



## POLICY AND PROCEDURE MANUAL CENTRAL VALLEY HEALTH DISTRICT

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### SECTION: NURSING SERVICES

#### POLICY #:406 CLIENT RECORDS

**POLICY:** All individuals seen at Central Valley Health District will have an individual client record for documenting of services performed.

**PROCEDURE:**

1. Front desk or nursing staff will initiate a client record at the time of initial visit.
2. Client record will consist of standardized forms approved by Central Valley Health District Director of Nursing and Unit Administrator. See attached list of forms.
3. Secretarial staff will reviews charts yearly to inactive charts not seen in 12 months.
4. Record Retention:
  - a. Client records are retained for 7 years from date of last visit.
  - 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.
  - e. Client records are placed inactive after 1 year from date of last visit and moved from active files to inactive storage until 7 years from date of last visit, then destroyed.
5. Storage of client records:
  - a. Active client records are filed by number and kept in locked file cabinet in front waiting area.
  - b. Active home visit or Health Maintenance Clinic charts are kept in locked cabinet in nurses office filed alphabetically.
  - c. Charts used at Health Maintenance Clinics or home visit will be in individual client folders and may be transported via a locked case to Health Maintenance Clinic site or home setting.
  - d. Immunization records are stored in immunization file cabinet unlocked.
  - e. TB record cards are stored in immunization file cabinet in designated area unlocked.
  - f. Community screening records are stored by date in folders and are filed in file cabinet in front waiting area.



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## Client Records

1. Every client will have a permanent record, consisting of a chart with appropriate forms.
2. Clients name and information will also be entered on the computer to record charges and other pertinent demographic information.
3. Use allergy stickers-Prominently displayed outside of chart if appropriate.
4. **Every visit will receive a client billing sheet that the nurse will circle the appropriate charges, charge sheets are given to the front desk following the visit.**
5. Inside Standardized charts for all clients are the following forms:

### Left side:

- Client Demographics
- Consent forms:
  - HIPAA
  - Central Valley Health District Release of Information
- Care Plan – use CVHD developed care plans

### Right Side:

- Flow Sheet-Yellow CVHD form
  - Continuation sheet for PH nursing records -State Form 8245 white
  - Physician Orders-Central Valley Health form
  - Medication List
  - Correspondence
  - Health History, foot care assessment
  - Special forms as outlined below
6. 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
      - Coumadin dosing flow sheet(under flow sheets)
    - 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
      - 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-initial visit only-Central Valley Health form
      - Lipid Flow sheet(Results)-Filed under flow sheet-Central Valley Health form
      - Follow up visits-vitals recorded on standard flow sheet.-Central Valley Health form
    - e. **Lab Forms**:
      - Throat culture request-filed under correspondence-Central Valley Health Form
      - For throat cultures use: Jamestown Hospital lab request, Pink throat culture request



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### **f. Interagency Communication Form**

- File under physician orders or correspondence (under orders highlight order with yellow marker)

### **7. Immunization records**

- Not part of client chart
- Cards are filed in immunization file cabinet
- Complete or retrieve previous immunization card from file cabinet. Start new card if no previous record.
- Complete State Form 18385-Vaccine Administration Record or 50922 Vaccine Series Record
- Complete Central Valley Health District Screening Questions for school based immunizations (10/98)-Central Valley Health Form
- Certificate of Immunization-completed for client record upon request-State form 16038
- Immunization Data entered into Thor System

### **8. 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

### **9. TB Screening**

- Tuberculin test registration card (state form 7722)
- If positive results-long term chart will be initiated

### **10. INH Therapy: clients on INH therapy**

- See INH Checklist