THINNING OF DOCUMENTS FROM CLINICAL AREA

– PROGRAM GUIDELINE - PCH AND TRANSITIONAL CARE CENTRES

1. The resident/patient 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 resident/patient chart.
3. Clinical judgement is required when reviewing the chart for thinning to ensure sufficient resident/patient information to maintain continuity of care and ensure the provider is able to assess resident/patient past medical history.
4. Forms not identified in this guideline may need to be retained on the resident/patient chart. Professional discretion and clinical judgement are required.

CLIENT CHART (HEALTH RECORD) ORDER	Recommendations for Thinning
In plastic sleeve in the front of the binder:	
Resident Medical Problem List	Current copy only
Pacemaker information	Permanent
Resident Information for Health Record	Permanent
Code Yellow form	Permanent
ADVANCE CARE PLANS	
Advance Care Planning – Goals of Care Form	Current copy only
Health Care Directive (if the resident has one)	Current copy only
Power of Attorney	Current copy only
Order of Committeeship/Public Trustee	Permanent
ORDERS	
Prescriber orders	Minimum 3 months
Standard orders	Permanent
Best Possible Medication History (BPMH)	Minimum 3 months
Care Maps ie UTI	Most current
Medication reviews	Current copy only
TRANSFER AND DISCHARGE	
Manitoba Transfer Information Referral Form	Minimum 1 year
PCR Reports (EMS Forms)	Minimum 1 year
Transfer and Discharge Summaries	Permanent
Emergency Department/Outpatient Records	Minimum 1 year
Wound and Skin Discharge Summary Forms	Minimum 1 year
INTEGRATED PROGRESS NOTES	
Integrated Progress Notes	Minimum 3 months
Quarterly Reviews	Minimum 1 year
Annual Care Conference	Minimum 3 years
Code Yellow form	Minimum 1 year

ASSESSSMENTS	
Clinical Records (vital signs, glucose monitoring, diabetic record, intake/output, stocking measurements, etc.)	Current copy only
Braden Scale for Predicting Pressure Injuries	Minimum 3 months
Pressure Injury Prevention and Management Intervention Checklist	Current copy only
Health Care Aide Skin Observation Form	Minimum 3 months
Wound Assessment and Treatment Form	Minimum 3 months
Wound photos	Minimum 3 months
Turning and Positioning Flow Sheet	Current copy only
Multidisciplinary Team Pressure Injury Safety Huddle Form	Minimum 1 year
Transfer and Mobility Assessment (SCHIPP)	Minimum 3 months
TTMD Feeding and Swallowing Screening Form	Original & current
Violence Prevention Screening Form	Original & current
Nutritional Screen	Original & current
Three day food records	Current copy only
Edmonton Symptom Assessment System-revised (ESAS-r)	Current copy only
Edmonton Symptom Assessment System-revised (ESAS-r) Graph	Current copy only
Behaviour mapping	Current copy only
Cognitive screening (e.g. MMSE, MOCA)	Original & current
PIECES forms	Current copy only
Antibiotic resistance screening	Permanent
Smoking history/assessment tool	Original & current
Neurological assessment	Minimum 3 months
Foot assessment	Current copy only
Oral health assessment	Current copy only
Suicide Risk Screening	Original & current
Geriatric Depression Scale/SIG E CAPS depression scale	Original & current
Resident activity participation record	Minimum 3 months
MEDICATION/TREATMENT	
Medication Administration Records	Minimum 3 months
Medication patch records	Minimum 3 months
Insulin records	Minimum 3 months
Exceptional Drug Status Forms (e.g. cholinesterase)	Permanent
Treatment Record	Current copy only
PCH Delivery of Care Records	Minimum 3 months
RESTRAINTS/FALLS	
Restraint documentation as per policy	Minimum 1 year
Falls documentation as per policy	Minimum 1 year
HISTORY/PHYSICAL	
Medical history	Original & current
History & Physical exam (every two years)	Current copy only
DIAGNOSTICS	
Radiology reports	Minimum 1 year
EKG	Minimum 1 year
Lab reports	Minimum 1 year

ADMISSION RECORDS	
Initial care plan	Permanent
Integrated Assessment	Permanent
Inter-ocular lens	Permanent
Pre-admission forms (e.g. acceptance letters, notes of pre-admission contact, home visit etc.)	Permanent
Resident agreement	Permanent
Application/Assessment for Long Term Care	Permanent
Dependency level	Current copy only
Admission checklist	Permanent
CONSULTS	
Palliative Care Referral Form	Permanent
Pastoral/Spiritual Care	Permanent
Seniors Consultation Team Referral	Permanent
Therapy Referrals (e.g. OT, PT, wound care, music etc.)	Current copy only
REHAB & THERAPY	
Power mobility device contract	Current copy only
Rental/Service agreements	Current copy only
CONSENTS	
Consent for treatment	Permanent
Consent for disclosure and record of release	Permanent
Agreement to share personal health information	Permanent
External services consents	Current copy only
Immunization consents	Permanent
Influenza consent	Minimum 1 year
Acknowledgement consent (e.g. fridge agreement, Enhanced Living Unit Agreement etc.)	Permanent
MISCELLANEOUS	
Integrated Care Plans (not current)	Minimum 3 months
Veterans Affairs Canada communications	Minimum 1 year
Letters to family	Minimum 1 year
External service providers	Current copy only
Photocopy eyeglasses	Current copy only
GST exemption	Permanent
Master Signature Sheet	Permanent