Title: Basic Rules for Documenting Service Records Procedure

Prepared By: Clinical Director

Purpose:

To define the practices and requirements for employees to use when documenting clinical case records.

Scope:

This procedure applies to all employees (including full-time employees, part-time employees, contractual providers, volunteers, students, and/or interns) of Huron Behavioral Health (HBH).

Information:

1. For the purpose of this procedure, "Clinical Records" are considered to be all documents relating to the assessment, treatment, progress, etc. These include, but are not limited to the following documents:

- Person Centered Plan (PCP)
- Periodic Review
- Clinical Assessment
- Progress Note
- Crisis Plan
- Psychiatric Consult
- Correspondence
- Prescription
- Evaluation
- Health Screening
- Safety Checklist
- Screening tools (CAFAS, DECA, MIDAS, RAS, PECFAS, etc.)
- Transfers/Referral
- Consent to Treat
- Release of Information
- Data Sheet
- Test/Lab Report

2. Huron Behavioral Health will make a good faith effort to comply with all record-keeping requirements defined in regulatory requirements and accreditation standards, including the "Medicaid Service Records Manual" and the Michigan Department of Health and Human Services (MDHHS) General Schedule #20 approved for Community Mental Health Services Programs (CMHSP) released on 05/01/07 (@ http://michigan.gov/documents/hal/mhc_rm_gs20_195724_7.pdf)

1. HBH utilizes an Electronic Medical Records (EMR) system. With this system, most of the clinical records are created electronically. Any clinical records that are generated in a hand-written format are scanned into the EMR system. To maintain the highest level of integrity and legibility with scanned records, all hand-written information must be created using BLACK ink as other colors do not scan well.

2. Copies of clinical case records must be made in accordance with the HBH "Confidentiality and Disclosure of Information Procedure" RR.2.07)

Procedure:

A. HBH employees will document clinical records in accordance with the following guidelines:

1. Be accurate – state the facts as observed, stated, or reported
2. Be timely – record the significant information at the time of the event, since delays may result in inaccurate or incomplete information
3. Be objective – record the facts and avoid drawing conclusions or interjecting personal opinions. When professional opinion is expressed, it must be phrased to clearly indicate that it is the recorder's view
4. Be specific, concise, and descriptive – record information in detailed terms rather than general terms. Be brief without sacrificing essential facts. Describe observations and pertinent information thoroughly.
5. Be consistent – if any contradictions occur, explain them and give reasons for contradictions
6. Be comprehensive and logical in thought process – record significant information relative to a consumer's condition and course of treatment/habilitation. Document pertinent findings, services rendered, changes in

consumer's condition, and responses to treatment. Information in the record must include justification regarding the medical necessity for initial services and on-going services/treatment. When any non-standard treatment method is utilized, the reasons must be clearly documented. (See SD.1.11 "HBH Treatment Philosophy, Evidence-Based Practices, and Approved Methods Policy).

7. Be clear – record meaningful information, particularly if there are other clinicians involved in the consumer's case. Write in non-technical terms whenever appropriate (for example the consumer's Person Centered Plan/PCP).

B. General Documentation Guidelines:

1. In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the consumer has a right to access all of their case records. Therefore staff should pay particular attention to any personal impressions they enter in the case record since such information may be viewed by others cannot be obliterated from the record.

2. With the exception of family records, notations should not be made in the record about another consumer as the records can be copied and released for various reasons (see also "Confidentiality and Disclosure of Information Procedure" RR.2.07).

3. The use of non-consumer names (for example a spouse, sibling, girlfriend, etc.) in the case record should be limited to those situations where the responsible professional determines that the use of the individual's name is necessary and is clinically pertinent. Any person who has significant influence on the consumer may be included by name as long as the extent and type of relationship and influence are also recorded. However, since HIPAA requires all portions of a record to be copied when a consumer requests it (see RR.2.07 Confidentiality & Disclosure Procedure), caution and discretion should be exercised by the clinician when using another person's name in any case record documentation. Using the names of persons other than the individual served should be avoided when possible.

4. For hand-written documents that are scanned into the consumer's case record, every page of multi-page clinical documents should include the consumer's name and/or case number to assure that all pages of the document are scanned into the correct case record and the record is complete.

