

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF STATE OPERATED HEALTHCARE FACILITIES**

PROGRAM RECORDS RETENTION AND DISPOSITION SCHEDULE

The Program Records Retention and Disposition Schedule and retention periods governing the records series listed herein are hereby approved. In accordance with the provisions of Chapters 121 and 132 of the General Statutes of North Carolina, it is agreed that the records of the

DIVISION OF STATE OPERATED HEALTHCARE FACILITIES

do not and will not have further official use or value for administrative, research, or reference purposes after the respective retention periods specified herein. The Department of Natural and Cultural Resources consents to the destruction or other disposition of these records in accordance with the retention and disposition instructions specified in this schedule. The agency agrees to comply with 07 NCAC 04M .0510 when deciding on a method of destruction. Electronic records will be destroyed so that the data and metadata are overwritten, deleted, or unlinked in such a way that the records may not be practicably reconstructed. Confidential records will be destroyed in such a manner that the records cannot be practicably read or reconstructed. However, records subject to audit or those legally required for ongoing official proceedings must be retained until released from such audits or official proceedings, notwithstanding the instructions of this schedule.

The Department of Health and Human Services and the Department of Natural and Cultural Resources agree that certain records series possess only brief administrative, fiscal, legal, research, and reference value. These records series have been designated by retention periods which allow them to be destroyed when "*reference value ends.*" The Department of Health and Human Services hereby agrees that it will establish and enforce internal policies setting minimum retention periods for records with this disposition instruction. Without the establishment of internal policies, the agency is not authorized by the Department of Natural and Cultural Resources to destroy these records. For those record series scheduled to be microfilmed, the Department of Health and Human Services will be responsible for cost of microfilm production.

The Department of Health and Human Services and the Department of Natural and Cultural Resources concur that the long-term and/or permanent preservation of electronic records require additional commitment and active management by the agency. The Department of Health and Human Services agrees to comply with all policies, standards, and best practices published by the Department of Natural and Cultural Resources regarding the creation and management of electronic records and to make electronic records accessible for the period of time prescribed in this schedule. Where the method of recording information changes (for example, to an electronic system), the retention periods governing the records listed herein still apply, provided the records document the same agency function.

E-mail messages sent or received by Executive Branch agencies shall be retained for 5 years pursuant to Executive Order No. 12 (issued May 21, 2013 by Governor Pat McCrory). Any e-mail messages requiring retention longer than 5 years, including those with permanent historical value, shall be designated with specific retention periods in this program records schedule. Public records including electronic records not listed in this schedule or in the *General Schedule for State Agency Records* are not authorized to be destroyed.

The Department of Health and Human Services agrees to destroy, transfer or dispose of records in the manner and the times specified herein. This schedule is to remain in effect until superseded.

APPROVAL RECOMMENDED

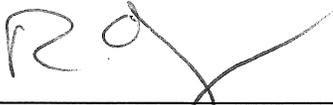


Dale C. Armstrong, Director
Division of State Operated Healthcare
Facilities



Sarah E. Koonts, Director
Division of Archives and Records

APPROVED



Rick Brajer, Secretary
Department of Health and Human Services



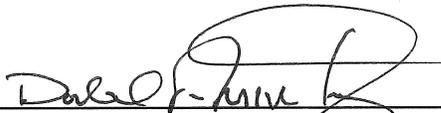
Susan W. Kluttz, Secretary
Department of Natural and Cultural Resources

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF STATE OPERATED HEALTHCARE FACILITIES
FACILITY RECORDS**

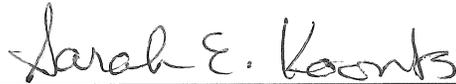
PROGRAM RECORDS RETENTION AND DISPOSITION SCHEDULE

Amend the program records retention and disposition schedule approved April 8, 2016, by amending Standard 9, Items 4, 13, and 14, as shown on the included schedule. No other items on this schedule have been amended, added, or removed.

APPROVAL RECOMMENDED



Dale C. Armstrong, Director
Division of State Operated Healthcare
Facilities

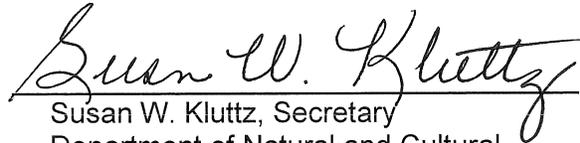


Sarah E. Koonts, Director
Division of Archives and Records

APPROVED



Rick Brajer, Secretary
Department of Health and Human Services



Susan W. Kluttz, Secretary
Department of Natural and Cultural
Resources

**Division of State Operated Healthcare Facilities
Facility Records**

STANDARD 1. ADMINISTRATION

Records common to all departments of a facility within the Division of State Operated Healthcare Facilities.

In accordance with **G.S. § 131E-97**, all medical records compiled and maintained by public health care facilities are confidential and exempt from public inspection as outlined in **G.S. § 132-6**. This exemption includes financial records concerning charges, accounts, credit histories, and other personal financial records. Similarly, this statute exempts from public inspection records acquired in connection with the credentialing and peer review of persons having or applying for privileges to practice in the facility and records concerning competitive health care activities by or on behalf of the facility. Custodians also should be familiar with Title 10A North Carolina Administrative Code (NCAC) 13B .3902 and 3903, which outline responsibilities of medical records managers, and **G.S. § 8-53** (confidentiality of communications between physicians and their patients).

ITEM #	STANDARD 1: ADMINISTRATION		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
1.	ACCREDITATION RECORDS Records generated or accumulated to prove compliance with those standards outlined by accrediting agencies, whether public or private. File includes survey results and inspection reports, notices of corrections, correction reports, and in-house surveys and testing done prior to the actual accreditation survey. File also includes public notices required by accrediting agencies and any additional supporting records necessary for the survey, inspection, and/or correction of deficiencies. File may include documentation for The Joint Commission and Clinical Laboratory Improvement Amendments (CLIA).	Destroy in office 5 years after next accreditation report is issued.	
2.	CONSULTATIONS RECORDS Summaries of consultations held with patients.	Transfer to appropriate clinical record upon completion.	
3.	 FACILITY ADVOCATE RECORDS Records concerning the advocates placed in each facility of the division. File includes reports and investigations regarding rights protection of individuals housed at division facilities.	Destroy in office after 5 years if no litigation, claim, audit, or other official action involving the records has been initiated. If official action has been initiated, destroy in office after completion of action and resolution of issues involved.	Confidentiality: G.S. § 122C-52

