National Hospitals Office Code of Practice for Healthcare Records Management

Part 5: Retention and Disposal Schedule

Reader Information

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Description:	The Code of Practice is a guide to the standards of practice required in the management of healthcare records in the NHO, based on current legal requirements and professional best practice
Superseded Docs:	The retention and disposal schedule replaces the previous retention schedule on acute hospital records outlined on pages 8-9 of the 'Policy for Health Boards on Record Retention Periods' (1999). Version 2.0 replaces Version 1 of Code of Practice.
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Part 5

Retention and Disposal Schedule

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1. Introduction

- Part 5 of the National Hospitals Office (NHO) Code of Practice for Healthcare Records Management sets out the schedules for retention and disposal of healthcare records in publicly funded acute hospitals in the National Hospitals Office. Part 5:
    1. Lists the minimum retention periods for healthcare records in the NHO.
    2. Provides a clear policy in order that hospitals can operate a healthcare records retention and disposal practice in a consistent manner across the Health Service Executive.
- The schedule replaces the previous retention schedule on acute hospital records outlined on pages 8-9 of the '*Policy for Health Boards on Record Retention Periods'* (1999).

2. Types of healthcare record covered by this schedule

- This retention policy applies to healthcare records of all types regardless of the medium on which they are held.
- These may consist of:
    1. Patient healthcare records (electronic or paper based, including those concerning all specialties).
    2. Emergency Department, birth, theatre, minor operations and other related registers.
    3. X-ray and imaging reports, output and images.
    4. Photographs, slides, and other images.
    5. Microform (i.e. microfiche/microfilm).
    6. Audio and video tapes, cassettes, CD-ROM etc.
    7. Computerised records.
    8. Scanned records.

3. Legal obligation and good practice

- The Health Service Executive 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 the Health Service Executive 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 the Health Service Executive **must have** a policy on retention periods for personal data that is retained. This policy must include defined retention periods for healthcare records and systematic disposal of healthcare records immediately after the retention period expires.
- Since 2003, Data Protection legislation also applies to electronic and hard copy records.

4. Basis for the National Hospitals Office healthcare 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 patients 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

- Each Department Head is responsible for making sure that all healthcare records retained in the department are periodically and routinely reviewed to ensure systematic implementation of the National Hospitals Office Healthcare Records Retention and Disposal Schedule.

6. Retention and disposal schedule:

- A retention and disposal schedule is a key document in a healthcare records management system which outlines:
    1. The types of healthcare records held within an organisation.
    2. The minimum period for which such records should be retained.
    3. The action required when the minimum retention period has been reached.
- The retention and disposal schedule lists all of the healthcare records for which predetermined periods of retention have been agreed.

Why is a retention and disposal schedule needed?

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

Decisions regarding the retention and disposal of healthcare records

- Healthcare records that have reached their offical retention period, should be reviewed under the following criteria, so that ill-considered disposal is avoided. Whenever the schedule is used, the guidelines listed below should be followed.
- Recommended retention periods should be calculated from the end of the calendar month following the last entry on the document.
- The healthcare records manager or designated person should carry out healthcare record reviews in line with the National Hospitals Office retention and disposal schedule.
- It is recommended that a multidisciplinary healthcare records users group should be established to provide advice on the retention and disposal of healthcare records. Input from local healthcare professionals should be a key element of the hospital's healthcare records management strategy.
- Where a set of healthcare records have reached their final date for retention, the Healthcare records manager shall confirm the implementation of the National Hospitals Office healthcare records retention and disposal schedule with the healthcare records users committee in the hospital.

Retention and disposal schedule

- If a record due for disposal is known to be the subject of an **access request** for records, then this contact will be regarded at the latest contact date and the relevant retention period will apply.
- Where an **adverse outcome** has been advised to the risk management personnel then these healthcare records should be retained for an additional period as advised by the hospital risk management committee.
- Hospital healthcare records **should not be kept any longer than** the appropriate retention period. Hospitals who wish to retain healthcare records for longer than the appropriate retention period for research or statistical purposes must obtain clear and unambigious consent from the patients concerned for the retention of their records for these purposes.

