opendoor Community Health Centers	CLINICAL RECORDS STORAGE-HANDLING	STANDARD OPERATING PROCEDURE
		Policy Ref: IM.102_Clinical Records Storage-Handling
Enacted:	Owner: Operations	Revision Date: 09/18

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OVERVIEW:
Outlines the procedure for storing and handling paper and electronic charts, in a manner that promotes maximum security of the physical chart and of the information within it.

RESPONSIBILITY:
All staff are responsible for maintaining the security and privacy of all medical records. Operations and Medical Records will work collaboratively to maintain this policy and standard operating procedure

PROCEDURE:
Storage Guidelines:

- Records older than 2 years may be moved to an off-site storage facility, upon prior approval from the Chief Operations Officer (COO). Records in off-site storage will be stored with the same attention to security as active records, and will be filed in a manner that permits easy retrieval.

Alpha File:

- The system will be arranged to permit easy retrieval of documents.
- Alpha file documents will be stored for a minimum of 3 months. If no chart has been established at that time, alpha documents will be destroyed.

Access to Records:

- The following staff may have unsupervised access to paper record storage areas:
    - Licensed Clinicians (Physicians, Advance Practice providers, Dentists, Nurses, Mental/Behavioral Health providers)
    - Medical Records Manager
    - Medical Records staff
    - Office Managers and Site Administrators
    - Other individuals with job functions that specifically include responsibility for records handling (i.e. dental receptionists, mobile health coordinators)
- Levels of access to clinical records will be defined in each employee's job description. Designated levels of access will not exceed those needed to perform job functions.
- Any staff member that accesses records outside the performance of their job functions, or in excess of designated access levels, will be subject to disciplinary action, up to and including termination.
- Access to medical records can be accomplished by:
    - Calling the Mini-Storage directly and requesting a paper chart, or
    - Calling the Medical Records Manager and requesting a paper chart, or
    - Medical records staff may have direct access to an associated storage unit.

Electronic Record Remote Access:

- Remote access may be made available to:
    - Licensed clinicians (Physicians, Advance Practice providers, Mental/Behavioral Health providers)

    - Other individuals with job functions that specifically include responsibility for off-site health center functions (i.e. mobile staff, administrators or on-call nursing staff).
- Any staff member that accesses records outside the performance of their job functions, or in excess of designated access levels, will be subject to disciplinary action, up to and including termination.

Paper Chart Destruction Process:

- Records older than the required retention period may be periodically purged and destroyed, as reviewed by the Medical Records Manager.
- A Clinical Record Destruction Worksheet will be kept for all paper charts destroyed. The Worksheet will include:
    - Patient name, DOB and gender.
    - First date of service as listed in the paper chart.
    - Last date of service as listed in the paper chart, or last date of service as listed in the EMR at any ODCHC health center site (depending on which is most recent).
    - Criteria for destruction.

Lost Paper Charts:

- A chart will be considered "lost" when Medical Records staff has been unable to find it after 30 days, or if the chart is stolen, damaged beyond recovery, or destroyed before the minimum retention period is completed.
- The Medical Records Manager is responsible for monitoring missing charts, and for determining when a missing chart will be designated as "lost". In general, any chart that is not available for 2 consecutive patient visits will trigger the 30 day timeline.
- A Consolidated Situation Report form will be completed any time that a clinical chart is lost, as defined in the operating procedure. This form will be reviewed by the Compliance Officer.
- In most cases, lost charts will be reconstructed according to the guidelines below. In some instances (for example, when the chart was destroyed too early, but the patient is not currently active at the health center), the Compliance Officer may authorize a more limited reconstruction process.
- The following procedure will be followed for lost charts:
    - A new chart will be made with the same number as the lost chart.
    - A notation will be placed at the beginning of the chart noting the date and circumstances under which the chart was lost.
    - A printout of all services rendered will be made from the computer system and placed in the chart to indicate the extent of the missing services.
    - Medical Records staff will reconstruct as much information as possible, placing it in the appropriate locations within the chart, including:
        - Reprinting dictations still available in electronic format.
        - Reprinting hospital records pertinent to the health center's care.
        - Reprinting of lab results ordered by the health center.
        - Reprinting of visit notes from relevant databases or registries.

        - Obtaining copies of pertinent records that may be available at other ODCDC health centers.
    - The patient will be contacted by the Site Administrator or Office Manager, who will:
        - In consultation with the Compliance Officer, notify the patient of the circumstances of the lost chart.
        - Obtain a Records Release Authorization so that we can obtain pertinent records from non-ODCHC providers.
        - Schedule an appointment with the patient's primary care provider for the purpose of reconstructing key chart documents, including the medications list and master problem list. There will be no charge to the patient for this visit.

Missing Electronic Chart:

- In most cases, electronic charts and their information are not lost and the information can be recovered.
- The following procedure will be followed for missing electronic charts:
    - The Service Area Administrator (SAA) should be notified immediately. The SAA will research and contact the appropriate database manager to assist with recovery.
    - For immediate access (in the case of an office visit, refill or patient phone call), a partial, slightly out of date record can be obtained and printed by the Site Specialist using the backup/testing environment for the Electronic Health Record (EHR).

REFERENCES:

None

ASSOCIATED DOCUMENTS:

AG_Clinical Records Storage-Handling
Clinical Record Destruction Worksheet Form #671.2
Consolidated Situation Report Form #624

KEYWORD TAGS:

None