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ITEM #	STANDARD 1: ADMINISTRATION		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
4.	FOLLOW-UPS RECORDS Records of follow-up appointments with patients.	Transfer to appropriate clinical record upon completion.	
5.	INFECTION CONTROL RECORDS Records created and/or received by a facility's infection control program. File includes surgical and device infection investigation reports; training course content and the review and evaluation of all septic, isolation, and sanitation techniques used in the facility; run and control charts; line listing; surveillance records and logs; infection control reports; and similar records which attempt to identify, report, and evaluate infections. File also includes records and reports of employees who may have been or were exposed to a communicable disease, their work restrictions, and estimated date of reinstatement.	a) Transfer records regarding work-related exposures to Personnel file. b) Destroy in office remaining records after 5 years.*	
6.	LOGBOOKS Logbooks documenting patient registration, medical record number, and date of admission.	Retain in office permanently.	
7. 	PATIENT SAFETY ORGANIZATION RECORDS Records created to oversee data sharing and patient safety initiatives within the facility. File includes event investigations and root cause analyses.	Destroy in office after 10 years.	Confidentiality: 42 USC 3.204 & 3.206
8. 	PERFORMANCE IMPROVEMENT AND QUALITY ASSURANCE RECORDS Records concerning quality assurance. File includes analyses of problems and lists of areas that need improvement, medication error reports, occurrence reports, incident reports, performance improvement summaries, critical pathways, and formal and informal data collection logs and records. (See also Item 12, Risk Management Records.)	a) Destroy in office after 10 years incident analyses and reports and performance improvement plans. b) Destroy in office remaining records after 3 years.	Confidentiality: G.S. § 122C-191(e)

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ITEM #	STANDARD 1: ADMINISTRATION		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
9.	POLICIES AND PROCEDURES Records documenting the formulation, planning, and adoption of policies, procedures, and functions of the agency and its departments. File also includes organizational charts, reorganization studies, and similar records describing the arrangement and administrative structure of the agency.	a) Retain records with historical value permanently. b) Retain HIPAA policies for 6 years. c) Destroy in office remaining records when superseded or obsolete.	Retention: 45 CFR 164.316(b)(2)
10.	REGISTERS Includes Admission and Death Registers.	Retain in office permanently.	
11.	RISK MANAGEMENT RECORDS Records created and/or received by a facility's risk management program in accordance with G.S. § 131E-96 . File includes records of education and training of all non-physician personnel, analyses of patient grievances, incident review reports and records, risk management committee minutes, risk management plans and corporate policy directives, and procedures manuals giving guidance to facility personnel on the care and treatment of patients to manage risks of injury to patients, visitors, employees, and property. These records are often vital to malpractice cases as they establish the conditions under which care was provided.	a) Transfer relevant documentation to Patient Safety Organization Records. b) Destroy in office remaining records after 10 years.*	Authority: G.S. § 131E-96
12.	SCHEDULING RECORDS: MEDICAL PERSONNEL Schedules for medical personnel including physicians, medical aides, nursing staff, and other support personnel who provide medical treatment. Schedules may be maintained on a daily, weekly, monthly or bimonthly basis.	Destroy in office after 5 years.*	
13.	SCHEDULING RECORDS: PATIENTS Lists of all patients seen or scheduled to be seen in the departments.	Destroy in office when superseded or obsolete.	
14.	STATISTICAL MONTHLY REPORTS Monthly statistical reports for all programs.	Destroy in office after 10 years.	

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ITEM #	STANDARD 1: ADMINISTRATION		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
15. 	TRAINING RECORDS: PERSONNEL Records documenting the training of facility personnel to improve competency in specific areas. File includes individual summary reports listing course number, date taken, course name, hours completed and total hours earned; credential, in-service, and competency records listing certifications received; mandatory in-service training; and competencies and other related records.	a) Transfer original records to the hospital's personnel office to be incorporated into employee's personnel file. b) Destroy in office reference copies when reference value ends.† Facility Policy: Destroy in office after _____	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
16.	TRAINING RECORDS: PROGRAM Records concerning the development and administration of in-service education programs to improve competency of facility personnel. File includes course schedules and curricula, attendance rosters, names of instructors, course materials, objectives and criteria, authorizations to participate in training programs, completion records, brochures announcing and describing training offered, and other related records. File includes bloodborne pathogen and hazardous materials training records.	Destroy in office after 6 years.	Retention: 29 CFR § 1910.1030
17.	WEEKLY REPORTS Weekly activity reports for all programs.	Destroy in office upon completion of annual or biannual summary report.	

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STANDARD 2. BUSINESS OFFICE AND PATIENTS' FINANCIAL RECORDS

Records concerning insurance claims and payments, Medicare and Medicaid disbursements, medical bills, and other financial activities for patients served by the state operated healthcare facility. See guidelines in the General Schedule for State Agency Records for the disposition of records concerning routine facility (non-patient related) financial activities.

In accordance with G.S. § 131E-97, all medical records compiled and maintained by public health care facilities are confidential and exempt from public inspection as outlined in G.S. § 132-6. This exemption includes financial records concerning charges, accounts, credit histories, and other personal financial records. Similarly, this statute exempts records acquired in connection with the credentialing and peer review of persons having or applying for privileges to practice in the facility, and records concerning competitive health care activities by or on behalf of the facility, from public inspection. Custodians also should be familiar with Title 10A North Carolina Administrative Code (NCAC) 13B .3902 and 3903, which outline responsibilities of medical records managers, and G.S. § 8-53 (confidentiality of communications between physicians and their patients).

ITEM #	STANDARD 2: BUSINESS OFFICE AND PATIENTS'/RESIDENTS' FINANCIAL RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
1.	ADJUSTED PATIENT ACCOUNTS Records of adjustments to patients' bills and insurance claims.	Destroy in office after 10 years.*	
2.	BAD DEBT MEDICARE LOGS Logs listing patients' accounts sent to collection agencies.	Destroy in office after 10 years.*	
3.	DAILY CHARGE REPORTS Reports summarizing charges to daily in-patients.	Destroy in office after 5 years.*	
4.	INSURANCE CLAIMS REPORTS Claim forms submitted to insurance companies.	Destroy in office after 10 years.*	
5.	INSURANCE PENDING REPORTS Reports summarizing unpaid insurance claims.	Destroy in office after 10 years.*	
6.	MEDICAID LOGS Logs listing payments made to healthcare providers by Medicaid.	Destroy in office after 10 years.*	
7.	MEDICARE DISBURSEMENT REPORTS Reports summarizing funds received from Medicare and the accounts to which they are posted.	Destroy in office after 10 years.*	

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<i>ITEM #</i>	<i>STANDARD 2: BUSINESS OFFICE AND PATIENTS'/RESIDENTS' FINANCIAL RECORDS</i>		
	<i>RECORD SERIES TITLE</i>	<i>DISPOSITION INSTRUCTIONS</i>	<i>CITATION</i>
8.	MEDICARE LOGS Logs listing payments made to healthcare providers by Medicare.	Destroy in office after 10 years.*	
9.	PAID-UP SLIPS OR ZERO BALANCES Records documenting paid balances.	a) Medicare/Medicaid patients: Destroy in office after 10 years.* b) All other patients: Destroy in office after 3 years.*	
10.	PATIENT REFUND LOGS Logs listing refunds issued to patients and insurance companies.	a) Medicare/Medicaid patients: Destroy in office after 10 years.* b) All other patients: Destroy in office after 3 years.*	
11.	PAYMENT VOUCHERS Vouchers for payments received by patients and insurance companies.	a) Retain in office until patient has expired.*	

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STANDARD 3. CLINICAL RECORDS**Records concerning patient care at division facilities.**

In accordance with **G.S. § 131E-97**, all medical records compiled and maintained by public health care facilities are confidential and exempt from public inspection as outlined in **G.S. § 132-6**. This exemption includes financial records concerning charges, accounts, credit histories, and other personal financial records. Similarly, this statute exempts records acquired in connection with the credentialing and peer review of persons having or applying for privileges to practice in the facility, and records concerning competitive health care activities by or on behalf of the facility, from public inspection. Custodians also should be familiar with Title 10A North Carolina Administrative Code (NCAC) 13B .3902 and 3903, which outline responsibilities of medical records managers, and **G.S. § 8-53** (confidentiality of communications between physicians and their patients).