C. Signatures/Credentials on Clinical Documents:

1. The EMR system automatically signs (e-signs) and credentials the clinician's documents. However, for any documents that are hand-written, they must be signed and dated by the responsible clinical staff.

2. When not e-signed, signatures must be legible and complete (first and last name) and followed by full credentials.

E. Requirements for Editing, or Changing Clinical Records:

1. No erasures, "wite-out", correction tape, or other camouflaging techniques are allowed on clinical documents that are generated for a consumer's case record. If an error is created on a hand-written document, the clinician will correct the error utilizing the following method:
    - Draw a line through the incorrect entry
    - Write the word "error" above the strike-out
    - Initial and date the correction
    - As close as possible to the crossed-out entry, re-write the correct entry

2. Any changes are to be made by the primary clinician who has completed the clinical documentation. It is not acceptable for a staff to change any information on a clinical record created by another employee.

F. Requirements for Correcting Omissions in Clinical Records:

1. If information is observed to be missing after the record is completed (e.g. date was inadvertently omitted by the worker from a record when it was generated), a correction may be made by the worker to add the missing information and clearly note that it was added at a date subsequent to the original record's date.

The worker must clearly identify the information that is being added (by hi-lighting, circling, etc.), sign their initials and date next to the added information.

2. If the correction effects the content of the record and the consumer has already received a copy of the record (e.g. PCP, Periodic Review, Crisis Plan, etc.), the consumer must be given a copy of the changed record. If there is no content change (e.g. adding a case number or date in the document), it is not necessary to re-copy the consumer.

G. Use of Abbreviations in Clinical Documents:

1. HBH has determined that abbreviations could potentially be misinterpreted or dangerous if used on clinical documentation. Employees should refrain from using abbreviations and/or acronyms in clinical documents in order to avoid misunderstanding/misinterpretation of information. The only exception allowed is if the abbreviation/acronym is used at the beginning of the document and immediately followed by an explanation of its meaning, whereupon the abbreviation may be used if it is felt to be necessary by the clinician. Whenever possible, employees should also refrain from using any abbreviations in clinical documents since case records can be view by the consumer or subpoenaed by the court where individuals outside of HBH may not be familiar with our internal acronyms/abbreviations.

2. The Record Review audits will monitor records for abbreviations, acronyms, or symbols and notify the primary worker of any needed corrective actions required.

Definitions/Acronyms:

EMR – Electronic Medical Record
HBH – Huron Behavioral Health
HIPAA – Health Insurance Portability & Accountability Act of 1996
PCP – Person Centered Plan

Forms:

N/A

Records:

Case records are retained in accordance with the HBH Record Retention & Storage Policy (QI.1.23).

Reference(s) and/or Legal Authority

Medicaid Provider Manual Chapter III Guidelines @ http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf
QI.1.23 HBH Record Retention & Storage Policy
RR.2.07 Confidentiality and Disclosure Procedure

Change History:

Change Letter	Date of Change(s)	Changes
A	12/03/04	Added "Signatures/Credentials" section, and reformatted procedure, added reference to RR.2.07.
B	05/30/06	Reformatted entire procedure by adding Alpha and numeric section, Broke sections "D" and "E" into separate sections and added section "F" and "G", added hyperlinks, and acronyms.
C	05/27/08	Added #3 in "Information" section for EMR needs, reworded D.2 to allow only black ink., changed "Prepared By" section (in header from "QI Coordinator" to "Executive Director", added "EMR" to "Acronym" section,
D	02/05/09	Added E.2 to clarify current expectation and practices
E	05/30/13	Reviewed and revised to comply with 8th edition standards – reworded last sentence in #3 in "Information" section, in last bullet in #1 in "Information" section changed "Testing Protocols" to "Tests/Lab Reports", removed example in E.1, in 3rd bullet in E.1 added "and date", reworded B.3 and removed use of consumer case number and first name, in D.1 changed "Medicaid Chapter IIII Guidelines" to "Medicaid Provider Manual", deleted G.1 which referred to removing case records from chart room, in G.2 changed "may" to "must".
F	03/08/16	Added section "G" and made numerous changes in sentences throughout document to clarify current practices with EMR and scanning, see Controlled Documentation Manager for full list of changes and/or previous versions.