Guidance Note

Record Retention & Management

Adult Social Care

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Record Retention & Management Guidance Note – Adult Social Care

This guidance note covers all adult social care information and applies equally to photographic, microfiche, electronic and manual records.

Background

This guidance note replaces the Devon Social Care 'Record Handling, Management and Retention Policy' dated June 2005 and should be read in conjunction with the corporate records management information detailed on the source below:

http://staff.devon.gov.uk/atoz.htm/recordsmanagement.htm

1. Record Retention

1.1 Adult Social Care Record Retention

The Adult Social Care Record Retention Schedule is attached in **Annex A.** The trigger point, such as last contact or date of death, is the point at which the retention period begins.

The Data Protection Act 1998 requires that personal data processed for any purpose "*shall not be kept for longer than is necessary for that purpose*". It is for this reason that retention periods have been kept to the minimum.

A report is run monthly detailing all records that are nearing the end of their retention period. Each record is reviewed and a number of considerations taken into account to decide whether the retention period should be extended such as:

a. When the person continues to owe money for services provided which is actively being pursued.

b. Where there is an ongoing complaint.

c. Where there has been a substantiated safeguarding investigation or where the record contains information relevant to legal action (including a criminal investigation) which has been started or is in contemplation.

d. Where the Council's assistance has involved the implementation of major aids and structural alterations leading to a legal charge being placed on a property, see **Annex A**.

e. Where the Council continues to have involvement with other members of the family.

If none of the above apply, the administrator may authorise the destruction of the record. Detailed process guidance can be found in **Annex B.**

For further advice, use the contact details on the website below:

http://staff.devon.gov.uk/atoz.htm/recordsmanagement.htm

1.2 Joint Team Record Retention

Where joint health and social care teams are co-located, integrated filing systems and single electronic records may exist, containing both social care and NHS patient health care information. A jointly held record containing both health and social care information should be

retained for the longest period for that type of record, ie if health care has a longer retention period than social care, the record should be held for the longer period. This only applies if the health information is unique to the joint record.

1.3 NHS Record Retention

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

All health records are Public Records under the terms of the Public Records Act 1958 and as with social care information anyone processing this information has a personal common law duty of confidence.

The retention schedule contained in the Department of Health 'Records Management: NHS Code of Practice Part 1 and 2' http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131747 details a minimum retention period for each type of health record and applies to health records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held. They apply to health and social care professionals.

Minimum retention periods apply to the following type pf health record:

Mentally disordered persons (within the meaning of any Mental Health Act)	20 years after the date of last contact between the patient/service user and any health/care professional employed by the mental health provider, or 8 years after the death of the patient/service user if sooner. (Records should be reviewed at the end of the retention period before destroying to take into account any genetic implications of the patient's illness).
Vulnerable Adults	Where a patient/service user is transferred from the care of one NHS or social care organisation to another, all relevant information must be transferred to the patients' health or social care record held at the receiving organisation and they should then be retained for the period of time appropriate to the specialty.
General (not covered by the above)	8 years after conclusion of treatment*

* Any reference to 'conclusion of treatment' should be taken to include all follow-up checks and action in connection with treatment.

2. Record Management

2.1 Multiple Records

Information on an individual may be kept in more than one location, for example, there may be an electronic record, a manual file that pre-dates electronic record keeping and also a manual file within an in-house residential/day care unit or domiciliary/reablement care team or with client finance services. It is important that once the service ends, information is held in situ and records destroyed in accordance with the guidance detailed in this document, making sure that the considerations detailed in 1.1 are taken into account.

2.2 Closed Records

Closed records may need to be retrieved to be examined either following a request from an individual wishing to see their records or because the individual is offered services again. If a record is temporarily retrieved this does not affect the closed status, however, if the record becomes active again due to a re-referral then the record will become an open record again.

2.3 Data Protection

Under the Data Protection Act 1998, individuals have a right of access to any personal information that may be held about them (manual and electronic), unless an exemption applies. Individuals also have a right to know to whom personal information has been disclosed.

2.4 Access to Records

Applications to see records made by individuals (the data subject), or someone acting on their behalf (such as a Solicitor), are known as 'Subject Access Requests'. For more information on accessing records please see **Annex C.**

If papers are locked overnight in a worker's cabinet, the cabinet must be accessible to others in their absence. Within the filing centres, tracer card systems are in operation to detail the whereabouts of manual files.

