Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
DELETING AN ENTRY IN THE PATIENT'S ELECTRONIC HEALTH RECORD

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*July 2024*	*New SOP - Internal IG process updated to a formal Trust SOP. Approved at Information Governance Group (17 July 2024).*

Contents

1. INTRODUCTION

Previously, the principle that applied to electronic clinical record systems was that no data should be permanently deleted from a record. Systems have the ability to "Mark in Error" or 'Void' (depending on the system) which is the electronic equivalent of a single line strike through of errors in the paper record leaving the original data present for audit purposes and to assist in understanding the history where decisions or actions may have been subsequently taken. This complies with Department of Health Records Management guidance and a Clinician's Professional body guidance.

SystmOne has the functionality to permanent remove information. This SOP details the process for requesting permanent removal from a record.

Important Note: The removal of data from <u>any</u> Patient Record is a significant process which should only be used in exceptional circumstances on a very infrequent basis when the situation justifies it.

2. SCOPE

This procedure applies to all employees of the Trust, including all staff who are seconded to the Trust, contract, voluntary, temporary and agency staff and other people working on Trust premises. This includes members of staff with an honorary contract or paid an honorarium.

The procedure applies to all services using SystmOne and Lorenzo.

3. PROCEDURES

3.1. Mark in error

Where information has been entered which is identified as being an error, the user can 'mark in error' or 'void it'. This removes the data to the deleted area of the record but leaves it visible to any user with access rights. This process should be used for most everyday instances of data entry errors.

The exception to this is for SystmOne entries that have been put onto the wrong record and contain identifiable information about another patient. Such entries will be included in any Subject access printouts and must be permanently removed from the record to reduce the possibility of breaching patient confidentiality. The process in 3.3 should be followed.

3.2. Permanent removal in Lorenzo

There is no functionality for permanent deletion in Lorenzo, only the system provider Dedalus can permanently remove information from the system. In the event data needs to be permanently deleted from Lorenzo, a user will need to discuss this with the clinical systems team and the request logged via the IT Service Desk. The user will be asked to complete the Form in Appendix 3 and submit to the IG Team.

The request for permanent deletion will be raised to the IG Team who will raise the request to the Caldicott Guardian. The Caldicott Guardian will determine whether it meets the 'criteria for deletion' and is appropriate for the data to be removed from the record. The Caldicott Guardian decision will be communicated to the Clinical Systems Team, if approved a ticket will be raised to Dedalus via Remedy to request permanent deletion of the information.

3.3. Permanent removal in SystmOne

Staff can request that specific data and/or registrations **be removed** from the electronic patient record.

The “request removal from the patient record” functionality will be a relatively rarely-used function, and will reflect specific scenarios where the data in the patient’s record (even if marked in error) can cause distress to the patient or present a clear clinical risk. It should only be used when an explicit request to remove specific data from the patient record has been made by a patient and/or representative

There are a number of reasons where actual removal of data from the record is appropriate, see criteria for deletion in Section 3.4.

There may also be times when actual or perceived sensitive data has been incorrectly entered against the patient record or the data may be factually correct but is nevertheless distressing to the patient.

It is important to note that removal from the record does not equate to permanent deletion, TPP (the system supplier) will maintain an audit of this data, but the data itself will not be visible in the electronic patient record. Once the data has been removed from the record the only people who will be able to see the audit are selected TPP staff. TPP staff would only access this data when there is a specific requirement to do so. As a very last resort, the information in the audit could be restored to the patient record or printed out on special application to TPP.

Marking any data for deletion will create an 'Approve Removal of Patient Data' task. This task should be assessed by the organisation’s designated Caldicott Guardian to determine whether it is appropriate for the data to be removed from the record. This process may involve negotiation with the patient, representatives, care providers etc. to assess the impact of removing this data from the record before any decision is made to either approve or reject the request.

When a clinician receives a request from patient or patients representative that certain data within the record is extremely distressing and they want it removed the clinician will discuss this with the patient, consider ways the distress can be managed without removal of the data and identifying with the patient the implications removal of this data may have.

If a decision is made that permanent removal would be appropriate, the process in Appendix 1 should be followed.

