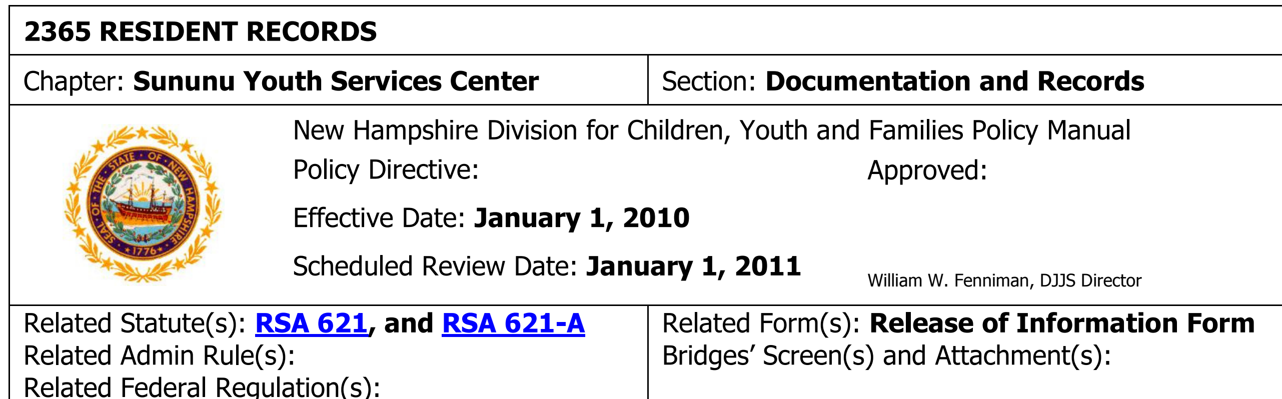

2365 RESIDENT RECORDS	
Chapter: **Sununu Youth Services Center**	Section: **Documentation and Records**
	New Hampshire Division for Children, Youth and Families Policy Manual Policy Directive: Approved: Effective Date: **January 1, 2010** Scheduled Review Date: **January 1, 2011** William W. Fenniman, DJJS Director
Related Statute(s): **RSA 621, and RSA 621-A** Related Admin Rule(s): Related Federal Regulation(s):	Related Form(s): **Release of Information Form** Bridges' Screen(s) and Attachment(s):

In order to increase the efficiency and effectiveness of service delivery and the transfer of information to the courts and release authorities the Division will ensure an orderly and timely system for recording, maintaining, and using data about the youth in our care with a focus on protecting residents' right to privacy. The Division will maintain information on each juvenile in the following manner:

- Bridges - The Statewide Automated Child Welfare Information System database. The Division's primary electronic information system.

- Active Permanent Record (Red Binder) - The most comprehensive paper file maintained by Records personnel, which shall contain all original documents except for medical, clinical and education documentation. All Active Permanent Records are stored in the Administration Building secure Records Room. Access to the Administration Building Records Room is controlled and there is a request and sign-out/in process for any Permanent Record that leaves the Administration Building Records Room.

    - Medical Record (Green Binder) - All medical records are maintained by the medical staff and are located in the secure Medical Facility Records Room. Access to the Medical Records Room is controlled and there is a request and sign-out/in process for any Medical Record that leaves the Medical Records Room.

    - Educational Record (Brown Binder) - All educational records maintained by the education staff and are located in the secure Education Records Room. Access to the Education Records Room is controlled and there is a request and sign-out/in process for any Education Record that leaves the Education Records Room.

    - Clinical Record (Yellow Binder) - All clinical records will be maintained by the Records personnel and shall be located in the Administration Building secure Record Room with the Active Permanent Record. Access to the Administration Building secure Records Room is controlled and there is a request and sign out/in process for any Clinical Record that leaves the Administration Building secure Records Room.

- Inactive Permanent Record - This file is an Active Permanent Record, which has become inactive due to the timetable discussed in this policy. The Medical Record, Clinical Record, and Education Record shall be separately attached to the Permanent Record.

Purpose

The purpose of this policy is to establish the creation and maintenance of all juvenile records for youth detained and/or committed to the SYSC.

Policy

I. Records Room: The Division shall maintain a secure Records Room in the Administration Building basement for all resident Permanent Records. Only authorized personnel may have access to the secure Records Room. The Records Room shall remain locked whenever authorized personnel are not present. No original document or copy of any original document will leave the secure Records Room without proper request and sign-out/in process being followed. After the prescribed timetable resident records shall be transferred to the New Hampshire Secretary of State's secure archive record storage.

