SOP Template: Documentation and Medical Record Management

This SOP details the processes for **documentation and medical record management**, including accurate record keeping, secure storage, confidentiality protocols, data entry standards, regular audits, compliance with legal and regulatory requirements, and procedures for updating and retrieving medical information. The goal is to ensure the integrity, accessibility, and protection of medical records to support effective patient care and organizational accountability.

1. Purpose

To outline standardized procedures for the creation, maintenance, storage, retrieval, and protection of medical records within the organization.

2. Scope

This SOP applies to all personnel involved in the documentation and management of medical records, including healthcare providers, administrative staff, health records officers, and IT personnel.

3. Responsibilities

- **Healthcare Providers:** Ensure accurate, timely, and complete documentation of patient encounters.
- **Administrative Staff:** Organize and index records, assist in retrieval, and support compliance efforts.
- **Health Records Officers:** Oversee secure storage, records integrity, and release of information.
- **IT Personnel:** Maintain electronic medical record systems and ensure data security.

4. Procedure

4.1 Accurate Record Keeping

- Document all patient encounters, diagnostics, and treatments contemporaneously.
- Use organization-approved forms/electronic records with clear identification (patient name/ID, date, provider signature).
- Correct errors using approved amendment protocol; do not erase or use correction fluid.

4.2 Secure Storage

- Store records in locked files or password-protected electronic systems when not in use.
- Limit access to authorized personnel only.
- Back-up digital records daily and keep copies in a secure off-site location.

4.3 Confidentiality Protocols

- Follow all legal and organizational privacy guidelines (e.g., HIPAA where applicable).
- Never share patient information without proper consent or legal requirement.

4.4 Data Entry Standards

- Enter data legibly and accurately; for electronic records, use standard data entry fields and coding.
- Abbreviations must be organization-approved and understandable.

- Review entries before finalizing for completeness and correctness.

4.5 Regular Audits

- Conduct quarterly audits of random records for accuracy, compliance, and completeness.
- Document and correct deficiencies found during audits.

4.6 Compliance with Legal and Regulatory Requirements

- Maintain records according to retention schedules and destruction policies aligned with legal standards.
- Stay up to date with changes in relevant legislation and regulations.

4.7 Updating and Retrieving Medical Information

- Update records promptly after new information or changes.
- Retrieval requests must be logged and tracked. Validate the authority of requester before release.

5. Record Retention and Disposal

- Retain medical records for the period required by law or organization policy.
- Destroy records in a secure manner (shredding paper, permanent deletion for digital records) when retention period expires.

6. Training

- All staff must complete annual training on documentation standards, privacy, and security.
- New staff to be trained before gaining access to medical records systems.

7. Revision and Review

- This SOP will be reviewed annually and updated as necessary to reflect best practices and regulatory changes.
- All revisions must be documented and communicated to relevant staff.

SOP Title	Documentation and Medical Record Management
SOP Number	[To be assigned]
Version	1.0
Effective Date	[To be entered]
Review Date	[To be entered]
Approved By	[Name/Title]