# NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES POLICY AND PROCEDURE

SUBJECT: CHART ORDER AND THINNING

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ORIGINAL DATE: 02/23/89

REVIEW/REVISE DATE: 01/09/91, 07/01/95, 09/15/95, 11/12/98, 10/12/00, 01/08/04,

08/07/08, 8/18/11

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APPROVAL:	Allan Mandell ,Interim Agency Director

## I. PURPOSE

The purpose of this policy is to standardize the order of documents in Northern Nevada Adult Mental Health Services (NNAMHS) medical records and standardize the thinning of records to facilitate easy access to documents used in the medical record.

#### II. POLICY

Specific documents may be thinned from the medical record as listed in this policy.

## III. REFERENCES

- Mental Health Facilities Rules and Regulations 10-22-71 (NAC 10-27-82 Chapter 449).
- 2. Conditions and Participation Part 482, (Federal Register V51, #116, 6-17-86)
- Joint Commission for Accreditation of Hospital Organizations, IM 2 through IM
   3. Joint Commission for Accreditation of Hospital Organizations, IM 2 through IM
   2.3; IM 5 through IM 5.1
- 4. H.I.S. Procedure

#### IV. PROCEDURE

- ALLERGY STICKERS: Open inpatient records will have this sticker on the front of the record and in the clear divider at front of record. All closed records and open outpatient records will have the allergy sticker on the front of the record.
- 2. NAME ALERT STICKER: Open inpatient records will have this on the spine of the binder. All other records will be labeled on the front of the record.
- ADVANCED DIRECTIVES: Open inpatient records will have this on the spine of the binder. All other records will be labeled on the front of the record.
- 4. RESTRICTED PHI: All records will have this on the front of the chart, if applicable.
- 5. GUARDIANSHIP: All records will have "consumer has guardian" written in RED at the top of the face sheet (MR 100).
- OPEN/ACTIVE INPATIENT RECORDS: The record is divided into ten sections
  and stored in a three-ring binder specifically obtained for this purpose. Unless
  otherwise indicated below, data is chronologically arranged with the most
  recent on top.
  - a. Front of chart
    - i MR 100 Admission Face Sheet
    - ii MR 100 Data sheets
    - iii MR 181 Consumer Identification Photograph
    - iv. Discharge packet for business office (Blank)
    - v MR 164 Personal Medication Account
  - b. Progress Notes
  - c. Physician Orders
  - d. Assessments

- e. Lab and X-ray (filed in date order, not by type of report.
- f. Treatment Plan
- g. Seclusion and Restraint/Vitals/ Medications
- h. Consents/Legal's
- i. Correspondence
- j. Miscellaneous
- CLOSED INPATIENT RECORDS Each section is in chronological order, oldest on top, most recent on bottom. When closed, the records are stored in manila folders.
  - a. Requirements for Death Charts
    - i. Death Certificate or Coroner's Report
    - ii. Autopsy (if applicable)
    - iii. Disposition of Body Certificate of Removal
  - b. Front of Chart
    - i. MR 100 Admission Face Sheet
    - ii. Discharge Data Sheet
    - iii. MR 181 Consumer Identification Photograph
  - c. Discharge Summary
  - d. Assessment

- e. Orders
- f. Plans
- g. Progress Notes
- h. Lab/X-ray (in date order)
- i. Medications
- j. TAB Graphics/Vitals
- k. TAB Consents/Legals
- I. TAB Miscellaneous
- OPEN/ACTIVE OUTPATIENT RECORD The record is divided into sections and stored in blue file folders. Data is chronologically arranged with the most recent on top.
  - a. Front of Chart
    - i. MR 100 Admission Form
    - ii. MR 103 Clinical Data Sheet
  - b. Physician's Orders/Progress Notes
  - c. Progress Notes
  - d. Treatment Plan
  - e. Assessments
  - f. Lab/X-ray
  - g. Consents/Legal's
  - h. Miscellaneous
- 10. OPEN/ACTIVE Psychiatric Observation Unit RECORDS
  - a. Front of Chart
    - i. MR 100 Admission Face Sheet
    - ii. Discharge Data Sheet
    - iii. MR 181 Consumer Identification Photograph

- b. Progress Notes
- c. Physician's Orders
- d. Assessments
- e. Lab/x-ray
- f. Treatment Plan
- g. Seclusion and Restrains/Vitals
- h. Consents/Legal's
- i. Miscellaneous

# 12. Thinning Records

- a. Inpatient and Outpatient Records Records may be thinned as necessary to accommodate the three-ring binders (Inpatient) or folders (Outpatient). If needed, thin the following:
  - MR 202 Needs/Readiness Assessment Scores, thin all but three months.
  - ii. Doctor's Orders and APN notes/orders, all but last 4 months inpatient, all but past 12 months outpatient
  - iii. Progress Notes, thin all but two months
  - iv. All but last three treatment plans
  - Lab reports, thin all but two months inpatient, all but past year outpatient
  - vi. Medication/PRN sheets, thin all but two months
  - vii. Vital Signs, thin all but two months, none in outpatient
  - viii. High Risk Precaution, thin all but one month (inpatient and POU only)
  - ix. Therapeutic Pass, thin all but one week
  - x. Activity Participation, thin all but last four pages.

xi. Note: Seclusion and Restraint to be thinned all but one month

## 13. DO NOT THIN:

- a. Face sheet/data sheets.
- b. Discharge Summary
- c. Physical Examination
- d. Psychiatric Evaluation
- e. Nutrition Assessment
- f. Outpatient Injection Record
- g. Treatment Plans Last three
- h. Legal papers
- i. Consent for Medications
- j HIV results
- k. Psychological Assessment
- I. Psychosocial Assessment
- m. Medication Clinic Vital Sign Sheet
- n. Medication Reconciliation