II. Resident Records: Resident records shall be created and maintained on all residents. All manual records shall be marked "Confidential." All entries in manual files shall be dated and identified clearly. It is the responsibility of all staff to ensure the security of resident records. Manual records shall be maintained in the following manner:

   A. Active Permanent Records: Each resident's Permanent Record shall contain all original external and internal documentation, which is not primarily stored in the resident's Medical Record, Educational Record, or Clinical Record. (Some documents in a resident's Permanent Record may be copies of originals located in the above-listed records.).Each resident's Permanent Record shall be formatted according to the attached list.

      1. Responsibility for Maintenance: The creation and maintenance of each resident's Permanent Record shall be the responsibility of Record's personnel. Only Record Personnel can make copies of any documentation in the Permanent Records.

      2. Permanent Record Storage: All Permanent Records will be stored in the Administration Building secure Records Room.

      3. Permanent Record Request: Upon request records personnel will make available Permanent Records for review in the Administration Building secure Records Room.

      4. Permanent Record Accountability: All Permanent Records will only be viewed in the Administration Building secure Records Room under the supervision of Records' personnel. No Permanent Record or copies of any portion of the Permanent Record will leave either location unless express permission is granted by the Director. Written requests will be made through the Administrative Assistant.

      5. Closed Permanent Records: Permanent Records shall be stored in the Administration Building Records Room while active and for one year after becoming inactive, at which point it will be attached to (but not consolidated with) the resident's Medical Record, Education Record and Clinical Record. The complete Closed Permanent Record will be moved to the Closed Section of the Administration Building Records Room and stored at least five years after the release of a committed resident and two years after the release of a detained resident. The combined record will then be transferred to the New Hampshire State Archives. The Records Clerk shall maintain an up-to-date list of closed records, including where they are stored.

6. Release of Records: No record (medical, school, clinical, etc.) will be released without proper authorization from the Division's Release of Information Form. Parents may receive one copy of their child's medical records at no cost upon request.

B. Medical Records

1. Responsibility for Maintenance: Creation and maintenance of each resident's medical record shall be the responsibility of the nursing staff. The content of the Medical Records shall be formatted according to the attached list.

2. Medical Record Storage: Each active resident's Medical Record shall be maintained and securely stored at the Nursing Station in the Medical Department until transferred to the Closed Permanent Record.

3. Medical Record Request: Complete medical files shall not be removed from the Medical Department without a court order, with the following exception: Copies of medical records may be given to authorized individuals upon completion of and approval of a DJJS Release of Information form. Parents, legal guardians, and residents' attorneys, and other appropriate requestors in accordance with RSA 169-B:35 and may view or receive copies of relevant portions of a resident's medical record with the authorization of the DJJS Director or designee.

4. Medical Record Accountability: Only SYSC Medical staff and other identified individuals authorized by the DJJS Director or designee shall have access to residents' medical records. Access to the health records shall be controlled by the Health Authority and shall maintain a list of authorized staff. Resident medical records shall be reviewed only in the Medical Department. When a medical record is removed from or returned to the SYSC medical records room, the person using the file shall make an entry in the Medical Record Sign-Out Log.

5. Closed Medical Records: Residents' Medical Record shall be maintained in the Medical Records Room while active, at which point it will be attached to (but not consolidated with) the resident's Education and Clinical Record with the Permanent Record.

C. Education Records

1. Responsibility for Maintenance: The creation and maintenance of each resident's Educational Record shall be the responsibility of the School Principal or designee. The content of the Educational Record shall be formatted according to the attached list.

2. Education Record Storage: All Educational Records will be securely stored in the School Administrative Office. The School Administrative Office is secured and access is strictly controlled.

3. Education Record Request: Upon request to the School Principal (at least 24 hour notice) anyone authorized to review Educational Records may review them in the School Office. The School Secretary will make one trip daily to retrieve requested Educational Records for sign out/in.

4. Education Record Accountability: All Educational Records will be signed out and returned in the same business day. No one will take an Educational Record without proper request and signing out/in for the record. No original or copy of any portion

of the Educational Record shall be brought outside the SYSC building without express permission from the Director or designee.

5. Closed Education Records: Residents' Educational Record shall be maintained in the School Office while active, at which point it will be attached to (but not consolidated with) the resident's Medical and Clinical Record with the Permanent Record.

6. Education Record Request: Complete Education Records shall not be removed from the Education Department without a court order, with the following exception: Copies of education records may be given to authorized individuals upon completion of and approval of a DJJS Release of Information form. Parents, legal guardians, and residents' attorneys, and other appropriate requestors in accordance with RSA 169-B:35 may view or receive copies of relevant portions of a resident's Education Record with the authorization of the DJJS Director or designee.

