1		Y	P	N
I O D	☐ ☐ ☐	**Are all communications delivered in a form and manner that the patient understands?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	10.3.2		Y	P	N
I O D	☐ ☐ ☐	**Are all communications with the patient personalised and the information concerning the appointment, date, time, location and special instructions written clearly and without ambiguity?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	10.3.3		Y	P	N
I O D	☐ ☐ ☐	**Do all relevant staff receive formal training in providing a personalised service and in using the patient systems appropriate to their area of work?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Communication and consultation

	10.3.4		Y	P	N
I ☐ O ☐ D ☐		Does communication with patients take account of local ethnic minorities and non-Irish nationals? Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	10.3.5		Y	P	N
I ☐ O ☐ D ☐		Does communication with patients take place in a confidential manner and is patient privacy respected? Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

	10.3.6		Y	P	N
I ☐ O ☐ D ☐		Are staff, patients and key stakeholders encouraged to use feedback procedures to the hospital for any concerns/level of satisfaction in relation to healthcare records management in the hospital? Supporting Evidence/Comments Risk Category_____			

Yes	No	Partial	A	B	C	Total score
Score 10	Score 0		Score 8	Score 5	Score 2	

Communication and consultation

	10.3.7		Y	P	N
I O D	☐ ☐ ☐	**Has the hospital developed and implemented a practical methodology for sharing best practice both internally and with key stakeholders in relation to healthcare records management?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	10.3.8		Y	P	N
I O D	☐ ☐ ☐	**Does the hospital have in place a formal system for recording and analysing customer complaints in relation to healthcare records management?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	10.3.9		Y	P	N
I O D	☐ ☐ ☐	**Does the hospital have in place a programme to reduce customer complaints in relation to healthcare records management?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Communication and consultation

Standard 10 Report Form

Standard 10: Communication and consultation
Appropriate and effective mechanisms shall be in place for communication and consultation with key stakeholders, within and outside the organization, on matters relating to healthcare records management.
Summary of documentation audited and referenced
Summary of main findings of the audit
Conformance in the area **Non-conformance in the area**
Standard Score:

Clinical coding

Standard 11: Clinical coding

The hospital shall use HIPE (Hospital In-patient Enquiry System), a computer based health information system, which collects clinical and administrative data on discharges, day cases and deaths from acute hospitals.

	11.3.1		Y	P	N
I O D	☐ ☐ ☐	**Do clinical coders undergo regular training under the guidance of the HIPE unit, Economic Social Research Unit (ESRI)?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	11.3.2		Y	P	N
I O D	☐ ☐ ☐	**Is the ICD-10-AM, 4th edition used?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	11.3.3		Y	P	N
I O D	☐ ☐ ☐	**Do clinical staff participate in validating the coding process?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Clinical coding

	11.3.4		Y	P	N
I O D	☐ ☐ ☐	**Is clinical coding complete for all inpatient and day case episodes within the time scale set down by the DoHC/ESRI guidelines?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

	11.3.5		Y	P	N
I O D	☐ ☐ ☐	**Is the HIPE Coordinator responsible for implementing regular audits of the quality of clinical coding?** Yes / No / Partial / A / B / C / Total score Score 10 / Score 0 / Score 8 / Score 5 / Score 2 Supporting Evidence/Comments **Risk Category_____**			

Clinical coding

Standard 11 Report Form

Standard 11: Clinical coding
The hospital shall use HIPE (Hospital In-patient Enquiry System), a computer based health information system, which collects clinical and administrative data on discharges, day cases and deaths from acute hospitals.
Summary of documentation audited and referenced
Summary of main findings of the audit
Conformance in the area **Non-conformance in the area**
Standard Score:

Quality improvement action plan

5. QUALITY IMPROVEMENT ACTION PLAN

Standard Reference	Area of Non-Conformance	Level of Risk	Corrective Action to be taken	Responsible Person	Time Frame	Cost Implications	Review of Implementation of Action	Comment *Office Use Only*

