



HURON BEHAVIORAL HEALTH PROCEDURE

Procedure #: **QI.2.19**
Issue Date: **07/16/03**
Rev. Date: **06/09/21**
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Title: **Basic Rules for Documenting Service Records Procedure**

Prepared By: **Clinical Director**

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Purpose:

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

Scope:

This procedure applies to all employees (including full-time and part-time employees), contract 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, planning, treatment, progress, etc. These include, but are not limited to the following documents:
 - Individual Plan Of Service (IPOS)
 - Addendums to the IPOS
 - Periodic Reviews
 - Clinical Assessments
 - Progress Notes
 - Crisis Plans
 - Psychiatric Consults
 - Correspondence
 - Prescriptions
 - Evaluations
 - Health Screenings
 - Safety Checklists
 - Screening tools (CAFAS, DECA, MIDAS, RAS, PECFAS, etc.)
 - Transfers/Referrals
 - Consent to Treat
 - Release of Information
 - Data Sheets
 - Test/Lab Reports
2. Huron Behavioral Health staff shall make a good faith effort to comply with all record-keeping requirements defined in applicable regulatory requirements and accreditation standards, including the Medicaid Provider 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)
3. HBH utilizes an Electronic Medical Record (EMR) system. With this system, most of the clinical records are created electronically. Any clinical records that are generated in a hand-written or typed format are scanned into the EMR system. To maintain the highest level of integrity and legibility with scanned records, all hand-written information are to be created using BLACK ink as other colors do not scan well.
4. Copies and/or disclosures 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

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6. Be comprehensive and logical in thought process – record significant information relative to a consumer's condition and course of treatment. 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 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 treatment. When documents are given to the consumer. They should be written at a third-grade reading level in non-technical terms whenever appropriate (for example the consumer's Individual Plan of Service, etc.)

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 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 and 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 may be copied and released to others 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 used. Use of names 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 document. 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 complete record is scanned.

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 (note: signing only initials is **not** acceptable).

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 permitted for any staff to change information on a clinical record which has been created by another employee.

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F. Requirements for Correcting Omissions in Clinical Records:

1. If information is observed to be missing after the record is completed and entered into the case record (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, sign their initials and date next to the added information.
2. If the correction affects the content of the record and the consumer has already received a copy of the record (e.g. IPOS, 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 when 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 viewed by the consumer or subpoenaed by the court where individuals outside of HBH may not be familiar with 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 (see also "[Record Review Procedure](#)" QI.2.08).

Definitions/Acronyms:

CMHSP – Community Mental Health Services Program
EMR – Electronic Medical Record
HBH – Huron Behavioral Health
HIPAA – Health Insurance Portability & Accountability Act of 1996
IPOS – Individual Plan Of Service
MDHHS – Michigan Department of Health and Human Services
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>
MDHHS General Schedule #20 @ https://www.michigan.gov/documents/hal/mhc_rm_gs20_195724_7.pdf
[QI.1.23 HBH Record Retention & Storage Policy](#)
[QI.2.08 Record Review Procedure](#)
[RR.2.07 Confidentiality and Disclosure Procedure](#)

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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 8 th 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 3 rd 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.
G	12/26/17	In "Information" section #1 added "Addendums to the PCP", in "Acronyms" section added CMHSP & MDHHS, in "References" section added "MDHHS General Schedule #20", made several additional minor wording/grammatical changes/corrections throughout document without changing sentence content.
H	10/23/19	Changed "Person Centered Plan/PCP" to "Individual Plan Of Service/IPOS" throughout document (4 places), in "Acronyms" section added "IPOS", added reference to "Record Review Procedure QI.2.08" (2 places), made several minor wording/grammatical changes/corrections throughout document without changing sentence content.
I	06/09/21	Made several minor wording/grammatical changes/corrections throughout procedure without changing sentence content