D. Clinical Record

1. Responsibility for Maintenance: The creation and maintenance of each resident's Clinical Record shall be the responsibility of Records personnel. Any and all clinical documentation shall be sent to Records personnel in the Administration Building's secure Records Room for filing. The Clinical Manager shall ensure each day at 8 AM the prior day's work product is submitted to the Administrative Assistant. The content of the Clinical Record shall format according to the attached list.

2. Clinical Record Storage: All Clinical Records will be stored in the Administration Building secure Records Room. The Administration Building secure Records Room's access is strictly controlled.

3. Permanent Record Accountability: All Clinical Records will only be viewed in the Administration Building secure Records Room under the supervision of Records' personnel. No Clinical Record copies of any portion of the Clinical Record will leave the Administration Building's secure Record Room unless express permission is granted by the Director. Written requests will be made through the Administrative Assistant.

4. Closed Clinical Records: Residents' Clinical Record shall be maintained in the Administration Building's secure Records Room while active, at which point it will be attached to (but not consolidated with) the resident's Medical and Educational Record with the Permanent Record.

E. Residential Records

1. Responsibility for Maintenance: All residential work products shall be maintained in resident Active Files. Each Unit Manager shall ensure that by 8 AM the prior day's work product (i.e., FOTPs, Weekly Service Update and Treatment Notes, Incident Reports, etc.) is submitted to the Administrative Assistant. Residential documentation or any copy of any residential documentation will not remain on the unit.

2. Unit Binder Content: Absolutely no original documents will be kept in the Unit Binder. The Unit Binders will be maintained by the youth counselor assigned to each resident and kept secured in the respective unit office. No Unit Binder will be left unattended

by staff at any time. No Unit Binder will leave the SYSC facility. The Unit Binders will be formatted according to the attached list.

F. Admission Paperwork: Admission paperwork will be put in a package and submitted to Central Control. The Admission Package will be formatted according to the attached list and submitted to Central Control. The Receptionist will pick up the Admission Packages each morning.

III. Document Flow: Document flow will proceed as follows:

A. Medical Records: When documents are received and/or produced the Health Authority shall ensure they are filed on a daily basis in the Medical Records. The Health Authority is responsible for all medical documents produced by medical staff.

B. Education Records: When documents are received and/or produced the Principal shall ensure they are filed on a daily basis in the Education Record. The Principal is responsible for all documents produced by school staff.

C. Clinical Records: By 8 AM every morning the Clinical Manager or designee shall ensure the Clinical document folder has the appropriate paperwork and is delivered to the Administrative Assistant. The Clinical Manager is responsible for all documents produced by clinicians.

D. Unit Binder: All original unit work product shall be submitted to the Unit Manager or designee before the end of their shift. All documentation shall be submitted to the supervisor by 8:00 AM every morning for review. The Unit Manager or designee shall ensure the appropriate paperwork has been collected and is submitted to the supervisor. Facility Supervisors shall review all Incident Reports, Use of Force Reports and Unit Inspection Reports. Residential Supervisors shall review all residential treatment documentation. All Unit Managers are responsible for all documents produced by residential staff in their unit. After the supervisor reviews the documentation it shall be submitted to the Administrative Assistant.

E. Administrative Files: Administrative forms (i.e., shift reports, staff rosters, daily population, etc.) shall be submitted by the Supervisors to the Administrative Assistant before the end of their shift. Administrative Files shall be stored in the Facility Administrator's Office.

F. Forms: All forms shall be approved by the Facility Administrator and will be stored on the Lotus Notes Policy Database. All requests to post a new or revised form shall be in writing to the Facility Administrator. No form shall be used except for forms located on the Lotus Notes Policy Database.

IV. Records Room Access: The Administration Building secure Records Room is open Monday through Friday, 8:00 AM to 4:00 PM. Residential, treatment, medical, and educational staff, as well as JPPOs, shall have the authority to review any resident's Permanent Record within the confines of the Administration Building secure Records Room. Any staff reviewing a resident's Permanent Record shall note their name and the date of their review on the View Log sheet provided in Section II of each resident's Permanent Record.

A. Outside Stakeholder Review of Permanent Record: Outside stakeholders with statutory authority and/or appropriate court order may view a resident's Permanent Record in the Administration Building secure Records Room. At least 24-hour notice is required.

V. Permanent Record Integrity: Permanent Records shall remain intact. No parts or portions shall be removed from the Permanent Record, even if they remain in the building.

