Why we have a procedure?

Accurate recording and the knowledge of the whereabouts of all health records is essential if the information they contain is to be located quickly and efficiently. The tracking systems used provide an up to date and easily accessible movement history and audit trail. Records are often misplaced or lost because their next destination has not been recorded.

It is vital that health records are appropriately retrieved and tracked to ensure they can be located as and when required to assist in the provision of quality care.

What overarching policy the procedure links to?

This Standard Operating Procedure is linked to the Health Records Policy

Which services of the trust does this apply to? Where is it in operation?

This applies to the following services of the Trust, including locations:

<table>
<thead>
<tr>
<th>Group</th>
<th>Inpatients</th>
<th>Community</th>
<th>Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services</td>
<td>✓</td>
<td>✓</td>
<td>All</td>
</tr>
<tr>
<td>Learning Disabilities Services</td>
<td>✓</td>
<td>✓</td>
<td>All</td>
</tr>
<tr>
<td>Children and Young People Services</td>
<td>✗</td>
<td>✓</td>
<td>All</td>
</tr>
</tbody>
</table>

Individual services may need to adapt this Trust wide SOP to meet the specific requirements of their service by ensuring that they have a localised SOP that follows their working practices. If a localised SOP is created then it must be based on the principles of this SOP and have been through the formal approval process.

Who does the procedure apply to?

This procedure applies to all staff involved in the tracking and retrieval of health records from their current location to a new location whereby the last recorded person will be held responsible for the recovery of any missing records.

When should the procedure be applied?

When a health record is removed from their current location to a new location it is mandatory to track the location of the record.

How to carry out this procedure

All services will operate and maintain a robust and efficient tracking system. There are currently two tracking systems, Manually Operated Tracking System and Electronic Tracking System.
Manually Operated Tracking System:

Use of Tracer Card System
- Locate the health record which is required
- Insert a tracer card in place of the health record which is being removed
- State on the tracer card:
  - Patient’s unique identifier
  - Name of patient
  - The destination – e.g. contact details of the person, unit or department to whom the record is being sent.
  - Date sent
- Sign and date the tracer card

Use of Paper Register
For those services that are not able to use tracer cards they must operate and maintain a paper register by using a book, diary, or index card to record transfers.
- Locate the health record which is required
- Record entry in register
- Entry to record the following
  - Patient’s unique identifier
  - Name of patient
  - The destination – e.g. contact details of the person, unit or department to whom the record is being sent.
  - Date sent
- Sign and date entry

Electronic Tracking System:
Where an electronic tracking system is operated as part of the clinical information system e.g. Case note tracking portal, the following actions must be followed:
- Locate the health record which is required
- Request the health record by selecting your organisation and service point that requires the health record
- Dispatch the requested health record to the requested location
- Receiver of health record to entry on electronic system which will automatically update current location and service point

If the case note tracking portal is not available the services must revert to the use of a manual tracking system (as above).

Retrieval
Retrieval of a health record is a critical role in the NHS due to the vast number of healthcare professionals involved in a patient’s care who need access to the vital information held within a health record at a moment’s notice.

All health records must be securely held but available on request for retrieval by authorised members of staff. Requests for health records (both routine and urgent) must be directed towards the appropriate services/departments who are responsible for their storage.

For further information regarding times of access refer to Health Records Policy, section 4.11.
The physical movement of records must be undertaken in a safe and secure way (refer to the Standard Operating Procedure 5 - Transportation of Health Records).

**Where** do I go for further advice or information?

**Clinical Leads, Team Managers and Department Managers**
The responsibility for local records management is devolved to the relevant clinical lead, team manager or department manager, who will ensure that:

- The management of records generated by their activities i.e. for ensuring that records are controlled within their service area are managed in a way which meets the objectives of the Trust’s Health Records Policy
- Staff within their remit who have any involvement with health records are made aware of and fully understand the content of the Health Records Policy

**Your local Health Records Manager/Team** will provide advice and support

**Training**
Knowledge and use of tracking systems is required (manually and electronic) to enable staff to track and retrieve health records. Staff will receive training on the relevant system.

**Monitoring / Review of this Procedure**
On the completion of Trust wide Electronic Health Record Tracking System being available to all the process(es) described within this document or an incident involving the described process(es) within the review cycle, this SOP will be reviewed and revised as necessary to maintain its accuracy and effectiveness.

**Equality Impact Assessment**
Refer to overarching policy: Health Records Policy

**Data Protection Act and Freedom of Information Act**
Refer to overarching policy: Health Records Policy
# Standard Operating Procedure Details

<table>
<thead>
<tr>
<th>Unique Identifier for this SOP is</th>
<th>BCPFT-REC-SOP-01-2</th>
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<tbody>
<tr>
<td>State if SOP is <strong>New</strong> or <strong>Revised</strong></td>
<td>Revised</td>
</tr>
<tr>
<td><strong>Policy Category</strong></td>
<td>Health Record</td>
</tr>
<tr>
<td><strong>Executive Director</strong> (whose portfolio this SOP comes under)</td>
<td>Director of Operations</td>
</tr>
<tr>
<td><strong>Policy Lead/Author</strong> (job titles only)</td>
<td>Record Services Manager</td>
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<tr>
<td><strong>Committee/Group Responsible for Approval of this SOP</strong></td>
<td>Information Governance Steering Group</td>
</tr>
<tr>
<td><strong>Month/year consultation process completed</strong></td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Month/year SOP was approved</strong></td>
<td>May 2019</td>
</tr>
<tr>
<td><strong>Next review due</strong></td>
<td>October 2020</td>
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<tr>
<td><strong>Disclosure Status</strong></td>
<td>‘B’ can be disclosed to patients and the public</td>
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## Review and Amendment History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Description of Change</th>
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<tbody>
<tr>
<td>2.1</td>
<td>May 2019</td>
<td>Review date extended to October 2020 until the implementation of the electronic record (RiO) and its impact on current practices identified for the proper review of the SOP.</td>
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<tr>
<td>2.0</td>
<td>Oct 2016</td>
<td>Full review to comply with Records Management Code of Practice for Health and Social Care 2016</td>
</tr>
<tr>
<td>1.0</td>
<td>Mar 2015</td>
<td>New SOP for BCPFT</td>
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