St Patrick's
Mental Health Services

Incorporating St Patrick's University Hospital,
St Edmundsbury Hospital & Willow Grove Adolescent Unit

Policy Name: Data Retention & Disposal of Confidential Material Policy		**Article**: 27
Policy No: MR 0001	**Department (*if applicable*):** Organisation Wide	
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Authorisation/Signature:

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1. Introduction:

The four factors governing data both paper and electronic in St Patrick's Mental Health Services are the ways in which we: -

1. Store – ensuring the optimum conditions for the preservation of clinical records for the requisite life span under the St. Patrick's Mental Health Services Data Retention Policy.
2. Retrieve – providing a system that can accurately record the whereabouts of all records, so they can be located quickly and efficiently.
3. Share – ensuring that access to service user information is fully restricted to authorised personnel only (please see *MR0004 Confidentiality, Security and Storing of Service Users Clinical Records* and *DP 0001 Policy for Data Access Requests)*, maintaining the confidentiality of St. Patrick's Mental Health Service Users at all time.
4. Destroy all data – ensuring the prompt disposal of clinical records whose retention period has ended.

This policy sets out the schedules for retention of clinical records in St Patrick's Mental Health Services. It:

- Lists the minimum retention periods for clinical records in St Patrick's Mental Health Services.
- Provides a clear policy in order that the hospital can operate a medical record's retention practice in a consistent manner across the service.
- Provides a clear procedure in order that St. Patrick's Mental Health Services have a consistent confidential document / material disposal practice across the service.

2. Types of clinical record covered by this Policy:

This policy applies to clinical records of all types regardless of the medium on which they are held.

These may consist of the following; however, this is not an exhaustive list:

- Service user clinical records (electronic or paper based)
- Clinical outcome assessment tools (including questionnaires), must be filed in an appropriate section of the service users clinical record.
- Records regarding service user procedures/treatments.
- 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.
- Lists containing service users' names or schedules.

3. Legal obligation and good practice:

St Patrick's Mental Health Services 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 St Patrick's Mental Health Services 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 St. Patrick's Mental Health Services must have a policy on retention periods for personal data that is retained. This policy must include defined retention periods for clinical records and systematic disposal of clinical records immediately after the retention period expires.

In disposing of confidential material, the hospital must comply with section 32(2) of the Waste Management Act 1996, as amended, which provide that a person shall not transfer the control of waste to any person other than an "appropriate person". Section 35(5) of the Waste Management Act 1996, as amended, defines an "appropriate person" as a local authority, the corporation of a borough that is not a county council, the council of an urban district or a person otherwise authorised under and in accordance with the Waste Management Act 1996, as amended, to undertake the collection, recovery or disposal of the class of waste in question.

Every clinical record, including information kept on paper and in electronic format is a confidential document of service user care and as such must be kept secure at all times. Service users have a right to expect that those working with the hospital (and its services) keep these personal documents confidential and secure at all times.

Since 2003, Data Protection legislation also applies to electronic and hard copy records.

4. Basis for St Patrick's Mental Health Services clinical 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 service users 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:

The Clinical Records Department is responsible for ensuring that all clinical records retained by St. Patrick's Mental Health Services in archive storage are properly identified, stored, indexed, easily accessible, stored in the most space efficient way and disposed of when the retention period has ended in accordance to St. Patrick's Mental Health Services Records Retention Policy.

The staff of the hospital are responsible for ensuring that confidential documents containing service user information and pertaining to service user care are kept secure at all times. Each Department Head is responsible for making sure that all clinical records retained in their department are periodically and routinely reviewed to ensure systematic implementation of St Patrick's Mental Health Services Records Retention Policy.

6. Retention & Disposal Policy:

A retention & disposal policy is a key document in the Hospitals clinical record management system which outlines:

- The type of clinical records held within the service.
- The minimum period for which such records should be retained.
- The action required when the minimum retention period has been reached.

The purpose of this policy is:

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

Decisions regarding the retention of clinical records:

Clinical records that have reached their official retention period should be reviewed under the following criteria, so that ill-considered disposal is avoided. Whenever the policy is used, the guidelines listed below should be considered.

- Recommended retention periods should be calculated from the end of the calendar month following the last entry on the document.