Standard scoring summary sheet

6. STANDARD SCORING SUMMARY SHEET

Standard	Actual Standard Score (AS)	Maximum Standard Score (MS) Total Number of Question x Maximum Score (10)	Standard Score as a percentage (AS/MS x 100/1)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
Overall Audit Score			

Auditors notes

7. AUDITORS NOTES

Auditors notes

AUDITORS NOTES

National Hospitals Office Code of Practice for Healthcare Records Management

Part 7: Additional Resources and Appendices

Reader Information

Directorate:	National Hospitals Office (NHO)
Title:	NHO Code of Practice for Healthcare Records Management
Document Purpose:	Standards & Recommended Practices—Part 7
Author:	NHO Healthcare Records Management Steering Committee
Publication Date:	October 2007
Target Audience:	All staff in the NHO who work in healthcare records management
Description:	The Code of Practice is a guide to the standards of practice required in the management of healthcare records in the NHO, based on current legal requirements and professional best practice
Superseded Docs:	The retention and disposal schedule replaces the previous retention schedule on acute hospital records outlined on pages 8-9 of the 'Policy for Health Boards on Record Retention Periods' (1999). Version 2.0 replaces Version 1 of Code of Practice.
Review Date:	October 2008
Contact Details:	Winifred Ryan, National Hospitals Office, Quality, Risk and Customer Care Directorate, Mid-Western Regional Hospital (Nenagh) Nenagh, Co. Tipperary, Ireland. **Email**: winifred.ryan1@hse.ie **Web:** www.hse.ie

Part 7
Additional Resources and Appendices

Contents

1. References

An Bord Altranais. Recording Clinical Practice Guidance to Nurses and Midwives. 2002

Audit Commission. Setting the record straight – a study of hospital medical records. 1995. HMSO.

Audit Commission. Setting the Record Straight - a review of progress in health records services. 1999. HMSO.

Bado W, Williams CJ. Usefulness of letters from hospitals to general practitioners. *Br Med J (Clin Res Ed)* 1984;288:1813-4.

Bolton P. A quality assurance activity to improve discharge communication with general practice. *J Qual Clin Pract.* 2001;21:69-70.

British Psychological Society Clinical Psychology Division. Clinical Psychology and Case Notes : Guidance on Good Practice. 2000.

British Psychology Society, Division of Counselling Psychology. Guidelines on Confidentiality and Record Keeping. 2002.

BS 5454: 2000. Recommendations for the storage and exhibition of archival documents.

Caspe Research Healthcare Accreditation Programme: Standards for Accreditation. 2006.

Chartered Society of Physiotherapy. Standards of Physiotherapy Practice, 2000 (revised 2005).

College of Occupational Therapists. Code of Ethics and Professional Conduct. 2005.

References

Cheney C,.Ramsdell JW. Effect of medical records' checklists on implementation of periodic health measures. *Am J Med* 1987;83:129-36.

European Region of the World Confederation of Physical Therapy. European Care Physiotherapy Standards. May, 2002.

Federation of the Royal Colleges of Physicians of the United Kingdom. Good Medical Practice for Physicians - Draft Guidance. 2002. FedRCP.

Guidelines in Relation to Obtaining Consent to Clinical Treatment in an Acute Hospital Setting. Hospital Network 3. HSE Dublin North East. 2006.

Hamilton W, Round A, Taylor P. Dictating clinic letters in front of the patient. Letting patients see copy of consultant's letter is being studied in trial. *BMJ* 1997;314:1416.

Health Building Note 47. Health Records Departments, 1991. HMSO.

HQS. Accreditation Standards for NHS Trusts. 2003.

Irish Health Services Accreditation Board. Acute Care Accreditation Scheme, A Framework for Quality and Safety. 2nd Edition. 2005.

Irish Medical Council. A guide to Ethical conduct and Behaviour. 6th Edition. 2004.

