ELECTRONIC AND PAPER CLINICAL RESULTS REVIEW AND RETENTION PROTOCOL

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Documents to read alongside this Protocol	Records Management Policy Records Management Retention/Destruction Protocol Archiving of Clinical Trial and Research Data:Standard Operating Procedure

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Author/Reviewee: Corporate Governance – Senior Information and Communication Manager

Executive Lead: Medical Director

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Divisional Management Teams

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Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	10/12/2012	12/12/2012	This is a new protocol and does not supersede any documents from the predecessor organisations.
1.1	03/02/2013	06/02/2013	Minor amendment to front page to reference Archiving of Clinical Trial and Research Data:Standard Operating Procedure. Section 1 - Introduction and paragraph 6.1 amended to re-enforce requirements regarding Clinical Trials and research projects. Paragraph 6.2 “were appropriate” added.

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1. INTRODUCTION

Advances in technology have resulted in traditional methods of health care being dramatically changed. With the onset of more sophisticated methods for diagnostic testing/result reporting and the advent of ever improving technology, new systems now exist that can be used in a more efficient and effective manner.

As health organisations move away from traditional paper health records and utilise electronic systems such as Clinical Workstations, PACS, Clinical Portal and PARIS. These systems have become a primary source of information and there is now less need to rely on paper records for delivering care to patients as the necessary information is available electronically, and in many cases available at the point of care.

Filing of clinical and diagnostic results in a patients health record is time consuming and is of limited value where they are also available electronically. In response to requests to review the current arrangements the Cardiff and Vale University Health Board (the UHB) has obtained legal advice which supports the decision to move away from retaining the results in a paper form on the health record when also available electronically. The electronic record will be the master copy for the purposes of reviewing historical results.*

This protocol identifies the arrangements and responsibilities with regard to electronic results reporting, review and retention of information. It identifies the arrangements for the disposal of any associated duplicate paper record that is created.

Note: it may be necessary to continue to maintain paper copies of results generated in connection with some research projects/clinical trials. There will be a clear indication as to the requirements within the specific Standard Operating Procedures and Trial Site File.

2. SCOPE

This protocol covers all clinical and diagnostic results/findings that are generated in a paper format in addition to being recorded on an electronic system. It **does not** include results where and electronic record is not available within the UHB e.g. those provided by external laboratories.

It is applicable to all employees who have access to clinical and diagnostic records/results both electronic and hard copy paper. The term employees includes all those who have a contract of employment or honorary contract with the UHB.

3. AIM

The aim of this protocol is to ensure all results generated are handled and managed in a correct manner in accordance with the relevant legislation

whilst ensuring that patient care remains the main focus at all times. It will ensure all clinical staff are aware of the requirements placed upon them when receiving clinical/results information in electronic and paper format and how they will manage, record, retain and destroy the records they access in both electronic and hard copy format.

4. OBJECTIVES

The objectives of this protocol are to:-

- Provide the highest level of patient care and treatment whilst ensuring that records are managed and handled appropriately in line with the relevant legislation.
- Ensure that documents are not retained unnecessarily and without need.

5. RESPONSIBILITIES

5.1 Caldicott Guardian

The Medical Director as Caldicott Guardian has overall responsibility for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing. The Medical Director is responsible for ensuring that Clinical Directors communicate the contents of this protocol to all relevant individuals and for ensuring they implement the protocol as required.

5.2 Clinical Directors

Clinical Directors will be responsible for communicating the requirements of this protocol to clinicians within their area and for ensuring the protocol is adhered to.

5.3 Clinicians

Clinicians will be responsible for complying with the requirements of this protocol in relation to patient information accessed. They will ensure that all patient information to which they have access is handled in a confidential and secure manner and that they put in place appropriate arrangements for the retention or destruction of records that need to be destroyed or retained.

5.8 Health Records Department and Ward/Departmental Staff

There will no longer be a requirement placed on the Health Records Department staff or other staff working in wards/departments to file paper copies of electronic results where they have been appropriately actioned by the responsible clinician.

5.9 GP's

This protocol will be circulated to all GP's for information but they do not have any responsibilities under this protocol. They are required to ensure that they have appropriate arrangements in place for the management of records within their practice.

6. PROCEDURE

Historically once electronic results are viewed by the responsible clinician such results are filed within the main patient notes. This practice is no longer necessary. Once results have been viewed and acted upon by the responsible clinician there is no longer a requirement to file the hard copy with the patient health record. The electronic information i.e. Clinical Portal or other appropriate electronic system will in future be the vital record for results reporting*. The following procedure should be followed:-

6.1 When a clinician requests a test they are responsible for ensuring that the results are considered when available, that any appropriate action is taken and that this is recorded in the health record*. The primary method for doing this will be via the electronic reporting system where available.

*Note: where tests are required as part of a research project/clinical trial the any specific requirements/exclusions will be detailed within the appropriate Standard Operating Procedures/Trial Site File.

6.2 When a paper copy is produced/received the clinician must ensure that 6.1 above has been followed. They must then, where appropriate, ensure that the paper copy is placed in the **confidential waste bin or shredded.** They must ensure that information containing personal identifiable information cannot be inappropriately accessed or made available to unauthorised individuals. It is the responsibility of the clinician viewing the results to ensure that destruction is completed in a safe, secure and confidential manner.

7. RESOURCES

There will be no additional resources required for this protocol to be implemented.

8. TRAINING

There will not be any training required to implement this protocol however there will need to be appropriate communications issued to all relevant staff to ensure the specifics of this protocol are communicated and fully understood and implemented.

9. IMPLEMENTATION AND DISTRIBUTION

On implementation of this protocol there will be a significant change to the established current practice in the UHB in relation to electronic results reporting. There will no longer be a requirement for printed copies of electronic results to be included within the patient health record.

Once approved, this Protocol will be available on the UHB Internet, Intranet and Clinical Portal.

The Medical Director will issue a communication to all Clinical Directors advising that this protocol in now in place. Clinical Directors will inform all relevant clinicians of the requirements of the protocol in their scheduled meetings.

Implementation for Health Records staff will be completed under the direction of Directorate Manager, Patient Administration and Outpatients.

Ward and Departmental staff will be notified of the requirements of this protocol by their ward and departmental managers.

10. EQUALITY

The UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups. This Protocol has been developed in support of the Records Management Policy. The Records Management Policy has been subject to an Equality Impact Assessment. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was a low positive impact to the children as appropriate retention of records are retained until they reach adulthood and in some circumstances beyond.

11. AUDIT

Clinical Directors will delegate responsibility for auditing compliance with this protocol to the most appropriate individual within their area. Audit findings will be reported to the appropriate Quality and Safety Group.

12. REVIEW

This Protocol will be reviewed to reflect any changes in guidance or legislation. As a minimum it will be reviewed three years after the approval date.