SECTION: NURSING SERVICES

POLICY #:406 CLIENT RECORDS

POLICY: All individuals seen at Central Valley Health District will have an individual client record in the Centricity Electronic Medical Record System (EMR) for documentation of services performed.

PROCEDURE:

1. Front desk or nursing staff will initiate a client record at the time of initial visit.
    - Client will complete a Client Intake form (Demographic form).
    - This signed document will be entered into the Centricity Electronic Medical Record (EMR).
    - Client intake form and contact information will be updated annually.
2. Secretarial staff will review charts yearly to update contact and demographic information. Nursing staff will also review client risk assessment and history with each contact for services.
3. Record Retention:
    a. Client's electronic medical records are kept indefinitely. Records are backed up nightly.
    b. TB cards are always retained and are not destroyed.
    c. Immunization records are always retained and are not destroyed.
    d. Community screening forms are kept in a folder and retained for 7 years from date of screening.
4. Storage of client records:
    a. Client computerized records are kept indefinitely. Records are backed up nightly.
    b. Immunization records are recorded in NDIIS and in the clients EMR as administered. Previously administered immunization records are stored in immunization file cabinet unlocked.
    c. TB record cards are stored in immunization file cabinet in designated area unlocked.
    d. Community screening records are stored by date in folders and are filed in file cabinet in front waiting area.

Client Records

1. Every client will have a permanent electronic medical record.
2. Clients name and information will also be entered into the Ahler's system to record charges and other pertinent demographic information.
3. Every visit will receive a client billing sheet that the nurse will-indicate the appropriate charges, charge sheets are given to the front desk staff following the visit.

Navigation of the Centricity EMR

Forms

- Update Chart-Enter type of visit and Summary of service requested
- Nursing Intake Form-recording of vital signs
  - Vital signs-Extended-repeated vital signs and information as indicated
  - Risk Factors-review on each visit.
- Geriatric Assessment-complete on admission for geriatric client as indicated thereafter
- PMH-Past Medical History/PSH-Past Surgical History-review and update with each visit

- FH-Family History; SH-Social History-review on each visit
- PE- Physical Exam-complete as appropriate.
- Diabetic Foot Exam-Documentation of foot care services, complete as appropriate.
- Immunization Management-immunization documentation
- Medication Administration
- A and P- Assessment and Plan-complete as appropriate.
- Other Forms- Medication List, Allergies, Flow Sheet, Print Instructions

4. In addition to above Special Forms are used for the following types of visits:
   a. **Coumadin Flow Sheet:** Clients who need blood coagulation monitoring
      - Physician Order form-Standing Orders for Coumadin
      - INR testing will be recorded on the Flow Sheet, therapeutic range may be indicated as appropriate as well as next scheduled testing.
   b. **Foot Care flow sheet**-documentation of Foot Care Services
      - Foot care diagram sheet – used to chart deformities.
   c. **Home Visit Referral Form**-assesses eligibility for home visit services. Brief summary of referral information will be entered in a phone note upon receiving information from referring agency/individual.
      - Central Valley Health District Public Health Referral Form Request for Services (CVHD yellow form 11/2006) file right side of chart under correspondence.
   d. **Lipid Screening**
      - Lipid Intake form will be completed by client and the front page will be scanned into the EMR.-initial visit only-Central Valley Health form. Risk assessment information will be entered into appropriate fields.
        Documentation will follow the same path as an office visit encounter

- Lipid Flow sheet(Results)-Filed under flow sheet-Central Valley Health form A copy of the test results will be given to client and results will also be entered into the EMR flow sheet.

e. **Lab Results**

Lab results received from an outside provider will be scanned into the clients EMR as External Correspondence.
Lab screenings done during CVHD visit will be entered into the EMR flow sheet

f. **Interagency Communication Form**

- Scanned in to the client's EMR under Interagency Communication- when signed and returned from provider.

g. **Physicians Orders.**

- Telephone orders will be sent to the provider for signature and scanned in the EMR upon return. The CVHD carbon order form will be used for all telephone orders. The original form will be sent for the provider's signature and the carbon copy retained until the original is returned to CVHD. The original signed order will be scanned into the client's record.
- Progress notes containing orders will be accepted if they contain the provider's signature.
- Standing orders are acceptable for designated services and are updated on an annual basis.

5. Immunization records

- All immunizations with the exception of seasonal influenza immunizations will be entered into a client's EMR. The completed Vaccine Administration Record is scanned into the EMR.
- Immunization Cards will no longer a part of the immunization record. All existing immunization cards will be retained indefinitely and will be filed in an unlocked immunization file cabinet.
- Client/Parent or Guardian will complete Central Valley Health District Vaccine Administration Record, including screening questions
- Complete Central Valley Health District Screening Questions for school based immunizations(10/98)-Central Valley Health Form
- Certificate of Immunization will be printed from the NDIIS upon request.
- All Immunization Data including previously administered immunizations will be entered into Thor System (NDIIS)

6. Health Screening Log Sheets

- Used in special circumstances when a group screening is conducted(i.e. health fair, business based, schools, community based screenings)
- Use Community based screening form to record results. Return to secretary
- File log sheet by date in log sheet folder

7. **TB Screening**

- All Clients requesting TB screening will have this visit entered into the EMR system
- Tuberculin test registration card(state form 7722)

8. **INH Therapy:** clients on INH therapy
    - Each visit will be entered into the EMR.
    - State forms will be completed and kept on file. Upon completion of treatment, required forms will be sent to the North Dakota Department of Health- (NDDoH) and scanned into the client's EMR. See INH Checklist