

Clinical Record Management Guidelines

For Pre-Hospital Health
Information Records





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Introduction

Recording pre-hospital care, interventions and medications administered to patients is an essential clinical responsibility of all pre-hospital emergency care practitioners and responders. It is vital that each patient report provides accurate information as it relates to the health of the patient and the activity of the organisation.

The patient report refers to all information collected, processed and held in both manual and electronic formats pertaining to the patient and patient care.

These clinical record management guidelines define the storage requirements for the patient reports to ensure that they are maintained, managed and controlled effectively in accordance with the legal, operational and information needs of the pre-hospital emergency care practitioners, responders and services.

Background

The ambulance service records provide evidence of actions and decisions and represent a vital asset to support daily functions and operations. They support policy formation, management decision-making and protect the interests of the service and the rights of patients, staff and members of the public who have dealings with the ambulance service.

Records management is the foundation layer of all information systems. Management of patient data, through the proper control of the content and the storage and retention of the records, reduces vulnerability to legal challenge or financial loss and promotes best practice through greater coordination of information.

The management of pre-hospital patient reports pose challenges and these clinical record management guidelines are the first step in developing a standard for the storage of patient information. This is an evolving document as standards and practices in relation to management of healthcare records change over time and thus will be subject to regular review and will be updated as necessary.

We spend most of our lives creating, collecting, recording information – but each of these records is only as valuable as the information it contains, and that is only of value if it can be found when needed, and then used effectively. Accurate recording and knowledge of the whereabouts of all records is essential

if the information they contain is to be located quickly and efficiently. One of the main reasons why records get misplaced or lost is because the destination is not recorded.

The quality of records maintained by pre-hospital emergency care practitioners and responders is a reflection of the quality of care provided by them to their patients. Pre-hospital emergency care practitioners and responders are legally accountable for the standard of practice which they deliver and to which they contribute. Good practice in record management is an integral part of quality pre-hospital care.

Types of reports covered in the PHECC Clinical Record Management Guidelines

These guidelines apply to all patient reports regardless of the medium in which they are held.

Report types currently consist of the following but this list is not exhaustive:

- Patient Care Report – paper copy (PCR)
- Patient Care Report – electronic (ePCR)
- Patient Care Report – scanned images
- Patient Care Report – paper copy of scanned image
- Patient Transport Reports (PTR)
- Cardiac First Response Report (CFR Report)
- Records of patients who are not transported
- Records of patients who have deceased while in the care of the practitioner
- ECG tracing
- Other images/photographs

Data protection and confidentiality

Data protection applies to all personal information regardless of the holder. It combines the three concepts of privacy, confidentiality and security. The Data Protection (Amendment) Act (2003), was brought in to ensure compliance with EU Data Protection Directive (95/46/EC), strengthens and makes explicit almost every aspect of the existing protections under Data Protection Act (1988). The Data Protection Acts, 1988 and Amendment Acts 2003 apply to both manual and computer files. It affects everyday practice and record management standards, maintaining confidentiality from initial collection to secure disposal.

The Eight Rules of Data Protection

You must:

1. Obtain and process information fairly
2. Keep it only for one or more specified, explicit and lawful purposes
3. Use and disclose it only in ways compatible with these purposes
4. Keep it safe and secure
5. Keep it accurate, complete and up-to-date
6. Ensure that it is adequate, relevant and not excessive
7. Retain it for no longer than is necessary for the purpose or purposes
8. Give a copy of his/her personal data to an individual, on request

All patient reports, regardless of whether they are paper based or on a computer in electronic format are confidential patient information and must be treated as such.

Practitioners and responders should ensure that the patient reports cannot be viewed or accessed inappropriately. This tradition of confidentiality is in line with the requirements of the Data Protection Acts 1988 & 2003, under which personal data must be obtained for a specific purpose and must not be disclosed to any third party, except, in a manner compatible with that purpose and must not be kept for longer than is necessary, for the purpose or purposes for which it was obtained.

Confidentiality concerning the patient record is an expression of the trust inherent in the pre-hospital emergency care practitioner and responders' relationship with the patient. The confidentiality of patient records form part of the ancient Hippocratic Oath, and is central to the ethical tradition of medicine and health care.

Legal considerations

All patient reports are legal documents. There is no limit to the range of records that may be required to aid the legal process. Healthcare records should be retained as long as there is a possibility of legal action being brought by the patient or on behalf of the patient.

Retention periods

The minimum recommended retention period for pre-hospital patient reports is:

Pre-hospital emergency care reports	Recommended retention period
Adult	8 years after conclusion of treatment or death
Maternity	25 years after birth of last child
Children and young persons	Until 25th birthday or 26th birthday if young person was 17 at the conclusion of treatment, or 8 years after death. If there is potential relevance to adult conditions or genetic implications, advice should be sought as whether to retain the patient reports for a longer period
Homicide / serious untoward incidents	30 years
Deceased patients, both adult and child	8 years after death
Clinical audit records	5 years
Record of destruction of individual patient reports	Permanently

If under investigation or if litigation is likely it is recommended that the original report be held indefinitely.

