Medical Records: Paper

What's the Risk?

Regardless of the format, paper, electronic or a little of both (hybrid), the medical record serves several important patient care, legal and regulatory purposes. From a patient care perspective, the record should provide a chronological summary of all clinical care, communications and consents. As such, the record is an essential tool to corroborate charges and billing. The record also serves as evidence in medical malpractice cases and complaints filed with the medical board. In order for the medical record to serve its various purposes, the record must be available, comprehensible and well-documented.

Medical malpractice allegations related to paper records include the following:

- Failure to manage, store and destroy records properly resulting in a confidentiality breach and potential for HIPAA sanctions;
- Misinterpretation due to illegibility; and
- Record tampering related to an improper correction.

When Is This Risk an Issue?

Storage, Destruction and Management

Paper records must be stored appropriately to ensure they are protected from unauthorized access, theft, loss and damage. Once a record has passed the recommended retention period, it may be destroyed. For more information on record retention, see the chapter titled ***Medical Records: Definition, Retention and Completion***.

Record destruction must be complete enough to ensure that the information is no longer identifiable.

Management of paper records is paramount to ensure that the records are available and organized. If poorly managed, paper records may be lost, stolen, damaged, misplaced, misfiled and/or unorganized. An available and organized paper record aids the healthcare professional in accessing the most current patient information, as well as referencing previous information gathered, to aid in diagnosis and treatment of the patient.

Legibility

One of the most significant benefits of electronic medical records is their legibility. Handwritten records can be very difficult to read, which presents a patient safety risk if information is

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misinterpreted. Illegible records may also negatively affect reimbursement and the ability to provide a defense in medical malpractice cases and medical board complaints.

Corrections
To reduce the risk of a record tampering allegation, be sure to use clear and standardized processes for making corrections, addendums, late entries and amendments.

How Can I Reduce Risk?

Ensure Records are Available	
Store current records appropriately	• Store records on shelves located away from patient areas and exits. • Lock records when they are not in use. Ensure that shelving units in corridors and open vestibules and/or workstations have lockable drawers or doors. Open or compressed shelving may be used when records are stored in a room with a lockable door. • Position shelving so that records are several inches above the floor and 8-10 inches below the ceiling.
Control access	• Designate who in the practice may remove (pull) records from the filing area and who may re-shelve records. • Implement a filing system that includes signing records in and out. Ensure that records are filed promptly after completion. • Restrict authority to remove records from the facility. If records are needed at another location for patient care, transport the records using a lockable, fireproof box. Implement a mechanism to sign out the record from the office, develop policies that identify who may retrieve the record to return it to the appropriate office, and implement a tracking system to identify the location of the record.
Facilitate retrieval	• Maintain a single record for every patient. Keep records for family members separated; do not include children's medical records in the parents' record and do not include siblings in the same record.

Ensure Records are Available

- Identify medical records using external markings/stickers (for example, colors, letters and/or numbers). In larger practices, consider including a specific marker (such as color) to identify the assigned primary care provider.
- Distinguish the records of patients with the same name. Consider including a warning label on the exterior of the record to indicate that there are multiple patients with the same name. To further reduce the risk of same name errors, require staff members to use a second identifier, such as date of birth or middle initial, when pulling records and documenting or filing in them.

Store inactive and old records appropriately

- Recognize that paper records are susceptible to damage from moisture, rodents and insects. When placing boxed older/inactive records into storage:
  - Ensure that the storage area is environmentally controlled and clean;
  - Use caution when storing old records in basements, crawlspaces and attics;
  - Ensure that records stored off-site are readily retrievable when needed.

Reconstruct lost records

- Conduct a comprehensive search when records are missing and document the process.
- If the record cannot be found, implement your health information privacy breach protocol. For more information, see the chapter titled ***HIPAA Privacy***.
- Determine if the patient has medical record information that can be used to rebuild the record.
- Contact hospitals, diagnostic facilities and other providers to whom you referred the patient to request records. These facilities will likely require authorization from the patient prior to releasing protected health information.
- Include a notice in the reconstructed record indicating that the original record was lost and noting

Ensure Records are Available

the date the record was recreated, so that users will know the record may not be complete.

