Medical Records - Handling and Retention

A brief summary of the more detailed advice is available [here](https://www.wessexlmcs.com/websitefiles/download/51) which includes advice about how long medical records should be kept.

For definitive advice please click here: [Records Management Code of Practice for Health and Social Care 2016](https://www.wessexlmcs.com/websitefiles/download/3089)

Please note that the consultation for the draft Records Management Code of Practice 2020 has now concluded. The revised version of the code has yet to be published and the 2016 version is still valid until the new code has been finalised.

[GMC Good Medical Practice](http://www.gmc-uk.org/guidance/good_medical_practice.asp) requires that:

*'you keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment.'  It also stipulates that you 'make records at the same time as the events you are recording or as soon as possible afterward.'*

All of the following should be part of the record forwarded when the patient is de-registered;

* records of consultations;
* letters;
* medical reports;
* other clinical information;

 They should **not**normally include:

* solicitors letters;
* documentation pertaining to complaints procedures;
* PMAs;
* Social Services reports (unless you believe this is necessary for the active and current treatment of the patient)

**Can I shred paper records once they have been scanned?**

Technically, if they are kept in an electronic format, **that cannot be altered i.e. scanned document**, then they can be deemed to provide a true and accurate record,  and it is probably safe to destroy paper records.  However, you must comply fully with the [Good Practice Guidelines for Electronic Patient Records (version 4).](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215680/dh_125350.pdf)    You should also remember that where any records relate to p known medico-legal issues, (complaints, civil or criminal law) practices should keep all relevant records pending further advice from their medical defence organisation.

When summarising and shredding you should ensure that you:

* identify each file or document to be destroyed;
* record that the complete file or document has been stored electronically;
* have ensured that the electronic version is a true and accurate copy of the original, or state how it is different.

[**Access to Health Records by Diagnostic Staff**](https://www.ibms.org/resources/documents/access-to-health-records-by-diagnostic-staff/)

This helpful document provides guidance for patients and Healthcare professionals and summarises guidance already available.  This is with regard to clinicians accessing medical information without direct consent, such as a radiologist wanting to view the history to help interpret a CXR or a clinical biochemist wanting to look at the medication list when interpreting results.