CHART ASSEMBLY OF ACTIVE MEDICAL RECORDS

POLICY STATEMENT.

The Division of Veterans Healthcare Services (DVHS) requires that each of the New Jersey Veterans Memorial Homes (VMH) establishes a uniform Medical Record, assuring all forms and documents are arranged in a consistent manner throughout the VMH facility.

PURPOSE.

This policy and procedure serves to ensure that each of the New Jersey Veterans Memorial Homes implements a medical records filing and chart assembly system that ensures all forms and documents within the Medical Record are systematically organized and readily available in accordance with N.J.A.C. 8:39-35.2 forms retention requirements.

PROCEDURE.

A. The Medical Record shall be divided into sections with the indicated forms that follow filed behind each section.

Top Sections	Binder--Resident I.D. picture in inside pocket. Admitting Record
Admission Records	Nursing History and Evaluation Nutritional Assessment Form Recreation Initial Interview Form Ombudsman Release Form
History and Physical	Current Physical Original Physical (done on Admission) Medical Plan of Care Re-certification and Review of Plan Care Abnormal Involuntary Movement Scale (AIMS) Folstein Mini-Mental Exam (as needed) Medication Consent Form
Physician's Orders	Physician Order Sheets (ensure any written carbon copies are sent to Pharmacy)
Physician Progress Notes	Physician Progress Notes Primary Physician 30-Day Assessment and Medical Plan of Care (POC) Dietary Progress Notes Dietary Communication Slips Activities Progress Notes
Interdisciplinary Team Notes	Interdisciplinary Team Progress Notes

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Nurse's Progress Notes	On-going Nurse's Notes relative to affairs of patient care (including Nursing Summaries) Assessment of Decubitis Ulcer Potential Assessment of Bowel and Bladder Training Assessment for Restorative Nursing Care Care Record and Restraint Check Records
Vital Signs	Clinical Chart Vital Sign Flow Sheet Intake and Output Record Seizure Record
Medication and Treatment	Medication and Treatment Records Insulin Control Sheets Release of Pass Medications
Lab and Special Reports	Lab, X-Ray, EKG slips/reports Immunization Record
Rehabilitation and Therapy	Physical Therapy Reports Occupational Therapy Reports Speech and Audiology Reports
Consultations	Consulting Pharmacist Flow Sheet Miscellaneous Consultant Reports Psychiatric Reports Dental Reports Podiatric Reports
Social Service	Social Service Records
Miscellaneous	Electrical Appliance Safety Check Receiving and Inventory Report Sign Out Sheets for Residents Inter-Disciplinary Behavior Log Activities Attendance Record Consent, Authorization and Release Forms Release of Responsibility for Leave of Absence Transfer Forms Clothing Inventory

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Care Plans	Health Care Plans (Nursing, Activities, Social Services, Dietary, Physical Therapy and Occupational Therapy) Case Conference Attendance Roster Resident Biographical Data Form Case Conference Evaluation Form

1. Known allergies and sensitivities must be written on a label on the chart cover.

2. Provide a note in back of chart indicating when, who, and where purged portions of the chart can be located.

B. Upon the admission of a resident, the Medical Record will be organized in the following format: (*) denotes if applicable to the resident.

LOCATION/TAB	RETENTION TIME
ADVANCE DIRECTIVE/ LIVING WILL/ POA	**PERMANENT**
1. ADMISSION RECORDS	
Admission/Discharge Record	**PERMANENT**
*Admission Information Face Sheet	**PERMANENT**
Discharge Planning (admits prior to 07/2003)	**PERMANENT**
Medical Information or 10-10 Forms	**PERMANENT**
Restrain Use Policy	**PERMANENT**
Privacy Act – Health Care Records	**PERMANENT**
VA Consent for Medical Records Release (VA10-5345)	**PERMANENT**
Medical Consent for Treatment/Admission	**PERMANENT**
Health Insurance Information (copy of insurance cards)	**PERMANENT**
Consent to be Photographed	**PERMANENT**
Resident Certification Sheet	**PERMANENT**
Barber/Hairdresser Consent Form	**PERMANENT**
Ombudsman Release Form	**PERMANENT**
2. HISTORY/PHYSICAL	
Comprehensive Medical Exam (admission)	**PERMANENT**
Comprehensive Medical Exam (yearly)	**ONE YEAR**
Medical Plan of Care	**PERMANENT**
3. PHYSICIAN'S ORDERS	
Physician's Orders – (white pre-printed and yellow sheets for the same month filed together)	**THREE MONTHS**

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4. **INTER-DISCIPLINARY PROGRESS NOTES**

Medical Update	**PERMANENT**
AIMS Report	**MOST CURRENT**
Vaccine Consent	**PERMANENT**
Admission Inter-Disciplinary Progress Note (Nursing)	**PERMANENT**
Inter-Disciplinary Progress Notes	**THREE MONTHS**

5. VITAL SIGNS

Neuro Check Sheet	**THREE MONTHS**
Vital Signs/Pain Intensity Scale	**SIX MONTHS**