Retention and disposal policy

- When original healthcare records are selected for disposal in accordance with this policy, a clear disposal policy must be applied.
- It is vital that the process of disposal safeguards and maintains the confidentiality of patient records. This can be done onsite or via an approved contractor, but it is the responsibility of the hospital to satisfy itself that the methods used provide adequate safeguards against accidental loss or disclosure of the records.
- Disposal of healthcare records should be carried out in accordance with environmental health regulations.
- Where a contractor is used to destroy records they should be required to sign confidential undertakings and to produce written certification as proof of disposal.
- Please note that optical and magnetic media require special disposal facilities.
- A record should be kept in perpetuity of all healthcare records destroyed. The register should contain the persons 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. If agreement is reached at a later date to the use of a unique healthcare identifier, then this identifier should also be recorded.
- 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 local policies and procedures.

7. Alternative media

- In order to address problems of storage space or for reasons of business efficiency, the hospital may consider transferral of hospital healthcare records to alternative media at any time during the life of the healthcare 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 healthcare 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.
- The Schedule has five columns:

1.	Reference	This is to facilitate reference to the schedule
2.	Type of healthcare record	This column identifies the type of healthcare record created in the National Hospitals Office.
3.	Retention period	The retention period is calculated from the time the healthcare record was closed.
4.	Derivation	Notes the details of legislation and any other references of relevance to the recommended retention period.
5.	Final Action	There are two possibilities: • Destroy under confidential conditions. • Likely to be of archival value. Contact the National Archives (records acquisition division).

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR1	A&E (Emergency Department) records (where these are stored separately from the main patient record)	Retain for the period of time appropriate to the patient/ specialty, e.g. children's A&E records should be retained as per the retention period for the records of children and young people shown below		Destroy under confidential conditions
HCR2	A&E (Emergency Department) registers (where they exist in paper format)	8 years after the year to which they relate		Likely to have archival value. Contact the National Archives (Records Acquisition Division)
HCR3	Admission Books (where they exist in paper format)	8 years after the last entry		Likely to have archival value. Contact the National Archives (Records Acquisition Division)
HCR4	Ambulance records - patient identifiable component (including paramedic records made on behalf of the Ambulance Service)	10 years		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR5	Audiology Records	Retain for the period of time appropriate to the patient/ speciality, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if the patient died while in the care of the organisation		Destroy under confidential conditions
HCR6	Birth Registers (i.e. Register of births kept by the hospital)	10 years		Likely to have archival value. Contact the National Archives (Records Acquisition Division)
HCR7	Blood Transfusion Records (see pathology records)			
HCR8	Breast screening X-Rays	8 years		Destroy under confidential conditions
HCR9	Cervical Screening Slides	10 years		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR10	Children and young people (all types of records relating to children and young people)	Retain until the patient's 25th birthday or 26th if young person was 17 at the conclusion of treatment, or 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period		Destroy under confidential conditions
HCR11	Clinical Audit Records	5 years		Destroy under confidential conditions
HCR12a	Clinical trials of investigational medicinal products – healthcare records of participants that are the source data for the trial	For trials to be included in regulatory submissions: 20 years. It is the responsibility of the Sponsor/someone on behalf of the Sponsor to inform the investigator/institution as to when these documents no longer need to be retained	European Commission Directive 2005/28/EC of 8 April 2005 laying down principles and detailed guidelines for good clinical practice as regards investigational medicinal products for human use, as well as the requirements for authorisation of the manufacturing or importation of such products: http:/ pharmacos.eudra.org/F2/. harmacos/dir200120ec.htm	

