

RETENTION, STORAGE AND DESTRUCTION OF CARE HOME RECORDS: GUIDANCE FOR INDEPENDENT CARE PROVIDERS WHEN A CONTRACT CEASES

Provided by LCC Patient Safety and Adult Safeguarding and LCC Records Management Service,
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This document provides general guidance to independent (non-LCC) care providers on how to manage their records when they are closing down and clients are being transferred to other homes. It covers compliance and responsibility, definitions and provides a four (4) step process on managing the treatment of records when a contract ceases.

The records are the responsibility of the care home and it is important that owners and managers are conversant with their responsibility. This guide should not be seen as exhaustive. Its purpose is intended to raise awareness and include reference to the relevant pieces of legislation but the responsibility remains with owners and managers.

Currently care home records may be required as part of the public Inquiry into the Government's handling of the COVID-19 pandemic so it is important that this guidance is followed so the records are available if requested.

Compliance and Responsibility

- Care providers have a legislative responsibility to create and maintain records.
- Under the Data Protection Act 2018 personal data must be kept securely and not kept longer than required.
- The ability of care providers to comply with the requirements of statute (primary legislation) and regulations (secondary legislation) relies on the maintenance and retention of appropriate records.
- When a care home is closing, the service provider retains legal responsibility for the work they have done and the records that have been created. This responsibility applies to the maintenance, retention, sharing and disposal of records.
- Compliant and responsible treatment of records will protect the service provider and in case of litigation or investigation.

Definitions of Care Home Records

Records may be held in paper, digital or physical electronic format. A record is defined as *'information created, received and maintained as evidence and information by an organisation or a person, in pursuance of legal obligations or in the transaction of business'*.¹

Care home records are any paper or electronic records created and stored by care providers to be kept in a care home in respect to each service user and other records to be kept in a care home.

Some care home records are **health records**, defined under the Data Protection Act 2018 as any record of information relating to someone's physical or mental health that has been made by (or on behalf of) a health professional.

What to Do With the Records- 4 Steps

For all closing care homes, a copy or summary of the entire record should accompany the resident to their new home and all original records should be retained by the former provider (except in the case of the original provider ceasing to operate in which case all original records should also be copied to LCC). As a general rule at any change of contract, including the point of service closure, the records must be retained until the time period for liability has expired. Follow the four (4) steps below.

Step 1. Identify what you have:

Make sure you have a complete list of all records held, divided into record type. This can be done on a spreadsheet or other electronic program. You should also include the date range of the records.

- It may be helpful to list record types under three (3) categories: "Residents", "Staff" and "Administration".
- Identify any copies and decide which the original record is. Copies can be disposed of.
- This list should be referred to as an "Information Asset Register".

Step 2. Assess what needs to be kept and for how long:

Check how long each record type should be kept for, using available retention resources. Some decisions will be outlined in legislation and some will depend on how long you need it for business reasons. The same retention periods should be applied to paper and electronic files.

- Health records need to be retained and subsequently destroyed in line with Records Management Code of Practice for Health and Social Care², refer to the retention schedule in Appendix 3 [linked here](#).

LCC maintains a retention schedule for care homes they administer. Whilst LCC does not have authority over the records of independent care providers, they do provide guidance. The "Example Retention Schedule" below can be used as a quick reference guide and you may contact:

ACS.RecordsManagement@lancashire.gov.uk

¹ The ISO standard, ISO 15489-1:2016 Information and documentation-Records Management, Available <https://www.iso.org/standard/62542.html>

² Available [HTTPS://DIGITAL.NHS.UK/ARTICLE/1202/RECORDS-MANAGEMENT-CODE-OF-PRACTICE-FOR-HEALTH-AND-SOCIAL-CARE-2016](https://digital.nhs.uk/article/1202/records-management-code-of-practice-for-health-and-social-care-2016)

They will be able to discuss the guidance subject to the waiver at the beginning of this guidance.