<i>ITEM #</i>	<i>STANDARD 3: CLINICAL RECORDS</i>		
	<i>RECORD SERIES TITLE</i>	<i>DISPOSITION INSTRUCTIONS</i>	<i>CITATION</i>
1.	ADMISSION/DISCHARGE/TRANSFER REPORTS Records documenting the admission, discharge, and transfer of patients. Files may include lists of patient's name, age, sex, race, address, financial class, services received, admitting doctor, date admitted, date discharged, and date transferred, floor, room, and other related information.	Retain in office permanently.	Retention: APSM 45-3, p.126

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ITEM #	STANDARD 3: CLINICAL RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
2. 	ADULT CLINICAL RECORDS (INPATIENT AND OUTPATIENT) Patient clinical records for adults served by the facility. File includes admission records, physical examination and laboratory reports, medical treatment notes, discharge plans and summaries, patient transfer certifications, radiology and diagnostic imaging records, medication administration records, living wills, authorizations to release patient information, and other related records.	a) Records of adults diagnosed with intellectual disabilities should be retained in office until the death of the client. b) Hospital: Destroy in office remaining records 11 years after date of last encounter.* c) Nursing Facility: Destroy in office remaining records 5 years from date of last encounter.* d) Outpatients: Destroy records in office 11 years after date of last encounter.*	Confidentiality: G.S. § 122C-52 Retention: 10A NCAC 13B .3903(a) – Hospital 10A NCAC 13D .2402(a) – Nursing Home Authority: 10A NCAC 13B .3903(d) – Hospital 10A NCAC 13B .5204 – Psychiatric or Substance Abuse Services 10A NCAC 13D .2401 – Nursing Home 10A NCAC 28F .0605 – state operated facilities
3.	CENTRAL STERILE SUPPLY RECORDS: BIOLOGICAL MONITOR NOTEBOOKS Monitoring strips generated regarding the proper functioning of the autoclave equipment.	Destroy in office after 5 years if no claim, audit, or other official action involving the records has been initiated.*	
4.	CENTRAL STERILE SUPPLY RECORDS: STERILIZER TEST Results of checks for sterilization effectiveness.	Destroy in office after 5 years if no claim, audit, or other official action involving the records has been initiated.*	
5.	CENTRAL STERILE SUPPLY RECORDS: MATERIAL SAFETY DATA SHEETS (MSDS) Records documenting safety hazards found in materials used in the dental clinic.	Destroy in office 30 years after materials have been disposed of according to manufacturer’s instructions.	Retention: 29 CFR 1910.1020 (d)(1)(ii)(B)

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ITEM #	STANDARD 3: CLINICAL RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
6.	CENTRAL STERILE SUPPLY RECORDS: PRINTOUT LOGS FOR GAS STERILIZER Logs documenting use of gas sterilization equipment.	Destroy in office after 5 years.*	
7.	CENTRAL STERILE SUPPLY RECORDS: STEAM STERILIZER LOG Logs documenting use of steam sterilization equipment.	Destroy in office upon final disposition of equipment.	
8. 	COMMUNICABLE DISEASE REPORTS Report cards and supporting records of communicable diseases reported to the North Carolina Department of Health and Human Services. File includes patient's name, address, Social Security number, race, sex, and date of onset and information regarding the specific disease being reported.	Transfer to patient's clinical record. (See Item 2, Adult Records (Inpatient and Outpatient) , and Item 12, Pediatric Records (Inpatient and Outpatient) , in Standard 3: Clinical Records).	Confidentiality: G.S. § 132-1.10
9.	CORRESPONDENCE LOG Logs and electronic records detailing patient-related correspondence, including patient release of records.	Destroy in office after 6 years.	
10. 	DEPARTMENTAL MINUTES Meeting minutes and notes of departmental staff meetings.	Destroy in office after 6 years.	Confidentiality: G.S. § 143-318.10
11.	MASTER PATIENT INDEX Medical record index listing patients' names, discharge dates, medical record numbers, dates of service, financial class, attending physicians' names, procedures performed, diagnostic and procedural codes, and other related information.	Retain in office permanently.	

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ITEM #	STANDARD 3: CLINICAL RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
12. 	PEDIATRIC CLINICAL RECORDS (INPATIENT AND OUTPATIENT) Patient clinical records for pediatric patients (birth to eighteen years of age) served by the facility. File includes admission records, physical examination and laboratory reports, medical treatment notes, discharge plans and summaries, patient transfer certifications, radiology and diagnostic imaging records, medication administration records, authorizations to release patient information, consent to test forms, and other related records.	a) Records of patients diagnosed with intellectual disabilities should be retained in office until the death of the client. b) Hospital: Destroy in office remaining records when patient reaches 30 years of age if patient has not received services within the past 11 years.* c) Nursing Home: Destroy in office remaining records after 4 years or when patient reaches 19 years of age, whichever occurs later. d) Outpatients: Destroy records in office when patient reaches 30 years of age if patient has not received services within the past 11 years.*	Confidentiality: G.S. § 122C-52 Retention: 10A NCAC 13B .3903(b) – Hospital Authority: 10A NCAC 13B .3903(d) 10A NCAC 28F .0605 – state operated facilities
13.	TRANSCRIPTION LOGS Logs detailing transcription activities for physicians' notes.	Destroy in office after 6 months.	

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STANDARD 4. EDUCATION RECORDS

Records concerning education services offered in state operated healthcare facilities.

ITEM #	STANDARD 4: EDUCATION RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
1.	DRIVER EDUCATION PROGRAMS Records concerning driver education programs. File includes Driver Eligibility form.	When issued, transfer driver education completion certificate to student's North Carolina Cumulative Record File (Item 49445). Destroy in office remaining records when student reaches 18 years of age or obtains a high school diploma or its equivalent, whichever occurs first.	
2.	 EDUCATIONAL PROGRAMS FOR CHILDREN WITH DISABILITIES Records in paper and electronic formats, including e-mail, concerning children with disabilities who are in facility educational programs. File includes achievement results; intelligence, eligibility, and physical test results; medical reports if the student is physically or mentally impaired; individual education plans (IEPs) and forms; multidisciplinary team reports; and screening, placement, referral, parental consent and notification forms, and correspondence.	The parent, guardian, surrogate parent, or eligible student must be notified prior to destruction of personally identifiable information so copies of records can be provided if desired. Information must be destroyed at the request of parents if no longer needed to provide educational services to the child. Destroy in office paper and electronic records 5 years after student separates from the educational program for children with disabilities if no litigation, claim, audit, or other official action involving the records has been initiated. If official action has been initiated, destroy in office after completion of action and resolution of issues involved.	Confidentiality: G.S. § 115C-114 G.S. § 115C-402
3.	EXCEPTIONAL CHILDREN'S HEADCOUNT REPORTS Records in paper and electronic formats of annual reports listing statistics concerning exceptional children. (Reports are used as a basis for federal funding and individualized student funding.)	Destroy in office after 3 years.	
4.	FIELD TRIP AUTHORIZATION Records concerning the approval or disapproval for students to leave school on field trips. File includes dates of trips, purpose of trips, trip destinations, itineraries, and other related information. File also includes parental consent forms.	Destroy in office after 5 years.	