- The Clinical Records Manager or designated person should carry out Clinical record reviews in line with St Patrick's Mental Health Services retention and disposal policy.
- Input from healthcare professionals should be a key element of the hospital's clinical records management strategy.
- Where a set of clinical records have reached their final date for retention, the Clinical Records Manager shall confirm the implementation of St Patrick's Mental Health Services disposal policy with the clinical records users group in the hospital.
- If a record due for disposal is known to be the subject of an access request for records, then this contact will be regarded as the latest contact date and the relevant retention period will apply.
- Where an adverse outcome has been advised to the Clinical Governance Committee then these clinical records should be retained for an additional period if advised by the Clinical Governance Committee.
- If a record relates to the subject matter of legal proceedings, the Hospital should contact the Hospital's legal advisers and indemnifiers to discuss retention of these records. Medical negligence claims must be taken two years from the date of the accrual of the cause of action or the date of knowledge of the person concerned, whichever occurs later. In addition, for persons who lack capacity to institute proceedings on their own behalf, the 2-year limitation period will only begin to run when they are no longer lacking capacity and this is something that the Hospital should be mindful of, particularly, where the records relate to a serious adverse incident.
- Hospital clinical records should not be kept any longer than the appropriate retention period. When the Hospital wishes to retain clinical records for longer than the appropriate retention period for research or statistical purposes it must obtain clear and unambiguous written consent from the service users concerned for the retention of their records for these purposes.
- A register should be kept in perpetuity of all clinical records destroyed. The register should, where available, contain the person's 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.
- 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 policies and procedures.

Decisions regarding the disposal of clinical records:

- It is vital that the process of destruction and disposal of confidential material safeguards and maintains the confidentiality of service user records.
- The destruction of confidential material can be done onsite or via an approved contractor, but it is the responsibility of the hospital to verify that the methods used to destroy confidential material provide adequate safeguards against accidental loss or disclosure of the records.
- Where a contractor is used to destroy records, they shall be required to sign confidential undertakings and to produce written certification as proof of disposal.
- Optical and magnetic media require special disposal facilities and shall be separated from other media prior to disposal.
- Disposal of confidential documents/clinical records shall be carried out by an approved contractor(s) who is an appropriate person(s) authorised under and in accordance with the Waste Management Act 1996, as amended.

- A list of approved contractors who are authorised to collect, transport and dispose of confidential documents/clinical records shall be kept by the hospital.
- A file shall be kept by the hospital containing copies of all permits/documents issued under the Waste Management Act 1996, as amended, to any approved contractor, which authorises them to collect, transport and dispose of confidential material.
- A record shall be kept in perpetuity of all clinical records destroyed. The register shall contain where available, the person's name, address, date of birth, clinical record number, dates covered in the clinical record, date of disposal and by whom the authority was given to destroy the records. For Service User clinical records that date prior to 1995, the Clinical Records Destruction Register records the record type, the date range, the data retention category, the retention end date and destruction date. Individual service user names and details are not required.
- This record shall be signed by the Clinical Records Manager and the Facilities staff member supervising the removal and disposal of records.

7. Alternative media

- In order to address problems of storage space or for reasons of business efficiency, the Hospital may consider transferral of clinical records to alternative media at any time during the life of the clinical 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 clinical 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.

Schedule of Records and Retention Periods

Under Irish Law there is a positive obligation to preserve documents where litigation is anticipated or ongoing. Documents which could be relevant to apprehended or actual litigation must be preserved and not destroyed. If in doubt, the Hospital should contact their indemnifiers or legal advisers for advice.

A. Clinical Records

Type of Clinical Record	Retention Period	Final Action
Hospital Chart (Adults i.e. persons 18 years+)	20 years from the last date of contact with the service provider or eight years after the service user's death whichever is the earlier	Destroy under confidential conditions.

Hospital Chart (Children i.e. persons under 18 years)	20 years from the date the child reaches 18 years of age or 20 years from the last date of contact whichever is the later, alternatively, if the child dies then the records shall be held for 8 years from the date of death.	Destroy under confidential conditions.
Hospital Chart of service users who committed suicide in St Patrick's University Hospital	10 years from date of death	Destroy under confidential conditions.

B. Other Clinical/Hospital related records not contained within a service user's chart

Type of Clinical Record	Retention Period	Final Action
Admissions	8 years after the last entry	Likely to have archival value
Bound copies of reports/ records if made	30 years	Destroy under confidential conditions.
Day books and other record specimens received by a laboratory	2 calendar years	Destroy under confidential conditions.
Death – cause of, Certificate Counterfoils	8 years	Destroy under confidential conditions.
Death Registers (i.e. register of deaths kept by the hospital whe they exist in paper format)	10 years	Likely to have archival value
Discharge Books	8 years after the last entry	Destroy under confidential conditions.