Irish Nutrition & Dietetic Institute (INDI). Guidance on Standards for Record Keeping/ Documentation for members. December 2005.

Irish Society Chartered Physiotherapists. Standards. June 2002.

References

ISO 15489-1: 2001. Information and Documentation on Records Management.

Joint Commission International. Accreditation Standards for Hospitals. 2002.

Joint Commission for the Accreditation of Healthcare Organizations (JCAHO). Accreditation manual for Hospitals. 87-88. 1980. Chicago Il.

Mann, R. Y., Williams, J. G., and Wade, W (ed.). Laying the Foundations for Good Medical Practice: A generic training programme for SHOs. 29-4-2003. London, Royal College of Physicians.

Rawal J, Barnett P, Lloyd BW. Use of structured letters to improve communication between hospital doctors and general practitioners. *BMJ* 1993;307:1044

Royal College of Physicians. Draft Standards for Record Keeping – inpatients. VERSION 6.0 2003.

Royal College of Speech and Language Therapists. Communicating Quality. 2nd Edition 1996.

UK Nursing and Midwifery Council. Guidelines for Records and Record keeping. 2002.

Wallis, C. and Webster, R. E. Discharge letters to General Practitioners: their importance and content. Care of the Critically Ill 9, 70-71. 1993.

Williams JG,.Mann RY. Hospital episode statistics: time for clinicians to get involved. *Clin Med* 2002;2:34-7.

Wrenn K, Rodewald L, Lumb E, Slovis C. The use of structured, complaint-specific patient encounter forms in the emergency department. *Ann Emerg.Med* 1993;22:805-12.

2. List of hospitals who participated in the consultation process

Waterford Regional Hospital, Co. Waterford
St Luke's General Hospital, Kilkenny
Lourdes Orthopaedic Hospital, Kilcreene, Kilkenny
Wexford General Hospital, Wexford
South Tipperary General Hospitals, Clonmel, Co.Tipperary
Cork University Hospital, Wilton Road, Cork
Cork University Maternity Hospital, Cork
St. Finbarr's Hospital, Douglas Road, Cork
St Mary's Orthopaedic Hospital, Gurranbraher, Cork
Mallow General Hospital, Mallow, Co. Cork
Kerry General Hospital, Tralee
Bantry General Hospital, Bantry, Co. Cork
Mercy University Hospital, Grenville Place, Cork
South Infirmary-Victoria University Hosp., Old Blackrock Rd, Cork
Our Lady of Lourdes Hospital, Drogheda, Co. Louth
Louth County Hospital, Dundalk, Co. Louth
Cavan General Hospital, Cavan
Monaghan General Hospital, Co. Monaghan
Our Lady's Hospital, Navan, Co. Meath
Sligo General Hospital, Sligo
University College Hospital, Galway
Merlin Park Reg. Hospital, Galway

List of hospitals who participated in the consultation process

Mayo General Hospital, Castlebar, Co. Mayo
Roscommon County Hospital, Roscommon
Portiuncula Hospital, Portiuncula, Ballinasloe, Co. Galway
Letterkenny General Hospital, Letterkenny, Co. Donegal
Midland Regional Hospital, Mullingar, Co. Westmeath
Midland Regional Hospital, Tullamore, Co. Offaly
Adelaide & Meath Incorp National Children's Hospital, Tallaght, D24
Naas General Hospital, Naas, Co. Kildare
Coombe Women's Hospital, Dolphins Barn, Dublin 8
Our Lady's' Hospital for Sick Children, Crumlin, Dublin 12
Midland Regional Hospital Portlaoise
Mid Western Regional Hospital Limerick, Dooradoyle, Limerick City
Mid Western Regional Orthopaedic, Croom, Co. Limerick
Mid Western Regional Maternity Hospital, Limerick City
Mid Western Regional Hospital, Ennis, Co. Clare
Mid Western Regional Hospital, Nenagh, Co. Tipperary
St John's Hospital, Limerick City
St Vincent's University Hospital, Elm Park, Dubiln 4
St Michaels Hospital, Lower George's St., Dun Laoghaire, Co. Dublin
St Columcille's Hospital, Loughlinstown, Co. Dublin
National Maternity Hospital, Holles St., Dublin 2