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ITEM #	STANDARD 4: EDUCATION RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
5.	ROUTINE REPORTS (SCHOOL ADMINISTRATORS AND TEACHERS) Reports summarizing inventories from individual schools or the central office. File also includes invoices for books and requests from schools to order books.	Destroy in office after 5 years if no litigation, claim, audit, or other official action involving the records has been initiated. If official action has been initiated, destroy in office after completion of action and resolution of issues involved.	
6.	SCHOOL ACTIVITY REPORTS Records in paper and electronic formats of reports and lists prepared by various programs. File includes school activity reports, principals', administrators', and teachers' monthly reports.	Destroy in office paper and electronic records after 1 year (excluding e-mail). Destroy e-mail after 5 years.	
7.	 SCHOOL ADMINISTRATOR'S FILE Records in paper and electronic formats, including e-mail, used to administer the principal's office. File includes or concerns schools visited by the principal, workshops attended by the principal, book and equipment inventories, student addresses, correspondence, donations, school reports prepared by the principal, and sales and use tax reports.	Destroy in office paper and electronic records after 5 years if no litigation, claim, audit, or other official action involving the records has been initiated. If official action has been initiated, destroy in office after completion of action and resolution of issues involved.	Confidentiality: 20 USC 1232g
8.	SCHOOL HISTORY Scrapbook collection of news articles and historical data concerning the school's achievements.	Retain in office permanently.	
9.	STATISTICAL REPORTS Reports prepared by the Department of Public Instruction and used by the local education agency for planning and long-range tracking of programs. File includes state of the state, SAT, ABC's of public education, block schedule achievement, report card, alternative learning evaluation, student performance, behavior survey, testing results reports, and other related records.	Destroy in office after 5 years.	
10.	STUDENT ACTIVITY REPORTS Records in paper and electronic formats of annual reports concerning students and their classroom assignments, classroom settings, and other related records.	Destroy in office paper and electronic records after 3 years (excluding e-mail). Destroy e-mail after 5 years.	

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<i>ITEM #</i>	<i>STANDARD 4: EDUCATION RECORDS</i>		
	<i>RECORD SERIES TITLE</i>	<i>DISPOSITION INSTRUCTIONS</i>	<i>CITATION</i>
11.	STUDENT HANDBOOK Records in paper and electronic formats of handbooks supplied to students at the beginning of each school year. File includes attendance and school policies and procedures, graduation requirements, disciplinary policies and procedures, academic policies, and general school rules and regulations.	Retain in office 1 copy permanently. Transfer 10 or more paper copies (as required) of each publication to the State Documents Clearinghouse, State Library of North Carolina. Destroy in office remaining paper and electronic records after 1 year.	Authority: G.S. § 125-11.8(b)
12.	TEACHER LESSON PLANS Records in paper and electronic formats used by teachers for the classes or subjects they are instructing. File includes worksheets, discussion notes, problem-solving materials, and other related records.	Destroy in office after 3 years.	
13.	TEACHER SCHEDULING Records in paper and electronic formats of reports documenting teachers' course schedules and timetables. File includes teacher timetable reports, room timetable reports, course load by teacher reports, teacher directories, and other related records.	Destroy in office after 2 years.	
14.	TEXTBOOKS AND EQUIPMENT Records in paper and electronic formats of inventories of textbooks and special equipment needed for students participating in education programs for children with disabilities.	Destroy in office after 2 years.	
15.	TRANSITORY CORRESPONDENCE Records in paper and electronic formats, including e-mail, of school administrator's routine outgoing correspondence.	Destroy in office after 1 year.	

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STANDARD 5. LABORATORY SERVICES

Records concerning laboratory services and analyses conducted by state operated healthcare facilities for patient and resident care.

In accordance with **G.S. § 131E-97**, all medical records compiled and maintained by public health care facilities are confidential and exempt from public inspection as outlined in **G.S. § 132-6**. This exemption includes financial records concerning charges, accounts, credit histories, and other personal financial records. Similarly, this statute exempts records acquired in connection with the credentialing and peer review of persons having or applying for privileges to practice in the facility, and records concerning competitive health care activities by or on behalf of the facility, from public inspection. Custodians also should be familiar with Title 10A North Carolina Administrative Code (NCAC) 13B .3902 and 3903, which outline responsibilities of medical records managers, and **G.S. § 8-53** (confidentiality of communications between physicians and their patients).

ITEM #	STANDARD 5: LABORATORY SERVICES		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
1.	ACCESSION RECORDS Accession records concerning chain of custody of laboratory samples.	Destroy in office after 2 years.	
2.	 CLINICAL LABORATORY RECORDS: BLOOD BANK RECORDS Records used to monitor the process by which blood products are made available and used. File includes donor information and informed consent forms; records concerning the storage, distribution, and visual inspection of blood products; compatibility testing; component preparation; therapeutic bleedings; and immunizations. File also includes blood collection and processing results; interpretations of all tests and re-tests; labeling; emergency release of blood; and equipment calibration and performance checks. File also includes transfusion reaction reports and complaints; investigations, errors and accident records; difficulties in blood typing reports; exposures to transmissible diseases; supplies and reagents including the disposition of rejected supplies; and reagents and the final disposition reports of blood products.	Destroy in office no less than 10 years after the records of processing have been completed, or 6 months after the latest expiration date for the individual product, whichever occurs later. Retain in office permanently records concerning blood products with no expiration date.	Authority: 21 CFR 606.160 21 CFR 606.165 21 CFR 606.170 Confidentiality: G.S. § 131E-97 Retention: 21 CFR 606.160(d)

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ITEM #	STANDARD 5: LABORATORY SERVICES		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
3.	CLINICAL LABORATORY RECORDS: DONORS DEEMED UNSUITABLE Records used to identify unsuitable donors so that their blood products will not be distributed.	Retain in office for life of donor, then destroy.	Authority: 21 CFR 606.160(e)
4.	CYTOLOGY RECORDS: SLIDES (NEGATIVE OR UNSATISFACTORY) Slides containing negative or unsatisfactory samples.	Destroy in office after 5 years.	
5.	CYTOLOGY RECORDS: SLIDES (SUSPICIOUS OR POSITIVE) Slides containing suspicious or positive samples.	Destroy in office cytological stained slides after 5 years. Destroy in office fine needle aspiration slides after 10 years.	
6.	LABORATORY PROCEDURES/PROTOCOL RECORDS Records and manuals detailing procedures for conducting tests, disposing of specimens, reporting instructions, and similar information.	Destroy in office discontinued or superseded procedures after 2 years.	
7.	LABORATORY REGISTER Log of laboratory tests performed.	Retain in office permanently.	
8.	LABORATORY REPORTS Autopsy, histology, pathology, chemistry, hematology, urinalysis, bacteriology, serology, cytology, and similar reports detailing the results of laboratory analyses.	Transfer original reports to patient's medical file. (See Item 2, Adult Records (Inpatient and Outpatient) , and Item 12, Pediatric Records (Inpatient and Outpatient) , in Standard 3: Clinical Records).	
9.	PROFICIENCY TESTING Records used to attest the handling, preparation, processing, examination, and reporting of results for all proficiency testing. File includes testing report forms, records documenting testing failures and corrective actions, and other related records.	Destroy in office 2 years after date of the test.	
10.	QUALITY CONTROL Records documenting each step in the processing and testing of all quality control samples to assure they are tested in the same manner as daily patient samples.	Destroy in office after 2 years.	

