QI CORNER

Best Practices Series

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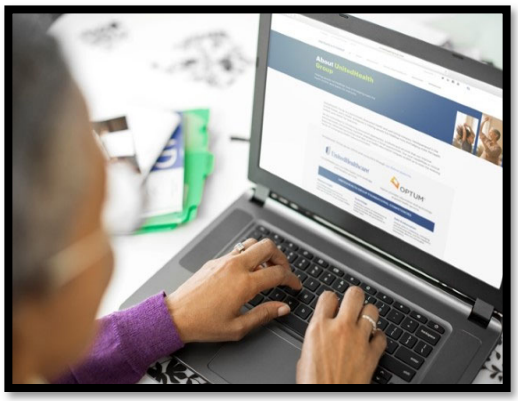
The importance of maintaining a uniformed clinical record cannot be overemphasized. To be complete, the clinical record must contain enough information to identify the client



Links and References

- County Approve Abbreviations
- FFS Operations Handbook (pdf) (optumsandiego.com)

Have Questions?

Email us at: SDQI@Optum.com

To help ensure your success with following County, State, and Federal guidelines, we highlight some best practices for record keeping and record requirements.

Best practices for record keeping Include:

- Separate record for each client
- Legible writing
- Caution when using templates
- Addendum to entry must be separate with credentials, signature, date and labeled “addendum”
- Use black ink or black type. Draw a diagonal line through all blank portions of a document and refrain from using white out
- Each entry must have the client name and providers signature with licensure
- When documenting late entry note, enter the date the service was provided and use the phrase “late entry”. The actual date of service should appear in the beginning of the note. The entry should be signed with the date the note was written, not the date the service was provided
- Use commonly used abbreviations (see link)
- The expectations for electronic record keeping are the same