Record Keeping General Guidelines

The importance of maintaining a comprehensive, detailed, and uniform clinical record and documentation system cannot be overemphasized. To be complete, the clinical record must contain sufficient information to identify the client clearly, support the diagnosis, and justify the treatment.

- Establish a single medical record per client.
- Writing is legible so that all entries in the clinical record are clear and readable.
- All portions of the medical record must be legible. Use caution when using double sided forms and hole punching pages.
- Errors are to be corrected by a single line though the incorrect information with the word “error,” written out. Date and initial each corrected entry. Never erase, over-write, ink out, or utilize white out to correct an error.
- Addenda to an entry already made must be made separately with a printed name, credentials, signature, and date. Such entries are to be labeled “addendum.”
- Use black ink pen or black type only. Do not use water base (felt) pens, pencils, or colored print when documenting in the clinical record.
- Draw a diagonal line through all blank portions of a document.
- Use commonly used abbreviations.
- Use behavioral descriptions to document a client’s progress.
    - *Imprecise*: Appears depressed.
    - *Precise*: Crying, poor eye contact, states she is not sleeping because she is worried about her illness.
- Laboratory work reports and radiology examination reports must bear the date the physician reviewed the report and his/her initials.
- Ensuring no duplication of service is the responsibility of all service providers. All providers share the responsibility to coordinate services and document service needs.
- A “Late Entry” is any documentation that is done on a calendar day other than the date the service was provided. When documenting a “Late Entry” note, enter the Date of Service that the service was provided, not the date the note is being written. When documenting the information of the service provided, the phrase “Late entry for (date service was provided)” should appear in the body of the note, preferably at the beginning of the note. After completion, the note should be signed and dated on the date that it is being written, not the date the service was provided, and should be filed in the medical record chronologically to when it was written, not filed by the date the service was provided. You may wish to insert a note referring to the late entry at the point it would have been included if written at the correct time.
- The medical record may be organized with the most recent entry on top (descending order) or in ascending order. However, when the medical record is closed, the record should read like a book, with the newest information at the end.
- Medical record retention is outlined in the provider contract to be a period of no less than ten (10) years.

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Treatment Record Requirements

Behavioral Health Assessment

- Initial assessments should be completed within 60 calendar days from day of admission
- Assessment shall include a typed or legibly printed name, signature of the service provider and date of signature.
- Reassessments/updates should be completed whenever is clinically indicated or at a minimum of 3 years fro
- The following elements must be contained in the assessment document:
    - Date of assessment.
    - Identifying information capturing client's age, date of birth, gender, and ethnicity.
    - Source of information.
- Assessments should use domains as identified below:
    - **Domain 1**: Presenting problem/needs:
      Current and history of presenting problem, current mental status exam, impairments in functioning
    - **Domain 2**: Trauma:
      Trauma exposures, reactions, screening, system involvement
    - **Domain 3**: Behavioral health history:
      Mental health history, substance use/abuse, previous services
    - **Domain 4**: Medical history and medications:
      Physical health conditions, medication, developmental history
    - **Domain 5**: Psychosocial factors:
      Family, social and life circumstances, cultural considerations
    - **Domain 6**: Strength, risk and protective factors:
      Client and family strengths, risk factors and behaviors, safety planning
    - **Domain 7**: Clinical summary, Treatment recommendations, Level of Care Determination
      Clinical impression, summary of clinical symptoms and functional impairments, diagnostic impress and treatment recommendation
- Clinical conclusion, which includes plan, recommendations, need for further evaluations, and/or referrals.
- DSM diagnosis/ICD-10 code with dual diagnosis subsections (including diagnostic code number), include and medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified).
- Note client has been given beneficiary protection information.

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Treatment Record Requirements

Progress Notes

Progress notes must be written for each service billed. Progress notes should be completed within three business days. Progress notes are communication tools; therefore, each progress note should be understandable when read independent of other progress notes. The progress note should provide an accurate description of the treatment provided, and plan for future care.

An **individual psychotherapy** note must outline:

- The type of service rendered.
- Narrative describing the service, including how the service addressed the behavioral health need.
- Sufficient detail to support the service code for the service.
- Date the service was provided.
- Duration of the service.
- Location of the person in care at the time of receiving the service.
- ICD-10 code.
- Next steps: referrals, follow-up date or timeframe.
- A type or legibly printed name, signature of provider, licensure, and date of signature.

A **family session** note must also identify all those present and their contribution and response to interventions.

A **group progress** note should include, in addition to above:

- The number of staff group facilitators, their specific involvement, and the specific amount of time involvement of each provider of the group activity, including documentation time.
- Total number of group participants.

A **medication management** note must also include:

- Medications prescribed, modified, discontinued and rationale.
- Current compliance level and issues.
- Client reactions to the medication.
- Tests and lab results when applicable (for dosing or monitoring side effects and recommended on a bi-annual basis).
- Medication side effects and adverse reactions such as any EPS, tics, anticholinergic, behavioral or medical issues.

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Treatment Record Requirements

Medication Consent

A signed consent for the use of psychotropic medications must be kept up to date in the client's medical record. Consent is effective until terminated or for a maximum of one calendar year from date of consent, whichever is earlier.

State law defines informed consent as the voluntary consent by client (or legal guardian) to take psychotropic medication after the physician has reviewed the following:

- Explanation of the nature of the psychiatric problem and why psychotropic medication is being recommended.
- The general class (antipsychotic, antidepressant, etc.) of medication being prescribed.
- The dose, frequency, and administration route of the medication being prescribed.
- The risks and benefits of the medication being prescribed. All current FDA and manufacturer Black Box warnings related to the prescribed medications should be given.
- What situations, if any, warrant taking additional medications.
- How long it is expected that the client will be taking medication.
- Whether there are reasonable treatment alternatives.
- Client/guardian must sign and date the form, or the provider must document verbal consent by the client/guardian (receipt of verbal consent and documentation should be witnessed by another person who would make a notation on the form with their full name signature, credentials/title, date, and time).
- Provider must sign, date, and print name.
- A new consent form is to be completed:
    - When a new or different class of medication is prescribed.
    - When the client resumes taking medication following a documented withdrawal of consent.

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