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR12b	Clinical trials of investigational medicinal products – healthcare records of participants that are the source data for the trial	For trials which are not to be to be used in regulatory submissions: 20 years	Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use Directive 2001/20/EC: The Medicines for Human Use (Clinical Trials) Regulations 2004. ENTR/F/2 D(2002) – detailed guidelines on the trial master file and archiving ICH Harmonised Tripartite Guideline, guidance for good clinical practice, CPMP/ICH/135/95: http://www.emea.eu.int.pdfs/human/ich/013595en.pdf	Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR13	Creutzfeldt-Jakob Disease (hospital and GP)	30 years from date of diagnosis including deceased patients		Destroy under confidential conditions
HCR14	Death - Cause of, Certificate counterfoils	2 years		Destroy under confidential conditions
HCR15	Death registers – i.e. register of deaths kept by the hospital, where they exist in paper format	10 years		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR16	Dental, ophthalmic and auditory screening records	11 years for adults For children 11 years or up to their 25th birthday, which ever is the longer		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR17	Dietetic and Nutrition	Retain for the period of time appropriate to the patient/ speciality, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if the patient died while in the care of the organisation		Destroy under confidential conditions
HCR18	Discharge Books (where they exist in paper format)	8 years after the last entry		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR19	Donor records (blood and tissue)	25 years post transplantation		Destroy under confidential conditions
HCR20	Drug trials, records (see clinical trials)			

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR21	Forensic medicine records (including pathology, toxicology, haematology, dentistry, DNA testing, post mortems forming part of the Coroner's report, and human tissue kept as part of the forensic record). See also Human tissue, Post mortem registers	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 patient's notes, which should then be kept in line with the specialty, and then reviewed. All other records retain for 30 years		Destroy under confidential conditions
HCR22	Genetic records	30 years from date of last attendance		Destroy under confidential conditions
HCR23	Healthcare records (excluding records not specified elsewhere in this schedule)	8 years after conclusion of treatment or Death		Destroy under confidential conditions
HCR24	Homicide / "Serious untoward incident" records	30 years		Destroy under confidential conditions
HCR25	Hospital acquired infection records	6 years		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR26	Human Tissue	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 patient's notes, which should then be kept in line with the specialty and then reviewed. All other records retain for 30 years		Destroy under confidential conditions
HCR27	Intensive Care Unit Charts	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions
HCR28	Joint replacement records	For joint replacement surgery the revision of a primary replacement may be required after 10 years to identify which prosthesis was used. Only need to retain minimum of notes with specific information about the prosthesis		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR29	Maternity (all obstetric and midwifery records, including those of episodes of maternity care that end in stillbirth or where the child later dies)	25 years after the birth of the last child		Destroy under confidential conditions
HCR30	Medical illustrations (see Photographs (HCR 43 below)			
HCR31	Mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001)	20 years after the date of last contact between the patient/client/service user and any healthcare professional employed by the mental health provider, or 8 years after the death of the patient/client/service user if sooner	Mental Health Acts 1945 to 2001	Destroy under confidential conditions
HCR32	Microfilm/microfiche records relating to patient care	Retain for the period of time appropriate to the patient/specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR33	Midwifery records	25 years after the birth of the last child		Destroy under confidential conditions
HCR34	Mortuary Registers (where they exist in paper format)	10 years		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR35	Notifiable Diseases Book	6 years		Destroy under confidential conditions
HCR36	Occupational therapy records	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001). 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR37	Oncology (including radiotherapy)	25 years. NB Records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes		Destroy under confidential conditions
HCR38	Operating Theatre Registers	8 years after the year to which they relate		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR39	Orthoptic records	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while		Destroy under confidential conditions
HCR40	Outpatient lists (where they exist in paper format)	2 years after the year to which they relate		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR41	Paediatric records (see Children and young people above)			
PATH1	Pathology Records *Documents, electronic and paper records* Accreditation documents; records of inspections	10 years or until superseded	http://www.rcpath.org/resources/pdf/retention - SEPT05.pdf—Applies to records PATH1 to PATH45.	Destroy under confidential conditions—Applies to records PATH1 to PATH45
PATH2	Batch Records Results	10 years		
PATH3	Bound copies of reports / records if made	30 years		
PATH4	Day Books and other Records of Specimens received by a laboratory	2 calendar years		
PATH5	Equipment / instruments maintenance logs, records of service inspections	Lifetime of equipment		
PATH6	Procurement, use, modification and supply records relevant to production of products (diagnostics) or equipment	11 years		