6. NURSES NOTES

Resident Summary	**SIX MONTHS**
CNA Care Sheet	**SIX MONTHS**
Diabetic Control Sheet	**THREE MONTHS**
Intake/Output Record	**ONE MONTHS**
*Bowel/Bladder Log – 7-days on admission 5-days on return from external transfer	**FIFTEEN MONTHS**
*Bowel/Bladder Log Management Plan	**FIFTEEN MONTHS**
Pressure Ulcer Record	**SIX MONTHS**
Daily Pressure Ulcer Log	**SIX MONTHS**
Stasis Ulcer Record	**SIX MONTHS**
Skin/Wound Log	**SIX MONTHS**
Orthopedic Check Sheet	**THREE MONTHS**
Physical Restraint Committee Review	**THREE MONTHS**
Physical Restrain Record	**THREE MONTHS**

7. CARE PLANS

MDS Admission Face sheet	**FIFTEEN MONTHS**
Minimum Data Set (MDS)	**FIFTEEN MONTHS**
RAP Modules	**FIFTEEN MONTHS**
Pain Assessment	**FIFTEEN MONTHS**
Braden Scale	**FIFTEEN MONTHS**
Risk for Falls Assessment	**FIFTEEN MONTHS**
Incontinence Review Sheet	**FIFTEEN MONTHS**
Quarterly Assessment	**FIFTEEN MONTHS**
Resident Status Sheet	**FIFTEEN MONTHS**
Inter-disciplinary Note	**FIFTEEN MONTHS**
MDS Tracking Form	**FIFTEEN MONTHS**
Inter-disciplinary Care Plans	**FIFTEEN MONTHS**
Nursing Assessment (admission, 3 pages)	**PERMANENT**

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8. MEDICATION/TREATMENTS

Drug Regimen Review Record	**ONE YEAR**
*Psychotropic Consent Form	**PERMANENT**
*Psychotropic Medication Reduction Program Report	**ONE YEAR**
Licensed Personnel Signature Sheet	**PERMANENT**
*Psychotropic Monitoring Sheet	**THREE MONTHS**
*Pain Intensity Flow Sheet	**THREE MONTHS**
Medication Administration Sheets	**THREE MONTHS**
Treatment Administration Sheets	**THREE MONTHS**

NOTE: Psychotropic Monitoring and Pain Intensity Flow Sheets will be filed in this order with the corresponding MAR/TAR for that month.

9. LAB AND SPECIAL REPORTS

Admission Labs	**PERMANENT**
Yearly Labs	**ONE YEAR**
Semi-Annual Labs	**SIX MONTHS**
*Monthly Labs	**SIX MONTHS**
*Weekly Labs	**SIX MONTHS**

10. EKGS

Admission EKG	**PERMANENT**
EKG Reports (minimum of two regardless of date)	**ONE YEAR**
*Pacemaker Reports	**ONE YEAR**
*Cardiac Echo	**ONE YEAR**
*Cardiac Ultrasound	**ONE YEAR**

11. X-RAYS

Admission Chest X-Ray	**PERMANENT**
Chest X-Ray (minimum of two regardless of date)	**ONE YEAR**
*Video Swallow	**ONE YEAR**
*Colonoscopy, EGD	**ONE YEAR**
*All other Ultra Sound Exams other than Cardiac	**ONE YEAR**

12. REHABILITATION AND THERAPY

*Rehabilitation Consent Form	**PERMANENT**
*Plan of Treatment (HCFA700)	**PERMANENT**
*Updated Plan of Care – Re-certification (HCFA 701)	**ONE YEAR**
*Weekly Progress Notes - Physical Therapy	**SIX MONTHS**
*Weekly Progress Notes – Occupational Therapy	**SIX MONTHS**
*Interdisciplinary Therapy Screening Form	**ONE YEAR**
*DRT Daily Report	**SIX MONTHS**

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13. RECREATIONAL THERAPY

Activities Admission Assessment	**PERMANENT**
*Activities Re-Assessment	**TWO YEARS**

14. CONSULTS

*Consults other than Dental, Podiatry, Eye, Ear	**ONE YEAR**
Dental Consults	**SIX MONTHS**
Podiatry Consults	**SIX MONTHS**
Ophthalmology Consults	**SIX MONTHS**
Audiology Consults	**SIX MONTHS**

15. SOCIAL SERVICES

Admission Psychosocial Assessment	**PERMANENT**
Social Service Referrals	**THREE MONTHS**
Admission Mandatory Rights	**PERMANENT**
Mandatory Rights Update	**MOST RECENT**
*Referral to Special Needs Unit	**PERMANENT**

16. DIETARY

Admission Nutritional Assessment	**PERMANENT**
Nutritional Assessment	**ONE YEAR**

17. *HOSPICE

All Admission Paperwork other than Interdisciplinary Progress Notes	**PERMANENT**

18. MISCELLANEOUS

Hospital Discharge Information	**MOST RECENT**
Clothing Inventory	**PERMANENT**
*Certificate of Responsibility	**ONE MONTH**
Resident Transfer Form (original admission)	**PERMANENT**
*Transfer Sheet – Internal	**SIX MONTHS**
*Transfer Sheet – External	**SIX MONTHS**
*Correspondence	**SIX MONTHS**

***NOTE: When thinning the Medical Record, the current month is NOT included in the time frame mentioned. For example, Physician Orders are to be retained in the Medical Record for a period of three months and thus if the present month is April, you would keep March, February and January on the open record. December and back would be thinned from the Medical Record and placed in the over-flow file.**