CLINICAL RECORD STORAGE-HANDLING OPS.061

Approved By:	**Chief Operations Officer**	Adopted Date:	**Unknown**
Distribution:	**Site Administrators, Facilities, Medical Records**	Revision Date(s):	**09/03, 3/04, 6/04, 9/05, 4/23/12**

PURPOSE:

To define guidelines for the routine storage and handling of clinical charts.

GOALS:

- To store and handle paper and electronic charts in a manner that promotes maximum security of the physical chart and of the information within it.
- To store and handle paper charts in a manner that ensures efficient retrieval to support clinical care.
- To comply with best practices and regulatory guidelines governing chart handling and paper chart storage.

POLICY:

1) Charts for each Facility:
   a) Each facility will maintain clinical records for the services that it provides. All services will be documented in standard medical charts. No temporary charts will be used.
   b) Prior to September 27, 2009: A patient will have one clinical paper record for each facility in which he or she receives services.
   c) After September 27, 2009: A patient will have one electronic clinical record for services rendered by ODCHC medical facilities, excluding telemedicine and visiting specialist services.

2) Storage Guidelines: Each facility will store paper records according to the following guidelines:
   a) Records storage areas will be lockable and keyed in a manner that restricts access to authorized personnel.
   b) Records storage areas will be protected from dampness, heat, and pests, and will include appropriate fire safety devices including fire extinguishers and smoke detectors.
   c) Records will be stored in a systematic manner (either numerically or alphabetically) that permits easy filing and retrieval.
   d) Records will remain in on-site storage for as long as possible and no less than 2 years. In the event that primary records storage spaces are full, older records may be moved to alternate on-site purged areas. Purged records will be stored with the same attention to security as active records, and will be filed in a manner than permits easy retrieval.
   e) Records older than 2 years of age may be moved to off-site storage facilities, upon prior approval of the Operations Officer. Records in off-site storage will be stored with the same attention to security as active records, and will be filed in a manner than permits easy retrieval. Notation of which charts have been removed to off-site storage will be maintained in the electronic management information system.
   f) Records of deceased patients will be retained on site according to the above policy.

3) Alpha File: Each facility will maintain a storage system for retrieval of items received for a patient that has not yet established care.
   a) The system will be arranged to permit easy retrieval of documents.
   b) Alpha file documents will be stored for a minimum of 3 months. If no chart has been established at that time, alpha file documents will be destroyed.

4) Handling:
   a) All paper charts will be placed in medical records, or in separately designated locked storage areas, when the clinic is closed.
   b) Out guides will be used for all paper chart pulls. Out guides will always indicate for whom the chart was pulled.

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c) Paper charts will not leave the clinic facility except for specifically designated purposes, such as mobile health services. Special handling procedures will be followed for charts that leave the facility:
   i) A list of all charts taken off site will be maintained.
   ii) Charts will be transported in a manner that limits the amount of time they are out of the facility. In general, charts should travel directly from one ODCHC location to another and should be housed at an approved ODCHC location each night.
   iii) Charts will be transported in a manner that ensures maximum possible protection during transit. They will be carried in secure containers, and will be carried in vehicle trunks when possible.

5) Electronic Record Remote Access
   a) Remote access may be made available to:
      i) Licensed Clinicians (Physicians, Midlevel Practitioners, Mental/Behavioral Health Providers)
      ii) Other individuals with job functions that specifically include responsibility for offsite clinic functions (ie mobile staff, Administrators, on-call Nursing Staff)
      iii) Any staff member that accesses records outside of the performance of his or her job functions, or in excess of designated access levels, will be subject to disciplinary action, up to and including termination.

6) Access to Records
   a) The following staff may have unsupervised access to paper record storage areas:
      i) Licensed Clinicians (Physicians, Midlevel Practitioners, Dentists, Nurses, Mental/Behavioral Health Providers)
      ii) Medical Records staff
      iii) Office Managers
      iv) Other individuals with job functions that specifically include responsibility for records handling (ie dental receptionists, mobile health coordinators)
   b) Level of access to clinical records will be defined in each staff member's job description. Designated level of access will not exceed that needed to perform job functions.
   c) Any staff member that accesses records outside of the performance of his or her job functions, or in excess of designated access levels, will be subject to disciplinary action, up to and including termination.

7) Retention
   a) The clinical paper record is the property of ODCHC and will remain in ODCHC possession during the required retention period.
   b) Minimum retention periods for clinical records at ODCHC are as follows:

Type of Chart/Patient	Date of Last Service
Patients over Age 18 with no obstetrical services	Greater than 7 years
Patients Age 1-18 with no obstetrical services	Greater than 7 years or until patient is 19 years of age, *whichever is longer*
Patients that received obstetrical services leading to live birth	Greater than 7 years or until child born under ODCHC care is age 19, *whichever is longer*

   c) In the event that a chart is lost or destroyed prior to the minimum retention deadline, notification will be made to the Privacy Officer, who is responsible for notifying the Department of Health Services of the loss.

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8) Paper Chart Destruction Process
   a) Records older than the required retention period may be periodically purged and destroyed, upon approval of the Operations Officer.
   b) The following documentation shall be maintained for destroyed charts:
      i) A notation will be made in the site's current MIS that the chart has been destroyed. This is typically stored in the comments field or as a patient alert.
      ii) For Humboldt county sites, the chart will be entered as "destroyed" in the chart manager of HealthPro XL.
      iii) In the event that a chart's status cannot be noted in the MIS (for charts that predate the computer systems), a separate database with the following information will be maintain on a shared server:
         (1) Patient Name
         (2) Patient Date of Birth
         (3) Chart Number
         (4) First Date of Service
         (5) Last Date of Service
         (6) Date of Destruction

9) Lost Paper Charts

   a) 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.
   b) The Medical Records Supervisor at each site 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 above.
   c) A Combined Situation Report form will be completed any time that a clinical chart is lost, as defined in this policy. This form will be reviewed by the Compliance Officer and Risk Manager.
   d) 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.
   e) The following procedure will be followed for lost charts:
      i) A new chart will be made with the same number as the lost chart.
      ii) A notation will be placed at the beginning of the chart noting the date and circumstances under which the chart was lost.
      iii) A printout of all services rendered will be made from the computer system and placed in the chart to indicate the extent of missing services.
      iv) Medical Records staff will reconstruct as much information as possible, placing it in the appropriate locations within the chart, including:
         (1) Reprinting dictations still available in electronic format.
         (2) Reprinting hospital records pertinent to the clinic's care.
         (3) Reprinting of lab results ordered by the clinic.
         (4) Reprinting of visit notes from relevant databases or registries.
         (5) Obtaining copies of pertinent records that may be available at other ODCHC clinics.
      v) The patient will be contacted by the Site Administrator or Office Manager, who will:
         (1) In consultation with the Risk Manager, notify the patient of the circumstances of the lost chart.
         (2) Obtain a Records Release Authorization so that we can obtain pertinent records from non-ODCHC providers.

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(3) 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.

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

Approved:

Cheyenne Spetzler
Chief Operations Officer