pronged clip can be threaded through clip holes in the folder or can be attached to the folder by the adhesive backing.

Each section of the medical record must be separated by a divider; the divider will be slightly wider than the forms in the medical record and have a tab on which to write “test results”, “operative reports”, etc. In addition, if combined with the inpatient notes, all outpatient notes can be stored behind an outpatient divider.

MR.11 The hospital has a system to manage voluminous medical records.

MR.11.1 There is a system that enables medical record linkage.

MR.11.2 When the medical record is divided into volumes, the number of each volume should be clearly visible on the folder and on the sign-out slip (e.g., "Volume 1 of 2", "Volume 2 of 2,").

MR.11.3 When the hospital practices thinning of voluminous medical records:

MR.11.3.1 The hospital develops thinning guidelines that remain consistent for the type of documentation contained.

MR.11.3.2 The hospital retains documentation in the medical record that reflects the current plan of care and services provided.

MR.11.3.3 The hospital removes parts of the medical record older than a certain date and moves them into a secondary record (the overflow record).

Standard Intent:

Hospitals need to have a process based on which voluminous medical records are handled. When a second volume is initiated, what is the essential information that needs to be accessible to care providers at all care intervals and the storage of those records should be clearly defined. This is part of ensuring integrity and completeness of patient records which influence continuity of the care provided as well as informed care plans and interventions.

MR.12 The hospital has a system for the retention of medical records in accordance with laws and regulations.

MR.12.1 The hospital has a policy on the retention of medical records.

MR.12.2 The policy is consistent with laws and regulations.

MR.12.2.1 The medical records are retained for a minimum of five years after the patient was last seen unless otherwise specified by laws and regulations. For minors, records shall be kept until he/she is eighteen years of age, and then for a minimum additional five years.

MR.12.2.2 The policy addresses the retention period of the different types of the medical records as well as the permanent types (e.g., records of medico-legal cases).

MR.12.2.3 The policy addresses the retention period of the different parts of the medical records as well as the permanent parts (master patient index, admission and discharge dates, name of the most responsible physician, diseases treated and operations performed; and a discharge summary for each admission).

MR.12.3 The method used for medical records destruction, when the retention period is complete, renders the information unreadable.

MR.12.4 When the hospital discontinues operation, it stores the medical records in a facility offering retrieval services for the specified retention periods. Patients or their representatives are informed.

Standard Intent:

The hospital determines the retention time of patient clinical records and other data and information. Patient clinical records and other data and information are retained for sufficient periods to comply with laws and regulations and to support patient care, management, legal documentation, research, and education.

The retention of records, data, and information is consistent with the confidentiality and security of such information. When the retention period is complete, patient clinical records and other records, data, and information are destroyed in a manner that does not compromise confidentiality and security.

MR.13 There is a policy that outlines how the medical records are stored.

MR.13.1 The policy addresses how the medical records are protected from loss, theft and deliberate alterations or destruction.

MR.13.2 The procedures for protection of medical records are implemented.

MR.13.3 The policy addresses how confidentiality, integrity, and security of the records will be maintained during storage.

Standard Intent:

Patient records and other data and information are secure and protected at all times. For instance, active patient records are kept in areas where only authorized health professional staff members have access, and records are stored in locations where heat, water, fire, or other damage is not likely to occur.