Sixth District Department of Correctional Services POLICY	Issue Date 10/16/09	Effective Date 09/20/20	Policy Number 2304-20
Subject **ANCHOR CENTER LICENSED SUBSTANCE ABUSE PROGRAM CASE FILES**		Review Month September	Author 0633 (RME)
Rescinds 2304-14	References Iowa Code, Chapter 155		

POLICY:

The Director and/or designee ensure that all records are secured, stored, maintained, and destroyed according to applicable standards and laws. The content of all files are organized and thorough.

PROCEDURE:

1. ANCHOR Center Licensed Substance Abuse records are maintained in a secure area of the facility readily accessible to staff but not easily accessed by clients. All files are secured by a minimum of two (2) locks (i.e. a door and a file cabinet) when not being utilized.

   Whenever possible documentation is completed in the I-SMART clinical record keeping system provided by Iowa Department of Public Health.

2. All paper files are uniformly organized with entries signed and dated by the staff member completing the documentation. Documentation is filed in chronological order where appropriate. All written materials are legible and made in ink or printed from digital file. Electronic submissions are made only via the employee's own unique log in credentials. Documentation is written in clear language consistent with professional standards and avoids jargon or unprofessional language. All data required by Iowa Department of Public Health is submitted through I-SMART.

3. All paper records remain on site while a client is active in the treatment program. Records are stored on-site for no less than one (1) year after the client has discharged from the program and the case has been closed. Records are maintained at either an on-site or off-site records archive location and are kept for a minimum of seven (7) years from the time the file was closed. After seven (7) years from the date of closing, staff may destroy the records by shredding them.

4. Confidential information about a client is not released without written consent of the client except in the situation of:

   A. Immediate danger to self / others;

   B. Court Order;

   C. Incident of suspected child or elder adult abuse / neglect.

PROCEDURE: (continued)

5. Any time confidential information is released without written client consent, for such situation as listed above, the following must be documented:

   A. The date the information was released;

   B. The person to whom the information was released;

   C. The reason the information was released;

   D. The nature and details of information given.

6. Any time confidential information is released without written consent by the client, the client is notified as soon as practicable that the information was disclosed. Staff documents notifying the client of disclosure or make written record as to why such notification was not feasible.

7. Contents of the case file are stored in I-SMART where possible and in paper form when electronic storage is not feasible. Content of the file includes, as applicable but is not limited to:

   A. Results of all examinations, tests, and intake assessment information.

   B. Reports from referring sources.

   C. Treatment Plans.

   D. Medication Records (if applicable from outside agencies).

   E. Reports from outside resources.

   F. Multi-disciplinary case conference / consultation notes (if applicable).

   G. Correspondence related to the client.

   H. Treatment consent / agreement forms.

   I. Progress notes.

   J. Release of Information Forms.

   K. Records of Services Provided.

   L. Discharge Summary.

BY ORDER OF:

Bruce Vander Sanden, District Director