List of hospitals who participated in the consultation process

St Luke's Hospital, Highfield Rd., Rathgar, Dublin 6
Royal Victoria Eye & Ear, Adelaide Road, Dublin 2.
St James's Hospital, James's St., Dublin 8
Mater Misericordiae University Hospital, Eccles St., Dublin 7
Beaumont Hospital, Beaumont Road, Dublin 9
Connolly Hospital, Blanchardstown, Dublin 15
Cappagh National Orthopaedic Hospital, Cappagh, Finglas, Dublin 1
Children's University Hospital, Temple Street, Dublin 1
Rotunda Hospital, Parnell St., Dublin 1

3. Glossary

Audit	A systematic examination to determine whether activities and related results conform to planned arrangements abs whether these arrangements are implemented effectively and are suitable for achieving the organisations policies and objectives
Document Imaging	Document imaging is the process of scanning paper documents, converting them to digital images that are then stored on Microfilm, CD, DVD, or other magnetic storage.
Hospital Information System	A **hospital information system (HIS)** is a comprehensive, integrated information system designed to manage the administrative and clinical aspects of a hospital. This encompasses paper-based information processing as well as data processing machines. The aim of a HIS is to achieve the best possible support of patient care and administration by electronic data processing. It can be composed of one or few software components with specialty specific extensions as well as of a large variety of sub-systems in medical specialties (e.g. Laboratory Information System, Radiology Information System).
Mandatory (guidance)	Compulsory (guidance) but not required by law
Microfilming	Microfilm is used to store images that have been reduced for storage convenience. When compared to paper, microfilm is much less bulky and weighs less, resulting in lower storage costs. The main problem with microfilm is that it must be magnified to be seen.
Monitor	To check, supervise, observe critically, or record the progress of an activity, action or system on a regular basis in order to identify change.
PACS	Picture Archiving and Communications System, more commonly known as PACS, enables images such as X-rays and scans to be stored electronically and viewed on video screens, so that doctors and other health professionals can access the information and compare it with previous images at the touch of a button.
Risk	The chance of something happening that will have an impact upon objectives. It is measured in terms of the severity of the consequence and frequency.
Risk Assessment	The process used to determine risk management priorities by comparing the level of risk against predetermined standards, target risk levels or other criteria.
Risk Management	The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

.

4. Abbreviations

A&E	Accident and Emergency (Emergency Department)
CEO	Chief Executive Officer
CTG	Cardiotocograph
DP	Data Protection
FOI	Freedom of Information
GIT	Gastrointestinal tract
GP	General Medical Practitioner
HBN47	Health Building Note 47
HIQA	Health Information Quality Authority
HCR	Healthcare Record
HCRD	Healthcare Records Department
HCRM	Healthcare Records Manager
HSE	Health Service Executive
ICD-10-AM	International statistical classification of diseases and health related problems, 10th revision
IT/ICT	Information Technology
MIS	Management Information System
NHO	National Hospitals Office
NCHD	Non Consultant Hospital Doctor
OPD	Outpatients Department
PAS	Patient Administration System
PATH	Pathology Record
TOE	Trans Oesophageal Echo

