

# CHAPTER 8

## Unit Health Record: Multi-Volume Records

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### I. POLICY

Patient health-related information shall be readily available at all times. Procedures shall be implemented to ensure the easy management of patient information. The Health Record Services (HRS) staff shall maintain the integrity of a UHR for each patient and ensure that records are easily manageable. Bulky material no longer needed to support the current treatment plan shall be purged/cleared from the active folder and placed in another volume. UHRs shall be separated into volumes when they reach a thickness of four and one-half inches. Health record staff shall clearly identify that a record has been purged of inactive information and placed in another volume. All volumes shall be labeled, using the multi-volume chart label.

UHRs noted to be purged shall not be retrieved unless specifically requested by the health care provider. All active records, and other volumes shall be retrieved for medicolegal purposes and for access by outside reviewers.

Health records shall be maintained in the UHR system. The UHR system shall provide for the maintenance of a single patient's bulky record in separate volumes, which has become unmanageable. The separate volumes shall be cross-referenced and maintained in the unit record filing space so that information is readily available to users of the record. UHRs shall be maintained in a format to assist health care providers to document treatment, care, and services provided to patients. Record organization shall provide for prompt retrieval of patient health-related information. The purging, or clearance of inactive bulky material from the UHR, and the placement of this information in another volume, shall provide records that are easily manageable.

### II. PROCEDURE

A. Health record staff shall:

1. Purge the record when:
  - a) Health care staff recognizes the need for purging the record.
  - b) The record exceeds 4 1/2 inches (thickness).
2. Separate or purge inactive material by "year" if possible; however, information needed to support the current treatment plan shall not be separated from the active record.
  - a) A UHR may have activity that requires purging of information more frequently (than yearly); however, the same principle shall apply: information needed to support the current treatment plan shall not be purged from the active record.

**B. Volume by Year:**

1. Select the date that will be used to separate portions of the active folder into the other volume, for example, December 31, 1994.
2. Purge all sections of the records using this date except, **DO NOT REMOVE**:
  - a) Most recent history and physical examination.
  - b) Most recent psychiatric evaluations.
  - c) Consents (treatment, medications, special) applicable to current treatment plan.
  - d) Results of HIV testing.
  - e) Results of tuberculosis testing.
  - f) Tuberculosis chronos.
  - g) Most recent dental information.
3. Retrieve from the UHR filing system all previously prepared volumes.
4. Incorporate all purged sections into the new volume using the policy, "Unit Health Record Organization of Contents" .
5. Prepare the new volume(s):
  - a) Label the folder with the specific patient identifiers (first and last name, CDC number, and date of birth).
  - b) Label the folder with the volume number(s).
  - c) Insert an instructional sheet into the folder(s) stating that it is a "closed" volume. Include instructions that no further information is to be included in this volume without the express authorization of the HRS Supervisor.
  - d) Place the volume label on the outside of each volume of the record. Place the label on the lower right side of the folder, opposite the "allergies" square.
  - e) Place a notice in the inactive record stating that the record is inactive and that material should only be filed in the current file.

**C. Volume Inpatient Section:**

1. Select the copies of the inpatient stay episodes that are to be separated from the active UHR.
2. Remove these sections from the active UHR and place them into the new volume in the inpatient section.
3. Insert within the active inpatient section the inpatient summary log, CDC Form 7297, "Inpatient Reference Sheet," reflecting all CDC inpatient admissions.
4. File all volumes of the UHR in the filing space designated for that specific CDC number.
5. Retrieve only the most current volume of an patient's record when required for accessing patient health care service. Notify the requester of additional volumes of the record.
6. Retrieve additional volumes when specifically requested to do so or when the request is for the patient's complete record.