Review of Retained Reports

Pre-hospital patient reports which have reached their official retention period should be reviewed so that ill-considered disposal is avoided. If a report, due for disposal, is known to be the subject of an access request, then this contact with the report will be regarded as the last contact date. Recommended retention periods should be calculated from the end of the calendar month following the last entry on the report. Review of retention periods also applies to electronic records, regardless of the medium in which they are stored.

A designated person should carry out patient report reviews in line with the retention schedule and records should not be kept any longer than the appropriate period. If you wish to retain records for a longer period for audit or research purposes you must obtain clear consent from the relevant patient.

A record should be kept in perpetuity of all patient reports destroyed outlining patients name, home address, DOB, incident number, date of call, date of disposal, by whom the authority was given to destroy the record and name of person who carried out the disposal. The record of disposal should be filed and stored in a secure location.

Storage recommendations

The provision of optimum storage conditions for storage of reports is of the utmost importance in ensuring their long-term preservation. Priority should be given to providing optimum environmental conditions within the storage area as follows:

- Patient reports must be stored in a secure storage cabinet/area with access restrictions
- Records should be stored on steel shelving units or in steel cabinets
- If using shelving units they should be properly braced and the bottom shelf should be at least 1 inch off the floor
- When a room containing records is left unattended, it should be locked at all times

Continued overleaf

- The storage cabinet/unit should be constructed of fire resistant materials, timber is not recommended. It is extremely difficult to salvage burnt records
- The storage cabinet/area should be located in an area where it is not at risk from flooding (natural or man-made), rising damp or poor drainage
- The storage area should be rapidly accessible for ease of retrieval of records
- The storage area should not be located close to atmospheric pollutants
- The storage area should be a self contained cabinet/unit or self contained unit within an existing building
- The building must restrict the entry of water, rodents, insects and birds
- If storage area is a separate building, it should not have windows and should be locked at all times
- The facility must be lockable in such a way to exclude unauthorised staff
- Designated key holder should be appointed
- Access to records must be restricted to designated persons only; this is particularly important if the storage facility is shared
- Ambulance services who employ other organisations or services who record patient data are the legal owners of those records. This does not mean, however, that anyone in the organisation has an automatic right of access to the records or the information contained in them.

Indexing of stored records

All patient reports must be filed according to a standard filing convention.

Filing convention options are as follows:

Option 1:

- station PIN
- followed by month
- followed by year
- followed by first digit of surname*

Option 2:

- practitioner PIN
- followed by month
- followed by year
- followed by first digit of patient surname*

**If patient surname is prefixed by O as in O'Neill record is filed under O.*

**If patient surname is prefixed by Mc/Mac as in McDonagh/Mac Carthy, patient reports are filed as M.*

Immediate filing process for completed patient reports (including loose information)

- After each call the patient report, including loose information, for example ECG record, will be placed in a secure daily desk file/storage box
- The practitioner or responder who initiates the patient record is responsible for the secure filing of the report at the end of each call/shift as appropriate
- At the end of the shift or day end a designated person will place the patient records in clinical record storage cabinet and file according to convention or return to the ambulance headquarters in his/her region for filing and storage according to convention
- It is preferred that reports are stored flat as this will assist in scanning of documents if this method of storage is adopted at a future time
- Remove paper clips and staples before filing as they can damage the paper record and ensure that loose patient related documents have the necessary identifiable data recorded for future retrieval

Recommendations for tracking the movements of active reports

The patient report tracking system should meet all ambulance service needs and provide easily accessible movement history and audit trail.

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

Cycle of the transfer of a patient record from record storage to another party

- Locate patient record according to convention
- Replace with tracer card
- Record the following on the tracer card:
 - o Patient surname/name or unique identifier as appropriate
 - o Date of incident
 - o Date of transfer to another party
 - o Name of person/unit/department record is being forwarded to
 - o Expected date of return
 - o Name of person removing report

If the patient report is removed on more than one occasion, the tracer card must be re-used as this will build up a report history. Store tracer cards separately.

Electronic storage of patient reports

Patient data is no longer stored on the tablet PC following the closing of the patient record and practitioner log off. All patient data is stored in a secure data centre and the highest level of data encryption and security standards are applied to both the data and the data centre.

The same retention and disposal schedule of rules apply to this electronic method of data storage as well as to alternative methods of storage, for example scanned images.

The Data Protection Acts, 1988 & 2003 apply to both manual and computer files but it does not prescribe that files should be kept/stored in both formats. The organisation's data controller must ensure that the quality of a record stored in an alternative medium is a true reflection of the original record by means of an intensive validation process. It is also important that appropriate back up procedures are in place for all electronic data.

Security of archived clinical records

Due to the irreplaceable nature of archived documents, they require maximum protection against theft, vandalism, unauthorised alteration and careless handling, particularly as they may be stored in non-current facilities, due to the fact that they are retrieved infrequently.

Management responsibility

It is the responsibility of senior organisational management to ensure the following:

- Staff are informed of the importance of the confidentiality of the patient health care information
- Confidentiality of patient reports is maintained at all times
- A record is maintained of all personnel who have access to stored data
- No patient report should be made available for unauthorised use

Patient information requests

Under Section 4 of the Data Protection Acts, 1988 and 2003, a patient has a right, by written request, to obtain a copy of any information relating to them, which is kept on computer, in a structured manual filing system or intended for such a system.

Acknowledgements

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NSAI, The National Standards Authority of Ireland.

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