

SUBJECT: CLINICAL RECORDS RETENTION

EFFECTIVE

DATE: 04-07-10 (replaces 09-16-09)

APPROVED BY:

Reviewed (no changes): 05-13-11 _____

Executive Director

POLICY

It is the policy of McIntosh Trail CSB that the consumers' clinical records are kept alphabetically in separate files (i.e., adults and children & adolescents). Additionally, the consumers' clinical records should be kept alphabetically in separate files (i.e., adults and children & adolescents) according to the year the clinical records were closed. The clinical records will be maintained in accordance with the applicable State of Georgia statutes and destroyed with the state's current Records Retention Schedule.

PROCEDURE

When the jacket of the current consumer's chart has reached or nears its maximum capacity for holding Protected Health Information (PHI), this is the point to begin another volume. For McIntosh Trail, the term **thinning** will hereafter refer to "the process of starting a new volume of the consumer's clinical record for the purposes of holding PHI".

1. Thinning Process:

Once the current chart has been determined to be adequately filled for safe-holding of PHI, then the new volume will be implemented. To implement the new volume, one should obtain a jacket similar as the original record and place all necessary identifying information as would be required for any clinical record to be opened. The phrasing of what volume the record is and the number of total records should be written in large print on the front of the jacket. For example, "Volume I of III" will indicate that there are three clinical records opened for this consumer and this is the first volume of three clinical records. (The numbers will be written in Roman Numerals.) Therefore, the other two clinical records will have "Volume II of III" and "Volume III of III" respectively written on the front of each record jacket. This will denote clearly how many volumes (records) there are and the order in which they are to view for identifying and/or locating historical information.

The clinical record that has reached its capacity should have a completed memorandum (located in FormDocs titled **Notice of Additional Volume**) placed at the very top on both the left and right sides of the chart. No form shall be entered into this record prior to the date listed on the Notice of Additional Volume form. Whenever the record is opened for viewing, the first form on either side should be the Notice of Additional Volume forms. The Medical Records Clerk, or whoever is adding an additional volume to the record with regards to placement of additional information, should print and sign the note.

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PROCEDURE (Continued)

2. Establishing the New Volume:

After the jacket for the new volume has been prepared as outlined, proceed to make copies of the following forms for placement into the new jacket. Once an applicable form has been placed into a clinical record, it is considered a part of the official record. The tampering or removal of applicable forms within the official record is strictly prohibited.

In the establishment of a new clinical record, only copies from the previous record and any original forms received as of or after the establishment of the new record will be placed within until an additional volume has been established or the record closed. Therefore, only a copy of the most current forms will be copied from the previous clinical record and placed into the new volume. They are:

- Admission Form (MH, AD, DD)
- Initial Biopsychosocial Assessment and Biopsychosocial Assessment Update
- Medication Reconciliation
- Medication Administration/Laboratory
- Medication/Prescription Record
- Physician Note (x3 months)
- Service Request (i.e., MICP, OTR, TRF, etc.) to include the treatment plan
- Supervised/Assisted Self-Administration Medication Record
- Aims
- Medical Consent Form

Write the word "**COPY**" in large print using a red marker or pen at the bottom of each copied form. These copies are for quick historical reference to minimize the provider from having to review multiple charts of the consumer. If the copy has room for additional entries, draw a diagonal line from left to right indicating no further entries. Utilize the applicable blank form (from FormDocs) to begin documentation within the chart. The sites designated as the Single Official Record (SOR) will maintain all active clinical records within the facility; however, the older volume(s) not being used frequently may be stored separately from the current volume, but within the facility. After one year of inactivity, or when the consumer ceases receiving services from the agency, the entire chart (plus additional volumes) will be closed and annotated as such within the M&M system.

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PROCEDURE (Continued)

3. Destruction Process:

The destruction process is implemented in accordance with the current State of Georgia Record Retention Schedule. The agency's Medical Records Manager will establish a set timeframe annually or utilize his/her discretion to destroy clinical charts in accordance with the current state Records Retention Schedule. In the event of any known legal proceedings that may involve the consumer's chart which is scheduled for destruction will be withheld until the final disposition of the legal proceeding. Each site will separate the closed clinical records for destruction apart from those that are not eligible, compile a list, and ensure the clinical records are properly closed within the agency's electronic software to reflect the closure and destruction of the consumers' clinical records. A copy of the list will be provided electronically to the Medical Records Manager to ensure compliance.

Once the clinical records have been separated for destruction, they will be placed into boxes. The sites must submit the number of boxes, the dimensions (Length x Width x Height), and number of clinical records (per year) for destruction to the Medical Records Manager. The Medical Records Manager will identify a company to facilitate the clinical records destruction in accordance with the applicable and current State of Georgia Record Retention Schedule. The company chosen must be in good standings with all applicable governing bodies that oversee the standards for records destruction. Once the clinical records have been retrieved for destruction and/or destroyed on site by the company, the site director or designee will submit a memorandum as outlined in the attachment.

INTEROFFICE MEMO

Date: mm/dd/yyyy
To: Medical Records Manager
Cc: Office Manager
From: Center Director, Site Name (Location Code)
Re: MEDICAL CHART DESTRUCTION

This memorandum implies that a thorough inventory of closed consumers' charts was conducted on (date). The consumers' charts were closed due to the member's extended discontinuance of services, permanently relocated out of the service area, and/or death. An electronic inventory file of the closed consumers' charts has been forwarded to the Medical Records Manager and the original will be kept on file at the site. Within the file, the inventory list is separated and grouped according to the closing year of the charts. The charts listed were collected for destruction and/or destroyed on site by (name of company) on (date). The chart destruction process was conducted in accordance with the (example: **Client Medical Records, Alcohol and Drug Abuse Client/Outpatient Case Files** (Schedule Number 12-001, Effective October 4, 2005) retention schedule.

The following is the statistical data concerning the destruction of charts:

- Total number of charts (#)
- {list the year(s) and number of charts per year}
- Dimension of box(es) (length x width x height)
- Total number of boxes (#)

A copy of this memorandum, applicable retention schedule, printed listing of inventoried charts for destruction, and all other documentation surrounding the handling of the charts will be maintained on site for future reference.

(Signature)

Center Director