Salvage water and weather damaged records

- Handle water damaged medical records as little as possible. Recognize that the paper will not disintegrate if the record is not overly handled.
- Control mold growth:
  - Carefully separate pages and spread wet records out on absorbent material, such as paper towel;[1]
  - Reduce the temperature and humidity in the room where the records are stored. The ideal temperature is between 50 and 60 degrees F;
  - Use dehumidifiers to maintain humidity levels at 40 percent;
  - Use fans to keep air circulating.
- Use a professional document restoration service if a large quantity of records are involved and/or the records are densely packed. Implement restoration processes within 48 hours.
- Ensure that the document restoration service is performed in accordance with the HIPAA privacy rules for business associates. Require a business associate agreement.
- Notify your general liability/property insurance carrier and your medical professional liability carrier.

Destroy Records Appropriately

Check retention period prior to destruction

- Do not destroy records until they have reached the end of the required retention period. Regardless of destruction method:
  - Store documents in secure containers until they have been shredded or otherwise destroyed.
- Maintain a record destruction log and note which records were destroyed, when and by whom. Recognize that the log may be invaluable at a later

date to help determine if a record is "lost" or has been destroyed.

Utilize an appropriate destruction method

- The following methods are appropriate for destroying a medical record:
  - Crosscut shredder:
    - Use a cross cut shredder to decrease the risk that information on paper remnants can be associated with a patient identifier.
    - Ensure that the shredding occurs in a secure location and is done by individuals with whom the practice has a confidentiality agreement or a business associate agreement.
  - Document destruction service:
    - Require the company to provide a certificate of destruction.
    - Recognize the following:

      Under the HIPAA privacy rule (45 CFR, Parts 160 and 164), when destruction services are outsourced to a business associate the contract must provide that the business associate will establish the permitted and required uses and disclosures and include the following elements:
      - The method of destruction or disposal;
      - The time that will elapse between acquisition and destruction or disposal;
      - Safeguards against breaches;
      - Indemnification for the organization or provide for loss due to unauthorized disclosure;
      - Require the business associate to maintain liability insurance in specified amounts at all times.[2]
  - Burning:
    - Practice fire safety. Do not burn records in a container in an unventilated area. Have a

working fire extinguisher available. Obtain necessary permits/permission from the local fire authority.

- Reduce the chance of records blowing away during burning by controlling the amount of records added to the fire at any one time and ensuring that the fire container is wide enough and deep enough to prevent records being blown out be wind and updrafts.

Ensure Records are Comprehensible

Organize the contents

- Organize clinical information in chronological order by category. Place most frequently accessed categories, such as medication lists, problem lists and allergies near the top. Chronological categorization of paper records will facilitate future transition to electronic medical records.
- Categorize the medical record using tabs bearing the title of the section they introduce. Include, but do not limit sections, to:
  - Problem and medication lists;
  - Patient demographics;
  - Progress notes;
  - Preventive health and cancer screening records;
  - Laboratory and X-ray results;
  - Letters of consultation;
  - Hospital notes, discharge summaries and history and physicals.
- Bind the contents using tabs or a ring binder. Do not file records with loose pages, as they can easily be lost.
- Use self-adhesive notes sparingly. Avoid the notes becoming dislodged, misfiled and/or lost by affixing them to the record with staples or tape. Also ensure that the notes are dated, signed and treated as a formal entry in the medical record.

Require legibility

- Review records for legibility. Share identified problems with the provider, provide examples, and

Ensure Records are Comprehensible	
	discuss improvement strategies. Involve medical staff leaders when necessary. • Consider using alternatives, such as dictation and speech recognition software, if a provider is unable to write in a legible manner. Prohibit the use of correction fluid, scrap paper and sticky notes in records.
Enter corrections appropriately	• Use the **SLIDE** rule to identify incorrect information. ○ Draw a **S**ingle **L**ine through the incorrect information. ○ **I**nitial and **D**ate the correction. ○ **E**xplain the correction. • Do NOT use correction fluid or otherwise obliterate the original entry.
Use caution with late entries, addendums or amendments	• Establish guidelines for late entries: ○ Identify the entry as a late entry, an addendum, or any term that is appropriate under organization protocol (for example, "late entry"); ○ Note the time and date the late entry is being recorded; ○ Clarify to which note or part of the chart the late entry pertains, for example: ○ "1/7/15 late entry to 1/5/15 progress note. Patient also reported …"

References:

1. National Archives, "Preservation - What Should I Do with Wet Records?" n.d., http://www.archives.gov/preservation/holdings-maintenance/wet-records.html, 0215/2015.
2. AHIMA, "Retention and Destruction of Health Information," Updated August 2011, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_049252.hcsp?dDocName=bok1_049252, 02/25/2015.