2.5 Transfer of Records (To Other Local Authority)

The original record should remain within Devon County. If a person permanently relocates to another Local Authority a summary of relevant information should be compiled and sent on by the allocated Practitioner. For more information on the transfer of records please see **Annex D.**

2.6 Archiving of Original Documentation

Important original documentation or treasured items such as birth certificates as detailed in the document 'Keeping original documents after Scanning' can be accessed at:

http://staff.devon.gov.uk/acs_retention_of_original_documents.pdf

2.7 Storage & Security

Electronic record keeping has been implemented widely across Adult Social Care. Manual filing systems are being centralised into filing centres. Over time the number of records in these centres will decrease as retention dates are reached and records are shredded.

All the archiving/manual record retrieval and document scanning will take place at the filing centres. These centres are fitted with purpose built filing systems to ensure that confidential manual records can be locked up securely when not in use. Records are stored alphabetically

for ease of retrieval and tracer cards are used to capture information on the whereabouts of absent files.

As part of the clear desk working arrangements and to safeguard individuals, all paperwork must be locked away overnight and computers shut down. It is the worker's responsibility to ensure this happens.

Person identifiable information should not be kept in cars or at home without the knowledge and permission of a Team Manager.

People working from home must ensure that their computer is not left unattended in a logged on state.

2.8 Record Format and Content

All records whether manual or electronic must be filed in the same format as detailed in **Annex E.**

Please note:

- One record per person, no joint records
- Separate carers record where a carer assessment has taken place
- Professionals should not provide information for more than one person within the same medium. Process for scanning requires original to be scanned as received. Information for multiple people should be supplied for scanning.
- Keep abbreviations and jargon to a minimum
- Legible handwriting
- Added notes should be dated and the author identified
- Include record management and training within the induction and appraisal process
- Forward archive filing and information to be scanned to the scanning and filing centre promptly
- Destroy files promptly

2.9 Destruction and Disposal

Information on the secure disposal of confidential waste, computer equipment and electronic media can be found on the Devon County Council website:

http://staff.devon.gov.uk/cex/strategicintelligence/keepdevonsdatasafe/kdds-pisp/pisp-disposal-information-computer-equipment.htm

Adult Social Care Records Retention Schedule*

ANNEX A

*Applicable to all records – manual/electronic/microfiche and photographic

Record	Trigger (event that prompts retention period)	Retention Period	Action (on exceeding retention period)	Reason for Retention (legal/regulatory/business need)
Individual Adult Case Record - Older People/ People with Physical or Sensory Impairment (including Supporting People Records and Records within In House Care Services such as Residential Care/ In Patient Units/ Respite Care/ Day Care Services/ Supported Employment/ Domiciliary Care / Reablement)	Last Contact / Death	3 years from date of last contact/death Note If the record includes a service agreement increase the record retention period to current year plus 6 from date of last contact/death. If the record includes a legal charge on a property as a result of the Council's assistance with major aids/structural alterations increase the retention period to 10 years from date of equipment provision/adaptation work	Shred/ Delete from computer	Limitation Act 1980; Accounts and Audits Regulations 1974
Individual Adult Case Record - Learning Disabilities/Mental Health (including Supporting People Records and records within In House Care Services such as Residential Care/ In Patient Units/ Respite Care/ Day Care Services/ Supported Employment/ Domiciliary Care / Reablement)	Last Contact / Death	8 years from date of last contact/death If treated under Mental Health Act 1983 retain 8 years after patient's death or 20 years after no further treatment is considered necessary Note If the record includes a legal charge on a property as a result of the Council's assistance with major aids/structural alterations increase the retention period to 10 years from date of equipment provision/adaptation work	Shred/ Delete from computer	Mental Health Act 1983; NHS Code of Practice – Record Management

Record	Trigger (event that prompts retention period)	Retention Period	Action (on exceeding retention period)	Reason for Retention (legal/regulatory/business need)
People who are Registered as: ▪ Disabled ▪ Blind & Partially Sighted CVI (Certificate of Visual Impairment) ▪ Deaf & Hard of Hearing BD8	100 Years of Age / Death	Record of registration to be retained until person reaches age of 100 or 3 years after date of death	Shred/ Delete from computer	
Adult Safeguarding / Deprivation of Liberty Service (DoLS) ▪ Individual Investigations ▪ Whole Home Investigations	Date of Last Alert or Authorisation for DoLS N/A	30 Years for Substantiated Individual Investigations DoLS Records should be reviewed at the end of the retention period before destroying to take into account any potential legal action that may be anticipated. Permanent retention for Substantiated Whole Home Investigations	Shred/ Delete from computer	DoH Protection of Vulnerable Adults Scheme Record Retention and Disposal Policy. Published 1 November 2010 Gateway Ref 14962 Safeguarding Team Decision