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STANDARD 6. NUCLEAR MEDICINE, RADIATION THERAPY, AND RADIOLOGY RECORDS

Records concerning patient x-rays, radiation treatments, and similar activities at the state operated healthcare facility.

In accordance with **G.S. § 131E-97**, all medical records compiled and maintained by public health care facilities are confidential and exempt from public inspection as outlined in **G.S. § 132-6**. This exemption includes financial records concerning charges, accounts, credit histories, and other personal financial records. Similarly, this statute exempts records acquired in connection with the credentialing and peer review of persons having or applying for privileges to practice in the facility, and records concerning competitive health care activities by or on behalf of the facility, from public inspection. Custodians also should be familiar with Title 10A North Carolina Administrative Code (NCAC) 13B .3902 and 3903, which outline responsibilities of medical records managers, and **G.S. § 8-53** (confidentiality of communications between physicians and their patients).

ITEM #	STANDARD 6: NUCLEAR MEDICINE, RADIATION THERAPY, AND RADIOLOGY RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
1.	APPOINTMENT LOGBOOKS Logbooks listing appointments for radiation therapy or radiology.	Destroy in office after 2 years.	
2.	CARDIAC CATHETER RECORDS Test on coronary arteries. File includes film and electronic images produced during procedure and report of procedure.	a) Transfer original reports to patient’s medical file. (See Item 2, Adult Records (Inpatient and Outpatient) , and Item 12, Pediatric Records (Inpatient and Outpatient) , in Standard 3: Clinical Records). b) Destroy in office film and electronic images concerning pediatric patients when patient reaches 30 years of age, if patient has not received services within the past 11 years.* c) Destroy in office film and electronic images concerning adult patients 5 years from date of last service.*	
3.	CUMULATIVE OCCUPATIONAL EXPOSURE HISTORY Records concerning radiation exposure levels of facility staff. File includes film badge reports and other related records.	Transfer to employee's personnel file upon termination of employment.	Retention: 29 CFR 1910.1020(d)(1)(ii)

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ITEM #	STANDARD 6: NUCLEAR MEDICINE, RADIATION THERAPY, AND RADIOLOGY RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
4.	DAILY STATISTICAL SHEETS AND LOGS Statistical sheets and logs documenting the number of patients given examinations during a given reporting period. Records list patient names, names of attending physicians, type and number of examinations performed, and other related information.	a) Retain in office 1 copy of each biennial and annual report permanently. b) Destroy in office remaining records after 3 years and when released from all audits, whichever occurs later.	
5.	ELECTRONIC RADIOGRAPHIC RECORDS Radiographic cases documented electronically. File includes reports produced from electronic images produced during the test.	Transfer original reports to patient's medical file. (See Item 2, Adult Records (Inpatient and Outpatient) , and Item 12, Pediatric Records (Inpatient and Outpatient) , in Standard 3: Clinical Records).	
6.	IMAGING SERVICES RECORDS Nuclear medicine exams and imaging diagnostic tests, including CAT scans and MRI scans. File includes reports produced from film and electronic images produced during the test.	Transfer original reports to patient's medical file. (See Item 2, Adult Records (Inpatient and Outpatient) , and Item 12, Pediatric Records (Inpatient and Outpatient) , in Standard 3: Clinical Records).	
7.	QUALITY CONTROL RECORDS Records concerning a facility's quality control for radiology programs. File includes routine surveys, instrument calibrations and quality control tests, silver recovery records, and other related records.	Destroy in office after 3 years.*	
8.	RADIATION PROTECTION PROGRAM RECORDS Records and reports documenting inspections by state and federal agencies, consultants, or radiology providers. File includes audit reports, review evaluations, proof of corrective actions taken, and program content and implementation records. File also includes radiation inspection reports completed by the N.C. Department of Environment and Natural Resources, Division of Radiation Protection.	Destroy in office after 10 years.*	
9.	X-RAY FILMS X-ray films. File also includes doctors' orders, x-ray reports, and other related records.	Transfer original reports to patient's medical file. (See Item 2, Adult Records (Inpatient and Outpatient) , and Item 12, Pediatric Records (Inpatient and Outpatient) , in Standard 3: Clinical Records).	

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<i>ITEM #</i>	<i>STANDARD 6: NUCLEAR MEDICINE, RADIATION THERAPY, AND RADIOLOGY RECORDS</i>		
	<i>RECORD SERIES TITLE</i>	<i>DISPOSITION INSTRUCTIONS</i>	<i>CITATION</i>
10.	X-RAY FILMS (DIAGNOSTIC) X-ray films created solely for diagnostic purposes.	Destroy in office when reference value ends. † Facility Policy: Destroy in office after _____	

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STANDARD 7. NURSING SERVICES RECORDS**Records maintained at nurses' duty stations.**

In accordance with **G.S. § 131E-97**, all medical records compiled and maintained by public health care facilities are confidential and exempt from public inspection as outlined in **G.S. § 132-6**. This exemption includes financial records concerning charges, accounts, credit histories, and other personal financial records. Similarly, this statute exempts records acquired in connection with the credentialing and peer review of persons having or applying for privileges to practice in the facility, and records concerning competitive health care activities by or on behalf of the facility, from public inspection. Custodians also should be familiar with Title 10A North Carolina Administrative Code (NCAC) 13B .3902 and 3903, which outline responsibilities of medical records managers, and **G.S. § 8-53** (confidentiality of communications between physicians and their patients).

<i>ITEM #</i>	<i>STANDARD 7: NURSING SERVICES RECORDS</i>		
	<i>RECORD SERIES TITLE</i>	<i>DISPOSITION INSTRUCTIONS</i>	<i>CITATION</i>
1.	AGENCY NURSE DATA RECORDS Records concerning contracted temporary nursing services. File includes resumes, applications, orientation records, biographical information, and other related information.	a) If hired, transfer original records to the facility's personnel office to be incorporated into employee's personnel file. b) Destroy in office records concerning individual not hired 3 years after contract expires.	
2.	CALL-IN REPORTS Records concerning ambulance reports generated when the ambulance is used to transport a patient. File includes copies of ambulance run reports.	Destroy in office after 1 year.	
3.	DAILY STAFFING RECORDS Records and assignment sheets concerning nurse's floor assignments. File includes nurse's name and number of patients seen.	Destroy in office after 5 years.*	
4.	EMERGENCY DEPARTMENT LOG Records concerning individuals receiving services in the emergency department.	Destroy in office after 5 year.*	
5.	EMERGENCY EQUIPMENT CHECKLISTS Checklist regarding equipment reliability on the code cart, which is used for cardiac arrests.	Destroy in office after 5 year.*	

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ITEM #	STANDARD 7: NURSING SERVICES RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
6.	FLOAT ROSTERS Lists of nurses sent to other units within the facility. File includes nurse's name, unit sent to, hours worked, and time sent.	Destroy in office when reference value ends. Facility Policy: Destroy in office after _____	
7.	FLOOR CENSUS RECORDS Records used to track room usage. File includes number of patients per bed and number of rooms available. File also includes patient's name, doctor(s), and diagnosis.	Destroy in office after 1 year.*	
8.	 NURSING STAFF MEETING MINUTES Minutes of all committee meetings including Council of Nursing and supporting records.	Destroy in office after 3 years.	Confidentiality: G.S. § 143-318.10
9.	OBSERVATION LOGS Records concerning observation of patients in the facility less than 24 hours.	Destroy in office after 5 years.*	
10.	PRIVATE DUTY CALL LISTS Lists of patient sitters used but not hired by the facility.	Destroy in office when reference value ends. Facility Policy: Destroy in office after _____	
11.	PRODUCTIVITY REPORTS Productivity reports showing hours spent on and off task, total hours worked, vacation time taken, overtime, etc. File is used to determine shift scheduling needs.	Destroy in office after 1 year.	