VI. Documents: No staff shall possess and/or maintain original and/or copies of any document related to any resident outside of a resident record maintained by the Division. All documentation shall be maintained in the records identified in this policy.

VII. Administrative Fees: Copies of resident files may be provided to families without charge. Reasonable administrative fees shall be charged to stakeholders with statutory authority and/or appropriate court order.

Addendum

Administrative Files:

- Incident Reports
- Use of Force Reports
- Daily Unit Security Reports
- Shift Report Package
- Shift Report
- Staff Roster
- Daily Population Reports (3 per day)
- Admissions Package
- Committed Resident Documents
  - Committing Order
  - Committing Petition
  - Dispositional Guidelines
  - Signed Medical Authorization and Release
  - JPPO Collateral Contact Sheet
- Detained Resident Documents
  - Detention Order
  - JDAI Screening Instrument
- All new residents:
  - Admission Report
  - Possessed Property Report
  - Mental Health Screen
  - Orientation Signature page
- Youth Counselor Treatment Paperwork
- Classification Paperwork

Permanent Record:

- Name, age, sex, place of birth, and race or nationality.
- Initial intake information form.
- Authority to accept juvenile.
- Referral source.
- Case history/social history.
- Medical consent form.

- Name, relationship, address, and phone number of parent(s)/ guardian(s) and person(s) juvenile resides with at time of admission.
- Driver's license, social security, and medicaid numbers, when applicable.
- Court and disposition.
- Individual plan or program.
- Signed release-of-information forms, when required.
- Progress reports on program involvement and all other residential documentation.
- Program rules and disciplinary record, if applicable.
- Referrals to other agencies.
- Final discharge or transfer report.
- Third party information.

Medical Record:

- Face Sheet
- Collateral Contact Sheet
- Court Orders mandating medical assessment/treatment
- Unusual occurrences
- Changes of address
- Physician Orders
- Progress Notes
- Physical Notes
- Individual Nutrition Plan
- Nutritional Progress Notes
- Nutrition Referral
- Psychiatrist Orders
- Psychiatrist Progress Notes
- Unit Weekly Updates
- Medical Correspondence
- External Physician Consultation Reports
- External lab, reports and x-ray results
- External Medical Reports
- Consent/Medical Authorizations
- Release of Information/Insurance Information
- Guardianship Papers and Medication Contract
- Nursing Assessments
- Flow Sheets
- Eyes and Hearing
- Discharge Summary
- Medication Sheets
- PRN Sheets
- Nursing Progress Notes
- Dental Records when discharged
- Medical Memos
- Furlough Medical Sheets
- Nursing Kardex

- ◻ Immunization Record

Education Record:

- ◻ Educational Chronological Sheet
- ◻ Face Sheet
- ◻ Transcripts
- ◻ Credit Checklist
- ◻ School Schedule
- ◻ Testing Information
- ◻ Classification Information
- ◻ Placement History (Bridges)
- ◻ Educational Correspondence
- ◻ Request for Records
- ◻ Permission from Parents for Field Trips
- ◻ Permission to Release Records

Special Education Files shall include:

- ◻ Educational Chronological Sheet
- ◻ Face Sheet
- ◻ Educational Meeting Minutes
- ◻ Local Education Agency Progress Reports
- ◻ Written Prior Notices
- ◻ Individual Education Plan Progress Reports
- ◻ Transcripts and Release Letter
- ◻ Individual Education Plan
- ◻ Individual Education Plan Compliance Checklist
- ◻ Special Education Evaluation Team Meeting Minutes & Determination
- ◻ Testing Information
- ◻ Correspondence to Local Education Agency and Parents

Clinical Record:

- ◻ Face Sheet
- ◻ External Psychological Evaluations
- ◻ External Neuropsychological Evaluations
- ◻ External Psychosexual Evaluations
- ◻ Discharge Plans
- ◻ Clinical Correspondence
- ◻ Notification Letters
- ◻ Electronic Mailings
- ◻ Disclosure Statement
- ◻ Internal Psychosocial Assessment
- ◻ Internal Spiritual Assessment
- ◻ Internal Vocational Assessment
- ◻ Beck Suicidal Ideation Assessment
- ◻ Treatment Plan

- ☐ Treatment Plan Reviews
- ☐ Restabilization Plans
- ☐ Weekly Treatment Team Progress Reports
- ☐ Clinical Treatment Notes Printout
- ☐ Clinical Treatment Notes/Schedule Updates
- ☐ Exit Guidelines/Aftercare Plan
- ☐ Community Support Card

Unit Binder:

- ☐ Face Sheet and picture
- ☐ Collateral Contact Sheet
- ☐ Treatment Plan