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
PATH7	External Quality Control records	2 years		
PATH8	Internal Quality Control Records	10 years		
PATH9	Lab File Cards or other working records of test results for named patients	2 calendar years		
PATH10	Near-patient Test Data	Result in patient record, log retained for lifetime of instrument		
PATH11	Pathological Archive / Museum Catalogues	30 years, subject to consent		
PATH12	Photographic Records	30 years where images present the primary source of information for the diagnostic process		
PATH13	Records of Telephoned Reports	2 calendar years		

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
PATH14	Records relating to investigation or storage of specimens relevant to organ transplantation, semen or ova	30 years if not held with health-care record		
PATH15	Reports, copies Post Mortem Reports	6 months Held in the patient's healthcare record for 8 years after the pa-tients death		
PATH16	Request forms that are not a unique record	1 week after report received by requestor		
PATH17	Request forms that contain clini-cal information not readily avail-able in the healthcare record	30 years		
PATH18	Standard operating procedures (current and old)	30 years		
PATH19	*Specimens and Preparations* Blocks for electron microscopy	30 years		
PATH20	Electrophoretic strips and im-munofixation plates	5 years unless digital images taken, in which case 2 years and stored as a photographic record		

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
PATH21	Frozen Tissue for immediate histological assessment (frozen section)	Stained microscope slides - 10 years. Residual tissue - kept as fixed specimen once frozen section complete		
PATH22	Frozen Tissue or cells for histochemical or molecular genetic analysis	10 years		
PATH23	Grids for electron microscopy	10 years		
PATH24	Human DNA	4 weeks after final report for diagnostic specimens. 30 years for family studies for genetic disorders (consent required)		
PATH25	Microbiological Cultures	Most positive cultures can be discarded within 24 - 48 hours of issuing a final authorised report. Specified cultures of clinical importance (Blood Culture isolates, Cerebro spinal Fluid (CSF) isolates, enteric pathogens, multiple resistant or methicillin resistant Staph. Aureus, 'outbreak strains, M. tuberculosis, Group A streptococci, and unusual pathogens of clinical significance) should be retained for at least 7 days. Where isolates have been referred to external laboratories they should be retained for at least 7 days after the issue of their final report.		

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
PATH26	Museum specimens (teaching collections)	Permanently. Consent of the relative is required if it is tissue obtained through post mortem	http://www.rcpath.org/resources/pdf/Retention-SEPT05.pdf	
PATH27	Stained Slides	Depends on the purpose of the slide - see RCPath document for further details		
PATH28	Newborn Blood Spot screening cards	5 years - parents should be alerted to the possibility of contact from researchers after this period and a record kept of their 'consent to contact' response		
PATH29	Body fluids / aspirates / swabs	48 hours after the final report issued by lab		
PATH30	Paraffin Blocks	30 years and then appraise for archival value		
PATH31	Records relating to donor or recipient sera	11 years post transplant		
PATH32	Serum following needlestick injury or hazardous exposure	2 years		

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
PATH33	Serum from first pregnancy booking visit	1 year		
PATH34	Wet Tissue (representative aliquot or whole tissue or organ)	4 weeks after final report for surgical specimens.		
PATH35	Whole blood specimens for full blood count	24 hours		
PATH36	*Transfusion Labaratories* Annual reports (where required by EU directive)	15 years		
PATH37	Autopsy reports, specimens, archive material and other where the deceased has been the subject of a Coroner's autopsy	These are Coroner's records - copies may only be lodged on the healthcare record with the Coroner's permission		
PATH38	Blood Bank Register, blood component audit trial and fates	30 years to allow full traceability of all blood products used	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)	
PATH39	Blood for grouping, antibody screening and saving and/or cross-matching	1 week at 4°C		