Record type	Retention Period	Action	Given by
Residents Records			
Resident Client Files Deceased and Ceased	3 years from closure as death or cessation of service	Destroy	LCC guidance
MAR (Medical Administration Records) OR Resident Client Files Deceased and Ceased <i>Including</i> MAR sheets	7 years from closure as death or cessation of service	Destroy	LCC guidance
Mental Health Care Records (where person is being cared for under the Mental Health Act)	20 years from date	Review at the end of the retention period and if no new requirements (for example ongoing legal action or complaint) destroy	RMCOP 2016 Mental Health Act 2007
Admission and Discharge Registers	10 years from final entry in the register	Review at the end of the retention period and if no new requirements destroy	LCC guidance
Incidents	10 years from date of incident	Destroy	RMCOP 2016
Complaints, Disciplinarys, Grievances and Investigations	10 years from date of complaint, disciplinary, grievance or investigation	Destroy	RMCOP 2016 LCC guidance
Accidents to Residents	25 years from date of accident (or for a log book from the date of last entry)	Destroy	LCC guidance
Residents Savings Records, Pensions and Receipts	6 years from EOFY (end of financial year 31st March)	Destroy	LCC guidance
Staff Records			
Personnel/ Staff Files	Review 6 years from end of service	Review at the end of the retention period and if no new requirements destroy	LCC guidance
Duty Roster/ Rotas	6 years from date of rosta	Review at the end of the retention period and if no new requirements destroy	RMCOP 2016 LCC guidance
Incidents	10 years from incident	Destroy	RMCOP 2016
Payroll and Wage Sheets	6 years from EOFY	Destroy	LCC guidance
Administration			
Home Management Meeting Minutes and Papers	10 years from date of meeting/paper	Destroy	LCC guidance
Inspection Records	10 years from date of inspection	Destroy	LCC guidance

Care Quality Commission Registration Certificate and Statement of Purpose	7 years after date of registration certificate/ statement	Destroy	Care Quality Commission Guidelines
Health and Safety Audits and Risk Assessments	3 years after date of audit/assessment	Destroy	LCC guidance
Temperature logs, ETC, Fire Alarm Logs	5 years after completion of log	Destroy	
Property Inventories, Repair and Maintenance	6 years from EOFY	Destroy	LCC guidance
Journals and Reconciliations	6 years from EOFY	Destroy	LCC guidance
Finance: Orders, Petty Cash, Statements, Stock records	3 years from EOFY	Destroy	LCC guidance
Meals Register	3 years from EOFY	Destroy	LCC guidance
Information Asset Register/ List of records	As long as any record is retained	Review at the end of the retention period and if no new requirements destroy	LCC guidance

Step 3. Make arrangements for Storage:

Records must be made secure and accessible for the length of their retention. Storage should be sourced for paper, electronic and physical electronic records.

If you do not have a secure storage area for records (locked/access controlled) it will be necessary to set up a contract with a record store. These companies provide storage and management in line with client's retention requirements. There are a number of local companies who can be found on the intranet.

Step 4. Confidentially Dispose of Records Not Required:

Records containing confidential personal information must not be put in with domestic waste or put on a rubbish tip, as this would be a breach of the Data Protection Act 2018. Once you have identified what needs to be kept or sent to storage and what can be disposed of, you need to make arrangements for confidential waste disposal.

- Confidential disposal of paper records involves shredding/pulping under secure conditions. If you do not have a contact for collection and disposal there are numerous professional local companies who can conduct one-off waste disposal which can be found on the intranet.
- Extra care must be taken when disposing of electronic records, and physical electronic media. Electronic records may be held on devices that need to be overwritten or physically destroyed ("deleted" files can often be recovered). A professional company or IT expert can assist you.
- All disposal should be recorded for evidence of compliance. Professional disposal companies will provide you with a certificate, or you can record disposal on your Information Asset Register.

Other Useful Guidance

CQC Regulations for Service Providers and Managers, Available: <http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers>

The ISO standard, ISO 15489-1:2016 Information and documentation-Records Management, Available <https://www.iso.org/standard/62542.html>

National Archives

<HTTP://WWW.NATIONALARCHIVES.GOV.UK/INFORMATION-MANAGEMENT/MANAGE-INFORMATION/>

NHS England

<HTTPS://WWW.ENGLAND.NHS.UK/IG/IG-RESOURCES/>

NHS England and NHS BSA guidance for controlled drugs

<HTTP://WWW.NHSBSA.NHS.UK/PRESCRIPTIONSERVICES/1120.ASPX>

And

<HTTPS://WWW.ENGLAND.NHS.UK/WP-CONTENT/UPLOADS/2013/11/SOM-CONT-DRUGS.PDF>