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STANDARD 8. PERSONNEL**Records concerning inactive personnel from division facilities.**

Except as provided in G.S. § 126-23 and G.S. § 126-24, personnel files of State employees shall not be subject to inspection and examination as authorized by G.S. § 132-6 [G.S. § 126-22(a)].

ITEM #	STANDARD 8: PERSONNEL		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
1954 	JULIAN F. KEITH ALCOHOL AND DRUG ABUSE TREATMENT CENTER PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File. (Prior to 1997, facility was known as the Black Mountain Alcohol Rehabilitation Center.)	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
1961 	RJ BLACKLEY ALCOHOL AND DRUG ABUSE TREATMENT CENTER PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File. (From 1950-1989, this facility was known as the N.C. Alcoholic Rehabilitation Center (ARC) at Butner; from 1989-2003, it was called Butner Alcohol and Drug Abuse Treatment Center; it was named R.J. Blackley Alcohol and Drug Abuse Treatment Center in 2003 and renamed RJ Blackley Center in 2015.)	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
2009 	WALTER B. JONES ALCOHOL AND DRUG ABUSE TREATMENT CENTER PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File.	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24

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ITEM #	STANDARD 8: PERSONNEL		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
1963 	CASWELL DEVELOPMENTAL CENTER PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File.	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
3592 	J. IVERSON RIDDLE DEVELOPMENTAL CENTER PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File. (Prior to 2004, facility was called Western Carolina Center.)	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
1995 	MURDOCH DEVELOPMENTAL CENTER PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File.	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
3497 	BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File.	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
1996 	LONGLEAF NEURO-MEDICAL TREATMENT CENTER PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File. (Prior to July 5, 2007, facility was called Wilson Special Care Center; formerly known as North Carolina Special Care Center.)	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
1998 	O'BERRY NEURO-MEDICAL TREATMENT CENTER PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File.	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
1957 	BROUGHTON HOSPITAL PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File.	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24

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ITEM #	STANDARD 8: PERSONNEL		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
50480 	CENTRAL REGIONAL HOSPITAL PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File.	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
1966 	CHERRY HOSPITAL PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File.	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
1974 	DOROTHEA DIX HOSPITAL PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File.	Records no longer being created. Destroy records currently held in the State Records Center 30 years from date of record.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
1989 	JOHN UMSTEAD HOSPITAL PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File.	Records no longer being created. Destroy records currently held in the State Records Center 30 years from date of record.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
31744 	WHITAKER PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File.	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24
50666 	WRIGHT SCHOOL PERSONNEL JACKETS (INACTIVE) Official records with all information transferred from the Active Personnel File.	Transfer to the State Records Center after 5 years. Records will be held for agency in the State Records Center 25 additional years and then destroyed.	Confidentiality: G.S. § 126-22 G.S. § 126-23 G.S. § 126-24

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STANDARD 9. PHARMACY RECORDS

Records concerning operations of state operated healthcare facility pharmacies. (See 21 North Carolina Administrative Code 46, Board of Pharmacy - Rules and Regulations Sections .0100 through .3000 for further information regarding the disposition of records.)

In accordance with G.S. § 131E-97, all medical records compiled and maintained by public health care facilities are confidential and exempt from public inspection as outlined in G.S. § 132-6. This exemption includes financial records concerning charges, accounts, credit histories, and other personal financial records. Similarly, this statute exempts records acquired in connection with the credentialing and peer review of persons having or applying for privileges to practice in the facility, and records concerning competitive health care activities by or on behalf of the facility, from public inspection. Custodians also should be familiar with Title 10A North Carolina Administrative Code (NCAC) 13B .3902 and 3903, which outline responsibilities of medical records managers, and G.S. § 8-53 (confidentiality of communications between physicians and their patients). Each registrant or practitioner manufacturing, distributing, or dispensing controlled substances under this Article shall keep records and maintain inventories in conformance with the record-keeping and the inventory requirements of the federal law and shall conform to such rules and regulations as may be promulgated by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services (G.S. § 90-104).

ITEM #	STANDARD 9: PHARMACY RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
1.	ADVERSE DRUG REACTION REPORTS Reports to the Food and Drug Administration (FDA) describing adverse drug reactions.	Destroy in office after 3 years.	
2.	BIENNIAL INVENTORY OF CONTROLLED SUBSTANCES Inventories of controlled substances.	Destroy in office after 3 years.*	Retention: 21 NCAC 46 .1414 (j)(6)
3.	DRUG DESTRUCTION RECORDS Inventories of drugs destroyed, their amounts, and when destroyed.	Destroy in office after 3 years.	Retention: 21 NCAC 46 .1414 (j)(6)
4.	DRUG DISPOSAL RECORDS Records documenting the disposal or final disposition of all out-dated, improperly labeled, adulterated, damaged, or unwanted controlled and non-controlled substances, or drug containers with worn, illegible, or missing labels. Amended 09-20-2016	a) Retain pharmaceutical waste manifests in office permanently. b) Destroy remaining records in office after 3 years.	Retention: DHHS Pharmaceutical Waste Policy

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ITEM #	STANDARD 9: PHARMACY RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
5.	DRUG DISTRIBUTION RECORDS Records listing who filled and/or checked a medication at time of issuing or dispensing and other related information.	Destroy in office after 3 years.	Retention: 21 NCAC 46 .1414 (j)(1)
6.	DRUG INVENTORIES Inventories of controlled and non-controlled substances. File includes inventory reports, ancillary drug cabinet inventories, annual and biennial inventories, perpetual inventories, and other related records used to account for medication compounding and dispensing by pharmacies and locations outside the pharmacy.	Destroy in office after 3 years.*	Retention: 21 NCAC 46 .1414 (j)(6)
7.	INSURANCE CLAIM RECORDS Insurance claim forms (including Medicaid), confirmation or denial reports, remittance and status reports, and other related records submitted by pharmacies for reimbursement. File includes electronic records used to maintain Medicare Part D billing.	a) Destroy non-Medicaid related records in office after 3 years.* b) Destroy Medicaid related records in office after patient has expired.* c) Destroy Medicare Part D medication and billing records in office after 10 years.	
8.	INTRAVENOUS HOOD PERFORMANCE REPORTS Records of the tests conducted on intravenous hood to ensure a sterile environment.	Destroy in office after 3 years.	
9.	MEDICATION ERRORS RECORDS Records documenting the administration of an incorrect medication or dose. File includes pertinent chronological information, appropriate health care facility forms, event reports, and investigative reports including the identity of individual(s) responsible.	Destroy in office after 3 years.*	Authority/Retention: 21 NCAC 46.1414(j)(2)
10.	MEDICATION STORAGE INSPECTION REPORTS Results of medication storage areas inspected on a routine basis including the removal of expired or expiring medication.	Destroy in office after 3 years.	