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
PATH40	Forensic Material - criminal cases	Permanently, not part of the healthcare record		
PATH41	Refrigeration and Freezer Charts	11 years		
PATH42	Request forms for grouping, antibody screening and cross-matching	1 month	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50	
PATH43	Results of grouping, antibody screening and other blood transfusion related tests	30 years to allow full traceability of all blood products used	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)	
PATH44	Separated serum / plasma stored for transfusion purposes	Up to 6 months		
PATH45	Storage of material following analyses of nucleic acids	30 years See RCPath document for further guidance	http://www.cepath.org/resources/pdf/Retention-SEPT05.pdf	
PATH46	Worksheets	30 years to allow full traceability of all blood products used	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)	

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR42	Patient-held records	At the end of an episode of care the hospital organisation responsible for delivering that care and compiling the record of the care must make appropriate arrangements to retrieve patient-held records. The records should then be retained for the period appropriate to the specialty		Destroy under confidential conditions
HCR43	Photographs (where the photograph refers to a particular patient it should be treated as part of the healthcare record)	Retain for the period of time appropriate to the patient/specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions
HCR44	Physiotherapy records	Retain for the period of time appropriate to the patient/specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR45	Podiatry records	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions
HCR46	Post mortem records (see Pathology records)			
HCR47	Post mortem registers (where they exist in paper format)	30 years		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR48	Psychology records	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR49	Records/documents related to any litigation	As advised by the organisation's legal advisor. All records to be reviewed. Normal review 10 years after the file is closed		Destroy under confidential conditions
HCR50	Records of Destruction of Individual Healthcare records (case notes) and other health related records contained in this retention schedule (in manual or computer format)	Permanently		
HCR51	Scanned Records relating to patient care	Retain for the period of time appropriate to the patient/ specialty e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR52	Social Work records	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation Note: Records created under the Child Care legislation – hold in perpetuity.		Destroy under confidential conditions
HCR53	Speech and Language Therapy records	Retain for the period of time appropriate to the patient/ specialty e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions
HCR54	Suicide – notes of patients havingcommitted suicide	10 years		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR55	Telemedicine records (see also Video records)	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions
HCR56	Transplantation records	Records not otherwise kept or issued to patient records that relate to investigations or storage of specimens relevant to organ transplantation should be kept for 3 years	The Retention and Storage of Pathological Records and Archives (3rd edition 2005) Addendum 1	Destroy under confidential conditions
HCR57	Ultrasound records (e.g. vascular, obstetric	Retain for the period of time appropriate to the patient/ specialty, e.g. children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR58	Video records/ voice recordings relating to patient care/ videoconferencing records	8 years subject to the following exceptions: Children and young people: Records must be kept until the patient's 25th birthday, or if the patient was 17 at the conclusion of treatment, until their 26th birthday, or until 8 years after the patient's death if sooner Maternity: 25 years Mentally disordered persons: Records should be kept for 20 years after the date of last contact between patient/client/service user and any healthcare professional or 8 years after the patient's death if sooner Cancer patients: Records should be kept until 8 years after the conclusion of treatment, especially if surgery was involved.		Destroy under confidential conditions

Reference	Types of Healthcare Record	Retention Period	Derivation	Final Action
HCR59	Ward registers, including daily bed returns (where they exist in paper format	2 years after the year to which they relate		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR60	X-ray films (including other image formats for all imaging modalities/diagnostics)	7 years (if there is an accompanying X-Ray report which is retained for the appropriate period of time as part of the patient record). If there is no accompanying X-Ray report the X-ray films (including other image formats for all imaging modalities/ diagnostics) are considered as a part of the patient record and should be retained for the appropriate period of time		Destroy under confidential conditions
HCR61	X-ray registers (where they exist in paper format)	30 years		Likely to have archival value. Contact National Archives (Records Acquisition Division)
HCR62	X-ray reports (including reports for all imaging modalities)	To be considered as a part of the patient record and should be retained for the appropriate period of time		Destroy under confidential conditions