Appendix 1: Membership of NHO Healthcare Records Management Steering Committee

Name	Title	Address
Dr Joe Devlin (Joint Chair)	Consultant Rheumatologist	Waterford Regional Hospital Ardkeen
Ms Winifred Ryan (Joint Chair)	Quality, Risk and Customer Care	National Hospitals Office
Ms Ann Duffy	Clinical Risk Adviser	Clinical Indemnity Scheme, Dublin 2
Mr Eddie Byrne	Director of Nursing	Cavan General Hospital, Co. Cavan
Siobhan Lynch	Health Records Manager	Cork University Hospital Wilton, Cork
Dr Cyrus Mobed	Consultant in Emergency Medicine	St. Josephs Hospital, Clonmel, Co. Tipperary
Ann Brennan	Quality Manager	St. Michaels Hospital, Dun Laoighre, Dublin
Vincent Jordan	IT representative	Information Services, HSE West, Merlin Park, Galway
Ann O'Connor	Risk Manager	Connolly Hospital, Blanchardstown
Bridget Howley	General Manager	University College Hospital, Galway
Dr Gerry Fitzpatrick	Medical Consultant	Adelaide & Meath incorporating the National Childrens Hospital Tallaght
Liam Quirke	FOI Officer	HSE West, Merlin Park, Galway
Sandra Kehoe (Secretariat)	Quality, Risk and Customer Care	National Hospitals Office

Appendix 2: Membership of Standards Sub-Group

Name	Title	Address
Ms Winifred Ryan (Chair)	Quality, Risk and Customer Care	National Hospitals Office
Dr Joe Devlin	Consultant Rheumatologist	Waterford Regional Hospital Ardkeen
Mr Brendan Murphy	General Manager	Organisation Development Unit Parnell Street, Limerick
Mr John Wickham	Assistant Manager	Organisation Development Unit Parnell Street, Limerick
Mr Eddie Byrne	Director of Nursing	Cavan General Hospital, Co. Cavan
Ms Siobhan Lynch	Health Records Manager	Cork University Hospital Wilton, Cork
Ms Mary Moynihan	Physiotherapist in charge	St. Lukes' Hospital Kilkenny
Ms Gay Murphy	Regional Medical Records Officer	Wexford General Hospital, Co. Wexford
Mr Gerry O'Sullivan	Laboratory IT Manager	LabMed Directorate St. James's Hospital, Dublin
Dr Elizabeth Mullins	Lecturer in Archives and Records Management	School of History and Archives, UCD
Sandra Kehoe (Secretariat)	Quality, Risk and Customer Care	National Hospitals Office

Appendix 3: Membership of Healthcare Records Chart Sub-Group

Name	Title	Address
Ms Winifred Ryan (Chair)	Quality, Risk and Customer Care	National Hospitals Office
Dr Joe Devlin	Consultant Rheumatologist	Waterford Regional Hospital Ardkeen
Mr Eddie Byrne	Director of Nursing	Cavan General Hospital, Co. Cavan
Ms Siobhan Lynch	Health Records Manager	Cork University Hospital Wilton, Cork
Ms Gay Murphy	Regional Medical Records Officer	Wexford General Hospital, Wexford
Sandra Kehoe (Secretariat)	Quality, Risk and Customer Care	National Hospitals Office

Appendix 4: Membership of Retention and Disposal Sub-Group

Name	Title	Address
Ms Winifred Ryan (Chair)*	Quality, Risk and Customer Care	National Hospitals Office
Mr Liam Quirke	FOI Officer	HSE Merlin Park Regional Hospital Galway
Mr Ken Lillis	FOI Officer	HSE North Western Area Ballybofey, Co. Donegal
Ms Mary O'Connor	Healthcare Records Officer	Mater Hospital Dublin
Ms Orlaith O'Brien	Director of Nursing	Midland Regional Hospital Tullamore
Ms Bernie Mann	Patient Services Manager	Midland Regional Hospital Tullamore
Mr Gerry O'Sullivan	Laboratory IT Manager	LabMed Directorate St. James's Hospital, Dublin
Brendan Naughton	Legal representative	HSE Western Area
Helen Power (Secretariat)	Project Co-Ordinator HSE West	HSE Merlin Park Regional Hospital Galway

*** Mr Pat McCarthy, Director of VFM was the chairperson of the retention sub-group from April to September 2006**

Appendix 5: Membership of Dublin Hospitals Group Risk Management Forum Documentation Committee Sub-Group

