SOP Template: Documentation and Prescription Filing Guidelines

This SOP provides clear **documentation and prescription filing guidelines** to ensure accurate, organized, and secure management of medical records and prescriptions. It includes procedures for proper documentation practices, prescription verification, filing systems, confidentiality protocols, and compliance with regulatory standards to maintain the integrity and accessibility of patient information.

1. Purpose

To establish standardized procedures for documenting, verifying, filing, and protecting medical records and prescriptions in compliance with legal and regulatory requirements.

2. Scope

Applicable to all staff involved in documenting patient care, handling prescriptions, and managing medical records within the facility.

3. Responsibilities

- **Healthcare Providers:** Ensure accurate and timely documentation of all patient interactions and prescriptions.
- **Pharmacists:** Verify and file all prescriptions as per protocol.
- **Medical Records Staff:** Maintain filing systems and enforce confidentiality protocols.
- **Supervisors/Managers:** Monitor compliance and provide training as necessary.

4. Procedure

4.1 Documentation Practices

- Record all patient interactions, diagnoses, treatments, and prescription details promptly and accurately.
- Use approved abbreviations and terminology only.
- Include date, time, and signatures/initials with each entry.
- Correct errors with a single line, initial, and date. Do not use correction fluid or remove original entries.

4.2 Prescription Verification

1. Confirm patient identity and prescription authenticity before processing.
2. Check for completeness: patient details, medication name, dosage, frequency, route, prescriber details, and signature.
3. Contact the prescriber for clarification if information is incomplete or unclear.
4. Document any amendments or clarifications obtained.

4.3 Filing System

- File prescriptions and medical records in chronological or alphabetical order as per facility policy.
- Use designated folders or electronic files with restricted access.
- Label all files clearly for easy identification and retrieval.
- Archive inactive or expired records according to retention schedules.

4.4 Confidentiality Protocols

- Ensure only authorized personnel have access to medical records and prescriptions.
- Store physical records in locked cabinets; implement password-protected electronic systems.
- Do not disclose patient information without written consent unless required by law.

4.5 Regulatory Compliance

- Maintain compliance with local, regional, and national regulations (e.g., HIPAA, GDPR).
- Conduct regular audits to ensure adherence to this SOP.
- Report any breaches or non-compliance to supervisory staff immediately.

5. Record Retention

Retain documentation and prescription records for the period specified by applicable regulations and facility policy (typically 5-10 years). Securely destroy expired records according to approved methods.

6. Training

- All staff must receive initial and periodic training on documentation standards, record management, and patient confidentiality.
- Document all training sessions and attendance.

7. Revision and Approval

Revision Date	Description of Changes	Approved By	Signature
YYYY-MM-DD	Initial release	_____	_____

8. References

- Relevant laws and regulations (e.g., HIPAA, GDPR)
- Facility policies and procedures
- Professional practice guidelines