Record	Trigger (event that prompts retention period)	Retention Period	Action (on exceeding retention period)	Reason for Retention (legal/regulatory/business need)
Residential / Nursing Home Records (other than Individual Case Record) including: ▪ Copy of Statement of Aims and Objectives of the home ▪ Daily register of all residents / Admissions and Discharges ▪ Staff records and Disciplinary records ▪ Record of staff and resident meetings ▪ Duty Rosters ▪ Visitor book/ Communications book/ Daily log ▪ Client Valuables and Inventory of belongings ▪ Complaints ▪ Accident records ▪ Daily menus and records of food provided and of any special diets prepared for particular residents ▪ Medication records ▪ Fire Drills and Procedures ▪ Record book of inspection visits and Inspection Reports		3 years except Inspection reports which are to be retained for 5 years	Shred	Schedule 4 of Residential Care & Nursing Homes Regulations 2001

ANNEX B

Record Destruction Process

The **DA097R Clients with Destruct Date** report identifies **adult** records on CareFirst that have had a destruction date automatically populated by CareFirst. Such records have been inactive* for at least three continuous years from date of last contact. The CareFirst guidance note 037 (Rev Feb '10) entitled "CareFirst File Destruction and People Not Deleted Process" (http://staff.devon.gov.uk/cfgn037-3.pdf) contains guidance on running and processing the reports.

Of note, records in TRIM will be automatically deleted as part of the Record Destruct Process.

* Inactive – Defined as the case has not re-opened since date of last contact for at least three continuous years. Cases that have been re-opened must not be destroyed; the destruct date must be removed from Carefirst.

ANNEX C

Data Protection 1998 Subject Access to Records Requests

Access to Records

Under the Data Protection Act 1998, individuals have a right of access to any personal information that may be held about them (manual and electronic), unless an exemption applies.

Applications to see records made by individuals (the data subject), or someone acting on their behalf (such as a solicitor), are known as 'subject access requests'.

Requests must be in writing and can be in any format such as e-mail, fax or letter (even on a scrap of paper). If an individual makes a request by phone they can be sent a copy of the Access to Information form to complete and return with appropriate proof of identity: http://www.devon.gov.uk/subject_access_form__july_2010_.pdf

Once the applicant's identity has been verified, the legal deadline for supplying the information (subject to any exemptions) is **40 calendar days**.

Processing a request

- Any team or individual can receive an access to records request in any written format.
- The request, with any relevant documents (such as signature of consent or authority) should be sent to the Information Governance Team dopoffice@devon.gov.uk.
- The request will be verified, logged and acknowledged and processed centrally.
- The relevant service team(s) will be contacted to request a copy of all relevant information.
- Locality specialist advice will be sought if required and any recommendations about exemptions.
- The information will be prepared centrally and edited as appropriate.
- The subject access requestor with be responded to with the information.

Partnership Records

Where joint records are held such as in Community Mental Health Teams it is not necessary for the applicant to apply to both organisations for access to their records. The request will be co-ordinated by the Information Governance Officers of the relevant organisations.

Processing a request for information about a deceased person

The Data Protection Act 1998 applies to personal information about living individuals, not those who are deceased.

Requests for information about deceased people however, still have to be processed in a confidential and sensitive way. The relatives or next of kin of someone who has died do not have an automatic right of access to the information.

Written applications should be sent with any relevant documents to the Information Governance Team, Room L10, County Hall, Topsham Road, Exeter, EX2 4QD.

ANNEX D

Process Information for the Transfer of Records

Written approval is required from a Team or Practice Manager to transfer records permanently to a different team or area.

Once approval has been given the following good practice guidance for transferring records should be followed. This guidance can also be used for records being temporarily transferred also.

Administration staff will support the record transfer process by ensuring the contents of the record are ordered correctly, that all records have been brought together and that duplicate documents are removed. This process applies whether the record is manual or electronic. Practitioners are responsible for the professional content.