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ITEM #	STANDARD 9: PHARMACY RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
11.	PATIENT MEDICATION PROFILE Lists of all prescribed medications for each patient.	Destroy in office when patient is no longer active at facility.*	
12.	PHARMACEUTICAL CARE ASSESSMENT RECORDS Records involving the interpretation and evaluation of a patient's drug therapy or other pharmaceutical care services. File includes on site drug and medication reviews and similar records.	Destroy in office when patient is no longer active at facility.*	
13.	 PRESCRIPTION ORDERS Prescription orders for controlled and non-controlled substances or other medication or a device for each patient. File includes patient's name, location, medical records number, medication name, strength, dosage form, date order was written, and signature of prescriber. Amended 09-20-2016	a) Maintain original order in clinical record. (See Item 3, Adult Records (Inpatient and Outpatient), and Item 10, Pediatric Records (Inpatient and Outpatient), in Standard-3, Program Operational Records: Clinical Records). b) Destroy paper records in office after 3 years. c) Destroy electronic records in office after 10 years.	Retention: G.S. § 90-85.26 21 NCAC 46 .2302 Authority: G.S. § 90-85.30 G.S. § 90-85.35 Confidentiality: G.S. § 90-85.36
14.	SCHEDULE II INVOICE AND RECEIVING RECORDS Ordering and receiving records for schedule II controlled substances. Amended 09-20-2016	Destroy in office after 3 years.*	Authority: G.S. § 90-90 G.S. § 90-107 Retention: 21 NCAC 46 .1414(j)(6) 42 CFR 423.505
15.	 SCHEDULE II, III, IV, AND V NARCOTICS USAGE RECORDS Records documenting the use of schedule II, III, IV, and V controlled substances.	Destroy in office after 3 years.*	Authority: G.S. § 90-90 through § 90-93 G.S. § 90-113.73 Confidentiality: G.S. § 90-85.36(c) G.S. § 90-113-74

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STANDARD 10. SOCIAL SERVICES AND ACUTE CARE RECORDS**Records concerning social service and acute care programs at state operated healthcare facilities.**

In accordance with **G.S. § 131E-97**, all medical records compiled and maintained by public health care facilities are confidential and exempt from public inspection as outlined in **G.S. § 132-6**. This exemption includes financial records concerning charges, accounts, credit histories, and other personal financial records. Similarly, this statute exempts records acquired in connection with the credentialing and peer review of persons having or applying for privileges to practice in the facility, and records concerning competitive health care activities by or on behalf of the facility, from public inspection. Custodians also should be familiar with Title 10A North Carolina Administrative Code (NCAC) 13B .3902 and 3903, which outline responsibilities of medical records managers, and **G.S. § 8-53** (confidentiality of communications between physicians and their patients).

<i>ITEM #</i>	<i>STANDARD 10: SOCIAL SERVICES AND ACUTE CARE RECORDS</i>		
	<i>RECORD SERIES TITLE</i>	<i>DISPOSITION INSTRUCTIONS</i>	<i>CITATION</i>
1.	APPROVAL FOR NURSING HOME PLACEMENT RECORDS Completed forms approving patients' placements in nursing homes.	a) Transfer relevant paperwork to clinical record or Utilization Review office. (See Item 2, Adult Records (Inpatient and Outpatient) in Standard 3: Clinical Records). b) Destroy in office remaining records 3 years after discharge or death of patient.	
2.	PATIENT CONFERENCE RECORDS Summaries of conferences with patients. File includes progress notes, discharge planning records, crisis consulting records, abuse-neglect reports, involuntary commitment reports, patient assessments, and similar records.	Transfer records to appropriate clinical record following conference. (See Item 2, Adult Records (Inpatient and Outpatient), and Item 12, Pediatric Records (Inpatient and Outpatient), in Standard 3: Clinical Records).	
4.	PATIENT TRACKING RECORDS Records used to track patients receiving care through a facility's social service program. File includes patient's name and address, room number, consultation date, placement information, and similar records.	Destroy in office after 3 years.	
5.	REFERRAL TO COUNTY DEPARTMENT OF SOCIAL SERVICES (PA-400) Completed forms used as referrals to county departments of social services for patients who may be eligible for Medicare.	Destroy in office after 4 years.	

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<i>ITEM #</i>	<i>STANDARD 10: SOCIAL SERVICES AND ACUTE CARE RECORDS</i>		
	<i>RECORD SERIES TITLE</i>	<i>DISPOSITION INSTRUCTIONS</i>	<i>CITATION</i>
6.	REFERRAL WORKSHEET FOR DISCHARGE PLANNING Completed forms detailing the recovery regiment that a patient should follow once discharged.	Transfer to appropriate clinical record. (See Item 2, Adult Records (Inpatient and Outpatient), and Item 12, Pediatric Records (Inpatient and Outpatient), in Standard 3: Clinical Records).	

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STANDARD 11. STUDENT RECORDS**Records concerning students served in education programs within division facilities.**

In accordance with the Family Educational Rights and Privacy Act (20 USC 1232g), student records are confidential and exempt from public inspection as outlined in G.S. § 132-6.

ITEM #	STANDARD 11: STUDENT RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
1. 	ACTIVE STUDENTS RECORDS Records in paper and electronic formats, including e-mail, concerning active school student records. File includes admission records, medical records, correspondence, evaluations, and various other social and academic records.	Transfer to North Carolina Cumulative Records File (Item 49445) when student terminates enrollment.	Confidentiality: 34 CFR 361.49 20 USC 1232g
2. 	CUMULATIVE PLANS Records in paper and electronic formats, including e-mail, of individual education plans concerning each student. File includes academic information, report cards, and Scholastic Aptitude Test, competence, and achievement testing results.	Transfer to North Carolina Cumulative Records File (Item 49445) when student terminates enrollment.	Confidentiality: 34 CFR 361.49
3. 	EXAMINATION MATERIALS Records concerning the administration of local or state standardized examinations and tests that measure students' performance or level of acquired knowledge. File includes all testing materials.	<ul style="list-style-type: none"> a) Destroy in office test materials specified by DPI via secure method immediately after the testing window closes. b) Destroy in office assessment guides after the testing window closes. c) Destroy in office remaining secure test materials after the storage time required by DPI. d) Return specified test materials to vendor or to DPI/TOPS after the testing window closes. e) Return used answer sheets to DPI/TOPS immediately after administration. 	Confidentiality: NC State Board of Education Policy GCS- A-010