Forensic medicine records (including: pathology, toxicology, haematology, dentistry, DNA testing, post mortems forming a part of the Coroner's report, and human tissue kept as part of the forensic record), Post Mortem Record	The Hospital does not carry out forensic tests, however, 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 service user's notes, which should then be kept in line with the retention period for an adult or Child as applicable. All other records shall be retained for 30 years and if the records are truly forensic then approval for destruction will need to be sought from the Gardaí.	Destroy under confidential conditions.

Type of Clinical Record	Retention Period	Final Action
Homicide/Serious untoward incident' records	30 years from the date of homicide/serious untoward incident, however, consult with 1. Indemnifier 2. Legal advisors 3 Gardaí 4. Coroner 5. Other interested parties, prior to destruction.	Destroy under confidential conditions.
Outpatient Lists	2 years after the year to which they relate	Destroy under confidential conditions.
Pathological Archive/ Museum catalogues	30 years, subject to consent	Destroy under confidential conditions.
Photographic records (does not apply to photos of service users within their hospital chart)	30 years where images present the primary source of information for the diagnostic process	Destroy under confidential conditions.
Request forms that contain clinical information that is not readily available in the clinical record	30 years	Destroy under confidential conditions.
Request forms that are not a unique record	1 week after report received by requestor	Destroy under confidential conditions.

Ward Registers, including Day / Night Reports, Ward Checklists, Record of Daily Changes Report And Daily Bed Returns.	8 years after the year to which they relate	Destroy under confidential conditions.
X-ray registers (where they exist in paper format)	30 years	Destroy under confidential conditions.

C. Miscellaneous records

Type of Clinical Record	Retention Period	Final Action
Clinical Audit Records	5 years from the date the clinical audit is completed	Destroy under confidential conditions.
Copy of Clinical outcome assessment tools (including questionnaires), made for the purpose of clinical outcomes data Entry	Copies made for data entry should be destroyed as soon as possible, but they must not be retained for longer than 1 year.	Destroy under confidential conditions.
Equipment/instruments maintenance logs, records of service inspections	Lifetime of equipment + 2 years	Destroy under confidential conditions.
External quality control records	10 years	Destroy under confidential conditions.
Internal quality control records	10 years	Destroy under confidential conditions.
Records of Telephoned Reports	2 calendar years	Destroy under confidential conditions.
Referral & Phone Log Sheets (generated by Referrals & Assessment Unit), paper or soft copies.	8 calendar years	Destroy under confidential conditions.
Records/documents related to litigation	Usually 10 years after the litigation has concluded, however, the Hospital shall consult the Hospital's legal advisor and indemnifier prior to the destruction of any records/documents related to litigation or a threat of litigation.	Destroy under confidential conditions.

Records of Destruction of individual clinical records (case notes) and other health related records contained in this retention schedule (in manual or computer form)	**PERMANENTLY**	**NEVER TO BE DESTROY**
Standard operating procedures (new and old)	30 years from date the standard operating procedure was replaced/superseded	Destroy under confidential conditions.
Worksheets	30 years to allow full traceability of all blood products used	Destroy under confidential conditions.
Research Materials including research documents, research tools & consent forms.	In the absence of specific legal or external requirements, 10 years after the completion of a research project.	Destroy under confidential conditions.

9. Process for Retention, Storage and Destruction of St Patrick's Mental Health Services' archived files

A record 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 is because the destination is not recorded. Good practice in record management is an integral part of quality care.

Optimum storage is important ensuring the long-term preservation of clinical records. It is also important that appropriate back up procedures are in place for all electronic data.

In order to achieve the efficient and accurate storing, retrieval and destruction of all archived items, the following processes will be followed:

Retention & Storage:

It is the Clinical Records Department responsibility to manage the storage and retention of archive materials and to maintain an effective index of every item currently in archive storage.

The Clinical Records Department is responsible for the appropriate filing and retrieval of all archived items whether it is paper based or electronically stored. It will ensure that all records are maintained, managed and controlled effectively in accordance with legal, operational and informational needs. It will manage the storage and retention of archived materials and maintain an effective index of every item in archive storage.