Name	Title	Address
Mr. Liam Duffy	CEO	Beaumont Hospital (Chair)
Ms. Geraldine Hiney	Informatics Nurse	AMNCH
Ms. Susan Hawkshaw	Nurse Practice Development	Beaumont Hospital
Prof. David Foley*	Consultant Cardiologist	Beaumont Hospital
Ms. Emer Agnew	Accreditation Manager	Cappagh N. Orthopaedic Hospital
Ms. Catherine Holland	Risk Manager	Mater M. U. Hospital
Ms. Jennifer Adams **	Nurse Practice Development	Mater M. U. Hospital
Ms, Angela Chadwick**	Nurse Practice Development	Mater M. U. Hospital
Ms. Vivienne Moffitt	Principal Physiotherapist	National Rehabilitation Hospital
Mr. Aghmat Mohammed	Clinical Placement Co-ordinator	St. James's Hospital
Ms. Ann Brennan	Quality Manager	St. Michael's Hospital
Ms. Mary Shore	Corporate Affairs Manager	St. Vincent's U. Hospital
Ms. Dorothy Staunton	Psychiatric Social Worker	Temple Street C. U. Hospital
Dr. Uma Rao	Quality Manager Oncology	OLHSC Crumlin
Ms. Patricia McCabe	Medical Records Manager	St. Vincent's Hospital Fairview
Ms. Mary Connolly	Senior Consultant	Aon, Healthcare Risk Management

Appendix 6: List of External Consultees

Consultees (External)	Consultees (External)
Irish Directors of Nursing and Midwifery Association	Association of Physical Scientists in Medicine
Royal College of Physicians of Ireland	Irish Society of Audiologists
Academy of Medical Laboratory Science	Information Commissioner
Dublin Hospitals Group Risk Management Forum	Data Protection Commissioner
HSE Safety & Advisory Group, Irish Public Bodies	Clinical Indemnity Scheme
Royal College of Surgeons of Ireland	Health Care Risk Managers Forum
Association of Occupational Therapists of Ireland	Freedom of Information Officers Association
Psychological Society of Ireland	Department of Health and Children
Irish Association of Speech & Language Therapy	Health Policy & Information Division, ESRI
Pharmaceutical Society of Ireland	National Archives of Ireland
Head Medical Social Workers Group	An Bord Altranais
Irish Chiropodists/Podiatrists Organisation	National Council for Nursing & Midwifery
Association of Clinical Biochemists in Ireland	Patient Focus
Irish Society of Chartered Physiotherapists	Irish Advocacy Network
Irish Institute of Radiotherapists	Patients Together
Irish Nutrition and Dietetic Institute	Patient Partnership
Irish Patients Association	National Archives of Ireland

Appendix 7: Legislation, guidance, regulations and standards

1. Child Care Act 1991 and related regulations
2. Civil Liability and Courts Act, 2004
3. Data Protection Acts, 1988 and 2003 and related regulations
4. Freedom of Information Acts, 1997 and 2003
5. Health Acts, 1947, 1953, 1970 and related regulations
6. Mental Health Acts, 1945 to 2001
7. Statute of Limitations Act, 1957
8. Statute of Limitations Amendment Act, 1991
9. Local Government Act, 2001, section 80
10. National Archives Act, 1986
11. ISO 15489 - International Standard on Records Management
12. BS 5454:2000 - Recommendations for the storage and exhibition of archival documents

Appendix 8: Suggested membership of healthcare records users group

Group Membership	Comment
Chair	Suggest Hospital CEO Manager or Deputy Manager
Healthcare Records Personnel	
Consultants	
Senior Administrative Staff	
Senior Nursing Staff	
Porter	
HIPE	
IT Manager	
Health & Social Care Professional	
Risk Manager	
Quality Manager	
Bed Manager	
Patient Services Manager	
Union Representative	
Links to local partnership committee	