IM.102 CLINICAL RECORDS STORAGE-HANDLING

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

POLICY:
Charts for Each Facility:

- Each facility will maintain clinical records for the services it provides. All services will be documented in standard medical charts. No temporary charts will be used.
- Prior to September 27, 2009, a patient will have one clinical paper record for each facility in which they receive services.
- After September 27, 2009, a patient will have one electronic clinical record for services rendered by Open Door Community Health Centers (ODCHC) medical facilities, excluding telemedicine and visiting specialist services.

Storage Guidelines:

- Records storage areas will be lockable and keyed in a manner that restricts access to authorized personnel only.
- Records storage areas will be protected from dampness, heat, and pests, and will include appropriate fire safety devices including fire extinguishers and smoke detectors.

Alpha File:

- Each facility will maintain a storage system for retrieval of items received for a patient that has not yet established care.

Retention:

- Retention of medical records will follow the ODCHC Record Retention Schedule.
- 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.

REFERENCES:
None

ASSOCIATED DOCUMENTS:
ODCHC Record Retention Schedule
SOP Clinical Records Storage-Handling
OPS.061 Clinical Records Storage-Handling (Retired)

KEYWORD TAGS:
None