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ITEM #	STANDARD 11: STUDENT RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
4. 	EXAMINATION REPORTS Records in paper and electronic formats concerning the administration of local or state standardized examinations and tests. File includes class record sheets, summary goal reports, individual and class roster reports, and other related records.	Destroy in office 3 years after test scores are posted to the individual student's North Carolina cumulative record.	Confidentiality: G.S. § 115C-174.13
5. 	INJURY REPORTS Records in paper and electronic formats concerning medical attention provided to students by school officials. File includes injury report forms.	Destroy in office paper and electronic records when student reaches 30 years of age and has not received services within the last 10 years if no litigation, claim, audit, or other official action involving the records has been initiated. If official action has been initiated, destroy in office after completion of action and resolution of issues involved.	Confidentiality: 20 USC 1232g 42 USC 1320d-2(d)(2) Retention: 10A NCAC 13B .3903
6. 	NORTH CAROLINA CUMULATIVE RECORDS Cumulative records of students' pre-school, elementary and secondary educational career. File includes personal and family information; health and immunization records; accountability worksheets; attendance reports; standardized test dates and results; pre-school, elementary, middle, and high school inserts or grade sheets; copies of birth certificates; and driver's education certificates. File may also include photographs, correspondence to and from parents or legal guardians and school personnel, and court order documents such as birth date and name change verifications. File also includes references to dates of separation due to graduation or withdrawal.	Destroy in office accountability worksheets when reference value ends. Microfilm cumulative records 2 years after student graduates or withdraws from the school system. Destroy paper records 30 days after microfilming. Retain in office microfilm records permanently. <i>Note: G.S. § 115C-402(e) states "The official record of each student is not a public record as the term 'public record' is defined by G.S. 132-1. The official record shall not be subject to inspection and examination as authorized by G.S. 132-6."</i>	Confidentiality: G.S. § 115C-402
7. 	PARENT CONFERENCES Records in paper and electronic formats, including e-mail, concerning conferences between parents, teachers, and/or other school officials. File includes correspondence, parent conference forms outlining reasons for conference, actions taken, and other related records.	Destroy in office after 11 years.	Confidentiality: 20 USC 1232g

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ITEM #	STANDARD 11: STUDENT RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
8. 	PERMANENT HEALTH RECORD CARDS Cards that provide information on a student's medical history and status while in a school or program. File includes immunization information, vision and hearing screening results, health status including chronic illness, seizures, allergies, special health considerations, and narrative notes entered by nurses or other school or program officials.	Transfer to North Carolina Cumulative Records File (Item 49445) when student terminates enrollment.	Confidentiality: 20 USC 1232g 42 USC 1320d-2(d)(2)
9. 	STUDENT ABSENTEE REPORTS Records listing names of students absent from school. File includes each student's name, gender, homeroom number, teacher's name, reason for absence, and whether the absence is excused or unexcused. File also includes each student's Social Security number or exceptional children's identification number.	Destroy in office after 1 year.	Confidentiality: 5 USC Section 552a
10.	STUDENT ATTENDANCE (CLASSROOM) Records in paper and electronic formats concerning each student's daily, weekly, and monthly class attendance. File includes attendance sheets, books, and/or cards listing student's name and whether absent, present, or tardy.	Destroy in office after 1 year.	
11. 	STUDENT CLASS WORK Records concerning material used in the classrooms by teachers and students. File includes non-standardized test material, term papers, completed homework assignments, assignment books, notebooks, and other related records.	Destroy in office after 3 years.	Confidentiality: 20 USC 1232g
12. 	STUDENT DROPOUTS Records in paper and electronic formats used to track student withdrawals from school. File includes students' names, ages, race, gender, grade levels, dates of withdrawals, suspension and family data, intervention/prevention profiles, and monthly summaries of all dropouts.	Destroy in office paper and electronic records after 5 years.	Confidentiality: G.S. § 115C-402

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ITEM #	STANDARD 11: STUDENT RECORDS		
	RECORD SERIES TITLE	DISPOSITION INSTRUCTIONS	CITATION
13. 	STUDENT ENTRY AND WITHDRAWAL Records in electronic formats of logs showing when students enter or withdraw from school. File includes student information sheets and withdrawal forms listing students' names, family data, identification numbers, entry/withdrawal codes, reasons for withdrawals or transfers, current grade levels, students' grades and absences to date, and signatures of school personnel.	Destroy in office after 3 years.	Confidentiality: G.S. § 115C-402
14. 	STUDENT GRADES (CLASSROOM) Records in paper and electronic formats of teachers' records of individual student's grades. File includes teachers' grade books, progress reports, and grade reports for each nine week grading period for the school year. (Grades are used to compute semester and yearly averages for each student by subject.)	Destroy in office 1 year after appropriate information has been posted to student's cumulative record.	Confidentiality: 20 USC 1232g
15.	STUDENT SCHEDULING Records in paper and electronic formats of reports documenting a student's course selection and timetables. File includes course loads, student reports, timetable reports, course selection and verification reports and slips, and student scheduling reports.	Destroy in office after 5 years.	
16.	STUDENT TRANSFERS Records in paper and electronic formats concerning the transfer of students within or out of the Local Education Agency (LEA). File includes transfer form listing student's name, parents' names, address, grade level, name of school, reason for transfers, and other related records.	Destroy in office after 3 years if no litigation, claim, audit, or other official action involving the records has been initiated. If official action has been initiated, destroy in office after completion of action and resolution of issues involved.	

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STANDARD 12. UTILIZATION REVIEW RECORDS**Committee records regarding the utilization of facility staff, programs, and resources.**

In accordance with **G.S. § 131E-97**, all medical records compiled and maintained by public health care facilities are confidential and exempt from public inspection as outlined in **G.S. § 132-6**. This exemption includes financial records concerning charges, accounts, credit histories, and other personal financial records. Similarly, this statute exempts records acquired in connection with the credentialing and peer review of persons having or applying for privileges to practice in the facility, and records concerning competitive health care activities by or on behalf of the facility, from public inspection. Custodians also should be familiar with Title 10A North Carolina Administrative Code (NCAC) 13B .3902 and 3903, which outline responsibilities of medical records managers, and **G.S. § 8-53** (confidentiality of communications between physicians and their patients).

<i>ITEM #</i>	<i>STANDARD 12: UTILIZATION REVIEW RECORDS</i>		
	<i>RECORD SERIES TITLE</i>	<i>DISPOSITION INSTRUCTIONS</i>	<i>CITATION</i>
1.	DAILY MEDICARE AND MEDICAID LOGS Record of money paid to provider by Medicaid or Medicare.	Maintain until Medicaid Cost Report Audit closes. Destroy in office after 10 years.*	
2.	FINANCIAL CLASSIFICATION LOGS Logs listing financial classifications applicable to patients.	Destroy in office when superseded or obsolete.	
3.	PATIENT ABSTRACT RECORDS Abstracts of codes used to track both patient billing and types of diseases diagnosed (used to report this information to insurance companies).	Destroy in office after 1 year.	
4.	PRIVATE PAID DISCHARGES RECORDS Records used to track those patients who pay their bill without insurance or Medicare.	Maintain until Medicaid Cost Report Audit closes. Destroy in office after 3 years.*	
5.	TRANSFER AND DISCHARGE LISTS Lists summarizing transfers and discharges of patients.	Destroy in office after 1 year.	
6.	UTILIZATION REVIEW PLANS Plans for utilization review.	Destroy in office when superseded or obsolete.	Authority: 42 CFR 482.30

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