3.4. Criteria for deletion

Deletion of the full record is appropriate in the following circumstances: -

1) A record has been made in error – someone has been incorrectly selected and registered as a patient.

2) Duplicate record – a second record has been created when a demographic error has been made when searching for a patient.

3) Merged record – when duplicate records have been identified that both contain information, once the information has been identified and transferred to the primary record, the secondary record will need deleting.

A full record will only be deleted on confirmation that all entries have been transferred to the correct record and entries in the incorrect record have been marked in error/voided.

Deletion of data within a record is appropriate in the following circumstances:-

1) When the removal of the data does not lead to potential misinterpretation of clear understanding of decisions made subsequent to the entry. (e.g. although the information is incorrect subsequent decisions/actions regarding management of the patient have been made based on the incorrect data).

2) The evidence of the extent of distress to the patient and when reasonable attempts have been made to resolve the distress without deleting the data from the record.

3) When the data should not have been entered into a record, this could be if it is against current legislation or guidance. e.g. adoption when a link between the old and new identity has been maintained.

4) When an entry has been added to the wrong record and contains patient identifiers or unique identifying circumstances. (SystmOne only)

3.5. Recording of requests

A record of all requests (Lorenzo and SystmOne) and their outcome will be kept by the CG Representatives on a Spreadsheet on the Caldicott Log, held by the IG Team. The forms and any correspondence will be held in a folder in a secure area on the Trust network drive by the IG Team.

4. REFERENCES/DEFINITIONS

TPP – Deleting an entry from the patient record.

Appendix 1 – Permanent removal process SystmOne

Clinicians

1) Mark the data for deletion within the SystmOne record.

   This can be done either by selecting the 'Request this item to be removed from the patient record (exceptional use only)' tick box when marking in error information or

   Right-clicking on an item in the Deleted Items node of a patient record and choosing to 'Remove from patient record'.

   In the case of registrations, by pressing the 'Request Removal' button on the GMS Registration Info node of the patient record.

2) Send a request via email to the IG Team at hnf-tr.igteam@nhs.net

3) In the subject header of the email put '**Marked for Deletion**'

IT HELPDESK & IT TRAINER

1) If a '**Marked for Deletion'** request is received the task will be allocated to the IT Trainers.

2) IT Trainers will assign the task in S1 to the IG Team and forward the email request to the Caldicott Guardian Representatives (IG Team).

CALDICOTT GUARDIAN REPRESENTATIVES (CG Representative)

1) Email a form (Appendix 2) to the requestor for them to complete and send back.

2) Once the completed form is received they will assess the request against the criteria for removal. If the task has been incorrectly marked for deletion (instead of mark in error) than the request will be rejected. The rejected process will be followed below.

   Rejected
   - User with Caldicott Guardian rights to delete "Approval of Removal of Patient Data" tasks will reject the task and document the reason why on SystmOne.
   - The data will be revert to "mark in error in" and will be visible in the "Deleted items" node of the record.
   - The user will be emailed to advise that the task has been rejected and the reason why.

3) If the request meets the deletion criteria, the request will be forwarded to the Caldicott Guardian who will review the request. The Caldicott Guardian will approve the request via email or reject the request stating the reasons why.

4) The CG Representative will action the task in Systmone and update the user via email.

Appendix 2 – Form to Request Permanent Removal - SystmOne

Clinician's Name _____ Job Title: _____

Team/Address: _____

_____

Managers Name _____

S1 Unit Name: _____

Please give a brief reason of why you are requesting permanent removal of information from the Patients Record**.**
DO NOT INCLUDE PATIENT INFORMATION (apart from NHS Number and name) OR SCREENSHOTS

Patient NHS No: _____ Patients Name: _____

The removal of data from a Patient Record is a significant process and will only be used in exceptional circumstances.

Appendix 2 – Form to Request Permanent Removal - Lorenzo

Clinician's Name: _____ Job Title: _____

Team/Address: _____

_____

Managers Name : _____

Please give a brief reason of why you are requesting permanent removal of information from the Patients Record**.**
DO NOT INCLUDE PATIENT INFORMATION (apart from NHS Number and name) OR SCREENSHOTS

Patient NHS No: _____ Patients Name: _____

The removal of data from a Patient Record is a significant process and will only be used in exceptional circumstances.