COBB COUNTY COMMUNITY SERVICES BOARD
DOUGLAS COUNTY COMMUNITY SERVICES BOARD

Policy # 5033	Purging/Thinning Paper Medical/Clinical Record
Origination Date: February 1998	
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Approved: Bryan G. Stephens Interim Executive Director	Jamie Allison, Chief Quality Officer

POLICY:

It is the policy of Cobb County Community Services Board and Douglas County Community Services Board to thin/purge active paper medical/clinical records of clients to provide filing space for the most recent client information. The active medical/clinical record folder will be labeled to alert users that additional information is on file in the purged chart section of the record room.

PROCEDURE:

Medical/clinical record support staff or designee:

1. Makes a **purged** folder for the thinned record documents.
2. Labels the purged folder the same as the active record folder.
3. Purges **active** record of documents not currently needed to provide treatment following the "Guidelines for Purging/Thinning Open Medical/Clinical Records" (Attachment A).
4. Places documents in purged folder in the same order as in the active folder.
5. Writes in pencil a "P" and the date of the purge in the space on the purged folder where the year label will be placed when the chart is closed.
6. Files purged record in alphabetical order in the purged chart area at site's record room.
7. Writes on the **active** folder in pencil a "P" and the date of the purge in the space on the folder where the year label will be placed when the chart is closed.
8. Circles appropriate number and Roman numeral on front of chart to identify the volume and number of charts, i.e., 1 of II, 2 of II. Update the number and Roman numeral on each chart as additional volumes are added
9. Files active folder on active shelf in alphabetical order.
10. Upon discharge, merges the client's active and purged folders and follows chart closing procedure. If the individual file volumes are too large to be merged into one chart volume, the active and purged charts are placed together with a rubber band in volume order. A year label is placed on all of the volumes. All of the volumes are then moved to the closed files area of the record room.

Guidelines For Purging/Thinning Open Medical/Clinical Records

RETAIN THE FOLLOWING DOCUMENTS IN THE MEDICAL/CLINICAL RECORD

Consent forms (Most current of each type of consent form) For DD – Keep the three most recent in the current chart

Screening Assessment

Admission Assessment

Nursing Assessment (Last Update) For DD - Keep all assessments

Psychiatric Assessment/Physician Assessment

History and Physical (Last Update) For DD – three most recent years of the annual physical

Mental Status Examination (Last Update)

Substance Abuse Assessment

Consultations (Until completed and reviewed)

Treatment Plans (Last Update) For DD = three years of ISPs (Individual Service Plans)

Physician Orders

Medication Administration Records (Last Year)

Progress Notes (Last two months)

Day Treatment Progress Notes (Last two months)

Program Event Ticket Progress Notes (Last two months)

Records from another facility (Purge after review completed by staff)

Lab(s)

Correspondence to and from other agencies (Purge when not needed for treatment)

Any electronic medical/clinical record document that does not require a signature is not placed in the purged folder.