Records should be checked carefully to ensure the case does not refer to more than one family member – combined records should no longer be used. Practice Managers will be responsible for signing off the record for despatch within the County or to another Local Authority.

Within County

The client record is reassigned a new team relationship in Care First, the TRIM electronic record remains unaffected with the exception of a transfer child care services and adult services.

Where a paper record exists a request may be required to move the paper file between filing centres.

Out of County

When a Devon County service user or a patient permanently relocates to another Local Authority or NHS all relevant information must be transferred to the social care record or patient's health record held at the receiving organisation. Transferred information should be retained for the period of time appropriate for the speciality. It is possible for the relevant Team or Practice Manager to approve and arrange the new case worker access to the original case record information and take relevant copies. A record of transferred information must be kept.

The original record should remain within Devon County.

Delivering Records

Irrespective of whether paper records are transferred within or out of county they must be transferred using an approved accredited carrier who provides a recorded delivery system whereby items are signed for upon receipt. A register of movements must be maintained by the filing centres.

ANNEX E

Case Records Management

File Format

Electronic Document Record Management (EDRM)

EDRM has been rolled out across a majority of services within Adult Social Care.

TRIM is the electronic record management system which has replaced paper files and is used to store all client records which have been input via CareFirst or scanned by designated administrative staff. Practitioners may also save electronic documents they have received direct into TRIM.

Generally after scanning documents are destroyed, however, there are exceptions. Information on 'Keeping original documents after Scanning' can be accessed at:

http://staff.devon.gov.uk/acs_retention_of_original_documents.pdf

New manual records are only created if a document is too large to scan or if the original document requires retention. These records are then retained at the appropriate filing centre. The number of manual records will decrease steadily over time reducing the need for filing centres.

Detailed information on the TRIM system, including the Adult Social Care electronic modular filing plan, can be accessed at:

http://staff.devon.gov.uk/acs/acsbusstructure/asbrfs/acsinftmantechnology/asssum/acs_trim.htm

Electronic Record Format

The link below details the scanning process of Adult Social Care

http://staff.devon.gov.uk/acs/acsbusstructure/asbrfs/acsinftmantechnology/asssum/acs_trim.htm

Each Electronic client file is divided into folders then documents, there are two files structures the team allocation determines which file structure is allocated to the client. i.e. CYPS (Children Young People Services) or ACS (Adult Community Services).

The link above contains EDRM processes for ACS only.

Manual Record Format (Pre Implementation of EDRM)

The modular file format is used to enable easy filing, viewing and retrieval of selected information or whole sections.

Each modular file is divided into sections. Documents are filed into sections in chronological sequence, with the latest contact / document shown first.

A separate file must be made up for each family member receiving services and where a separate Carer's Assessment has been completed, the Carer should have a file in his / her own right. Cross reference to separate family member and carer files should be made on the case summary form (SS5).

The Case Summary Form (SS5) is retained on the inside cover of the file. A Practitioner is required to record in chronological sequence such matters as, change of address, allocation of resources, information / quality leaflets issued, and any other matter of significance. It is not intended to record visits, or for any purpose other than a basic summary of a person's factual circumstances.

File Sections

Documents are filed in all sections in chronological sequence, with the latest contact / document shown first.

Recording:	Workers' legible handwritten case notes.
Case Plans:	Initial request for assistance, full Assessment, Care Planning, Monitoring and Reviewing documentation. Includes financial assessment.
Administration:	Process Forms used for computer input. Information on admission to establishments. Information for statistical and register purposes. Blue Badge paperwork. Case closure / transfer checklist.
Documents:	Agreements and forms of consent. Contract documents. Legal forms, such as Court Orders. Plans, for example, Adaptations. Agreements, such as foster carer agreements or OT equipment agreements.
Correspondence:	Letters to / from the service user. *Letters to / from relatives / friends. *Letters to / from other agencies. *This also includes e-mails. *These may be regarded as Confidential Reports if the content of a letter is regarded as confidential to the Directorate and the third party. E-mail correspondence does not constitute recording.
Confidential Reports:	Medical Reports (commissioned). Letters from GP containing medical diagnosis. Reports from Court / other agencies. Minutes of Case Conferences. Any other restrictive material authorised by a designated Senior Officer.

BD8 Forms (signed by a consultant ophthalmologist to confirm a person as being Partially Sighted or Blind, and registerable as such) should be placed in a C5 envelope clearly marked BD8 affixed inside the rear cover of the file, please note the retention.