Medical Record Thinning Guidelines Cheat Sheet

by [deleted] via cheatography.com/2754/cs/14749/

Introduction

Common Chart Forms – The chart forms and location are not meant to represent a recommended chart order or forms. Chart order and the types of forms used are facility-specific. The forms named represent common types of documentation found in a long term care record.
Thinning Guidelines – These guidelines are recommendations and provide a baseline. Each facility should adapt and develop thinning guidelines that meet the needs of their resident population and staff needs.

Source: http://bok.ahima.org/Pages/Long%20Term%20Care%20-Guidelines%20TOC/Practice%20Guidelines/Maintenance

Identification and Admission Documentation

Chart Form	Guidelines
Admission Record/Facesheet	Current Facesheet
Pre-admission Screening (PASARR)	Most Current
Preadmission Assessment/Intake	3 months after admission
Admission Agreement (new agreement not required on readmission after temporary discharge with return anticipated)	Financial/Administrative file
Admission Consent	Permanent

History / Physical / Hospital Records

Chart Form	Guidelines
H&P	Most Current
Hospital Discharge Summary	Most Current
Hospital Transfer Form	Last Hospital Stay
Other Hospital Records (All hospital records received should be retained as part of the facility clinical record)	Retain pertinent records for 1 month after hospitalization & then thin
Immunization Records	Permanent

Advance Directives/Legal Documents

Chart Form	Guidelines
CPR Directive	Most Current
DNR Order from physician	Most Current
Resident Self Determination Act Acknowledgement	Most Current
Living will	Most Current
Advance Directive	Most Current
Durable Power of Attorney	Most Current
Guardianship/Conservator	Most Current
Legal incapacitation	Most Current
Consents, Acknowledgements (For example, Physical Restraints Consent, Admission Consents, Consent to Treat, Consent to Photograph, MDS Consent, MDS Acknowledgement, Release of Information Consent, Release of Responsibility/Leave of Absence)	Most Current

Rehab Nursing

Chart Form	Guidelines
Rehab Screen	Most Recent
Rehab Nursing Assessment	Most Recent
Progress Notes/Treatment Records	3 months

Activities (Therapeutic Recreation)

Chart Form	Guidelines
Progress notes	6 months to 1 year
Assessments	Most Recent

Dietary (Nutrition Services)

Chart Form	Guidelines
Progress notes	6 months to 1 year
Assessments	Most Recent

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Social Service

Chart Form	Guidelines
History	Permanent
Progress notes	6 months to 1 year
Assessments	Most Recent

Clinical Assessments

Chart Form	Guidelines
Nursing Assessment	6 months to 1 year
Wound and Skin Assessments	6 months to 1 year
Fall Assessment	6 months to 1 year
Bowel and Bladder Assessment	6 months to 1 year
Pain Assessment	6 months to 1 year
Mini-Mental/Cognitive Exam	6 months to 1 year
Restraint Assessment	6 months to 1 year

(At a minimum, retain most recent assessment plus one previous)

Minimum Data Set and Care Plan

Chart Form	Guidelines
MDS	15 months readily available
Care plan	Current plan
Specialty Care Plans ie: hospice/dialysis	Current plan
Care Plan Signature Records	Current plan
Care plan recap (if used)	Current plan

Physicians Orders

Chart Form	Guidelines
Monthly Recaps or Renewals	3 months
Telephone Orders	3 months
Interim orders	3 months
Protocols or Standing Order Policies (if used)	Current
Fax Orders	3 months

Physician & Professional Progress Notes/Consults

Chart Form	Guidelines
Physician Progress Notes	1 year
Cumulative Problem/Diagnosis List	Most recent
Annual Exams	Most recent
Other specialists/consultation	1 year
Dental Progress Notes/Exams	1 year
Podiatry Progress Notes/Exams	1 year
Psychological Evaluation	Current

Nursing Notes/Interdisciplinary Notes

Chart Form	Guidelines
Nursing Notes	3 months
Interdisciplinary Notes	6 months
Nursing Summary Forms/Flowsheets	3 months

Medication, Treatment and Other Flowsheets

Chart Form	Guidelines
Monthly Medication & Treatment Records	
Vitals Sign Record	1 year
Weights Record	1 year
Intake and Output Records	3 months
Behavior Monitoring Records	3 months
Other Flow Sheets (Diabetic site rotation, etc)	3 months
Pharmacist/Drug Reviews Recommendations	1 year

Lab, X Rays, and Special Reports

Chart Form	Guidelines
Lab Reports (frequently ordered)	3 months
Annual or interim Lab Reports	1 year
X-Ray Reports	1 year
Special Diagnostic Tests	1 year

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Rehabilitative Therapy (PT, OT, SLP)

Chart Form	Guidelines
Therapy Evaluation	Most Recent
Therapy Certification/Recertification	3 months
Progress Notes	3 months
Discharge Summary	Most Recent
Therapy Screen	Most Recent

*Once therapy is discontinued thin therapy information for that discipline except the evaluation and discharge summary.

HIPAA Documents

Chart Form	Guidelines
HIPAA Requests	Most Current
Accounting of Disclosures (if applicable)	Most Current
Requests for Amendment	Most Current
Requests for Alternative Communication	Most Current
Requests for Restriction of Access to PHI	Most Current
HIPAA Complaints	Most Current
Request to Opt Out of NPP practices	Most Current
Authorization to Use and/or Disclose Protected Health Information	Most Current

Miscellaneous/Legal

Chart Form	Guidelines
Clothing list or Inventory List (If required)	Most Current

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