It is the Clinical Records Administrator's responsibility to identify each item in archive storage under the following criteria:

A. Individual Service Users clinical files

These records will be catalogued and indexed.

A destruction date will then be established for each record as outlined in the data retention policy.

A definitive plan for storage, retention and destruction will be established for each record in accordance with St Patrick's Mental Health Services data retention policy and in consultation with the Clinical records Review Group.

Upon records reaching their retention limit and before it is sent for destruction, it is cross referenced with the SPMHS database to confirm the last date of contact with the service user is correct.

B. Records / Reports not contained within a Service User's clinical record such as:

- Admission Reports
- Discharge Books
- Outpatient lists
- Ward Registers
- Day/Night Reports
- X Ray Films
- Incident Reports
- Diaries – Ward / Personal / Clinician.
- Research Reports
- Miscellaneous documents as found.

Procedure

- The Clinical Records Administrator identifies each item stored in the archive storage areas.
- The Clinical Records Administrator ensures that each report / record is stored in an appropriate storage container, clearly label the contents with the document title and the date or date range to which the documents relate.
- The Clinical Records Manager consults with Department Managers and Hospital Directors to categorize every record under the Schedule of Records and Retention Periods contained in this policy.
- An inventory list of all items in archive storage, detailing box / file numbers, location, description of content, data type and date of destruction is kept updated and reviewed on a monthly basis in order to maintain the prompt destruction of records once the retention period has passed. This Archive Inventory / Retention Schedule will be reviewed and approved by the Clinical Records Review Group on an adhoc basis. The Clinical Records Administrator establishes if the appropriate medium is being used in order to maintain the documents throughout their retention lifespan. Digital scanning & computer storage is considered if appropriate in order to reduce the storage space required.
- The Clinical Records Administrator liaises with the head of the relevant department and agrees upon the optimum method of storage (paper or electronically stored).

In the event that it is agreed that the storage medium is being changed from paper to an electronic format and the original records are to be destroyed, this change is recorded and signed by the Clinical Records Manager and the Department Head on the Change of Storage Medium Authorisation form. This form also records the confirmation by the Clinical Records Manager and Department Head that each record has been fully and correctly electronically filed and is accessible by the authorised personnel only.

Destruction

- Upon records reaching their retention limit and before records are sent for destruction, the Clinical Records Department cross references the Archive Inventory / Retention Schedule with the SPMHS database to confirm the last date of contact with the service user is correct.
- A Certificate of Destruction form is completed for each record that is due for destruction as per the Archive Inventory / Retention Schedule.
- This certificate is reviewed and signed by the Clinical Administrations Manager, the Chair of the Clinical records Review Group and the relevant Department Head, authorising the destruction of said record in accordance to the Data Retention & Destruction of Confidential Materials Policy.
- The Clinical Records Manager witnessed by the relevant Department Head marks the record due for destruction clearly with a printed label marked 'For Destruction'
- Documents that have been identified for disposal shall be disposed of within one week.
- Documents that are being stored in anticipation of disposal shall be kept secure at all times.
- The Clinical Records Manager maintains a Records Destruction Register which records a list of all clinical records destroyed.
- This shall be kept in perpetuity in the office of the Director of Clinical Governance & Chair of the Clinical Records Review Group. The register shall contain where available, the person's name, address, date of birth, clinical record number, dates covered in the chart, date of disposal and by whom the authority was given to destroy the records.
- This record shall be signed by the Clinical Records Manager and Facilities staff member supervising the removal and disposal of records.
- For records outside the catalogued Service User clinical records that date prior to 1995, the Records Destruction Register lists the record type, the date range, the data retention category, the retention end date and destruction date. Individual service user names and details are not required.
- The destruction of confidential material is carried out onsite or via an approved contractor, but it is the responsibility of the hospital to verify that the methods used to destroy confidential material provide adequate safeguards against accidental loss or disclosure of the records.
- Where a contractor is used to destroy records, they are required to sign confidential undertakings and to produce written certification as proof of disposal. Disposal of confidential documents/clinical records are carried out by an approved contractor(s) who is an appropriate person(s) authorised under and in accordance with the Waste Management Act 1996, as amended.
- Optical and magnetic media require special disposal facilities and are separated from other media prior to disposal.

10. New / Future Archived Materials

As the new electronic health record system is implemented in the coming future, the process and procedures around archiving, retention and destruction will be reviewed and updated in order to ensure continued best practice in electronic storage, retention and destruction of files.