# Record Keeping General Guidelines

The importance of maintaining a comprehensive, detailed and uniform clinical record and documentation system cannot be overemphasized. The clinical record stores the knowledge concerning the client and his/her care. It is potentially one of the most important and persuasive items of evidence available in counteracting a client's allegation of medical negligence. To be complete, the clinical record must contain sufficient information to identify the client clearly, support the diagnosis, and justify the treatment. The clinical record must record observations, plans, interventions, and the client's responses accurately. It is also used for planning future services, evaluating outcomes, collecting data for research, and training. Finally, it is fundamental to the payment and subsequent verification of claims. Incomplete documentation can not only become a risk management issue, it can result in the recoupment of provider reimbursement by the State or Federal government.

1. Establish a single medical record per client. That is, all records from the same provider relating to one client shall be filed together. A complete picture of the client is then available.
2. Writing is legible so that all entries in the clinical record are clear and readable.
3. All portions of the medical record must be legible. Use caution when using double sided forms and hole punching pages.
4. Errors are to be corrected by a single line through 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.
5. 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."
6. 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.
7. Draw a diagonal line through all blank portions of a document.
8. Use commonly used abbreviations.
9. 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.
10. Laboratory work reports and radiology examination reports must bear the date the physician reviewed the report and his/her initials.
11. Ensuring no duplication of service is the responsibility of all service providers. All providers share the responsibility to coordinate services and document service needs.
12. Each page must bear the client's name and Medi-Cal ID number or date of birth.
13. 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.
14. 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.
15. Medical record retention is outlined in the provider contract to be a period of no less than four (4) years.

# Treatment Record Requirements

## Behavioral Health Assessment

1. Complete the written assessment on all clients within 30 calendar days of the client's assessment session.
2. When significant changes occur the assessment may be revised by adding information, noting the date and initialing the addendum, or a new assessment or update may be completed.
3. 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.
   - Presenting problem/needs, which include the precipitating factors that lead to behavior(s), with description of events in sequence leading to present visit.
   - Client and family strengths.
   - Assessment of potential for harm/risk.
   - Current functioning.
   - School history, outlining current functioning.
   - History of treatment, which includes mental health, substance abuse treatment, and any psychotropic prescribed medications.
   - Social history with current issues.
   - Family history with current issues.
   - Developmental history.
   - Medical history with outline of current medications, remembering to note any known allergies on chart jacket. Additionally, be sure to note any physical health issues and medications through the primary care physician or any other specialist.
   - Mental status exam.
   - Substance use information and outline of substance use by drug category.
   - Cultural issues.
   - Clinical conclusion, which includes plan, recommendations, need for further evaluations, and/or referrals.
   - DSM diagnosis with dual diagnosis subsections (including diagnostic code number).
   - Note client has been given beneficiary protection information.
   - Clinician's printed name, credentials, and signature with date of form completion.

# Treatment Plan

1. Identify the client's strengths and challenges.
2. The client's presenting problem(s) with specific behavior(s) and frequency shall be noted and be consistent with the diagnosis.
3. Outline the goal/desired outcome with specific objective(s), which delineate how it will be measured, by whom, and noting when it is achieved.
4. Include the anticipated duration to achieve objectives and interventions, specifying modality, frequency, and titration plan.
5. Outline the coordination of current resources and anticipated transition/discharge plan. It shall outline any other mental health services offered, community resources, alcohol/drug services, or any other services or recommendations.
6. Complete the treatment plan by obtaining the client's signature with date, making sure to cross-reference the date of a progress note, explaining when a client's signature is not obtained. For children, obtain the guardian signature with date, noting when the client is a dependent of the court and therefore no signature is obtained, or cross-referencing the date of a progress note explaining when a guardian's signature is not obtained for any other reason. Efforts shall be made to obtain guardian's signature and involvement in the treatment plan development. However, when guardian is not available to sign the plan but provides verbal authorization, note discussion on progress note and cross-reference the date on the treatment plan. At a later time, when guardian is available to sign, signature shall be obtained.
7. Finally, the provider shall sign name with credentials and date.
8. Signature updates shall be obtained whenever an addition or modification is made to the client plan.
9. Note if the client was offered copy of the plan, if the plan was explained in client's and (if applicable) guardian's primary language, with explanation when it is not.

# Progress Notes

Progress notes must be written for each service billed. The note must include; date of service, DSM Code(s) and corresponding CPT Billing Code(s) which is the focus of session, face to face time, total time in minutes (if different from time spent face to face with client), provider signature, provider printed name, provider credentials, and date note was completed.

An **individual psychotherapy** note must outline:

- client's complaints, symptoms, appearance, orientation
- change in cognitive capacity
- changes from previous visits
- potential for harm, if any
- any new precipitator
- any new strengths
- focus of session
- provider interventions
- progress towards client goals

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

A **collateral session** note must identify the significant support person(s) participating in the service being documented and describe the purpose related to the client's needs. The provider's contribution and overall plan of action must be outlined when documenting consultations or team meetings.

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

- medications prescribed, modified, discontinued and rational
- current compliance level and issues
- client reactions to the medication
- test 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

# Medication Consent

A signed consent for the use of the 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 the 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 manufactures 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.

Medication Information Sheets can be obtained on various web sites, including www.fda.gov.