Thinning of Documents from Client Charts in Clinical Area
- Program Guideline - Home Care/Nursing

1. The client chart is reviewed on a regular basis to determine if thinning is required.
2. The following reflects the minimal length of time/date the documents are to be retained in the client's chart.
3. Clinical judgement is required when reviewing the chart for thinning to ensure sufficient client information to maintain continuity of care and ensure the provider is able to assess clients past medical history.
4. Forms not identified in this guideline may need to be retained on the client chart. Professional discretion and clinical judgement is required.

STANDARD CLIENT CHART (HEALTH RECORD) ORDER	Recommendations for Thinning
Section 1 A	
Client Profile Record	Current copy
Nursing Care Plan (most current care plan first)	Minimum 3 months
Nursing Service Request Form	Minimum 3 months
Health History Assessment	Original and Current Copy
Working Alone Safety Assessment and Plan	Current Copy
Violence Prevention Plan (treatment clinic only)	Current Copy
Section 1B	
Interdisciplinary Notes	Minimum 3 months
Section 2A	
Signature Record	Permanent
Thinning of Documents from Client Chart Tracking Form	Permanent
Section 2B	
Client Diabetic Record	Minimum 3 months
Client Medication Record (Daily or Monthly)	Minimum 3 months
Client Treatment Record	Minimum 3 months
Client Wound Assessment Treatment Flow Sheet	Minimum 3 months
Extra Blank Forms	N/A
Miscellaneous Forms	N/A
Section 3A	
Physician Orders	Minimum 3 months
Physician / Nurse Practitioner's Correspondence	Minimum 3 months
Assigned Task Record	Minimum 3 months
SBAR Communication	Minimum 3 months
Best Possible Medication History (BPMH)	Minimum 3 months
Skin and Wound Communication	Minimum 3 months
Section 3B	
Braden Scale	Original & current
Pressure Injury Prevention and Management Individualized Care Plan – Home Care	Minimum 3 months
Referrals	Minimum 3 months
Discharge Summary	Minimum 3 months
Client Chart Order Document	Permanent