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**CHAPTER 13: MENTAL HEALTH CLINICS**

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**SECTION 13.3: RECORD KEEPING**

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**RECORD KEEPING**

Provider records must be maintained in an organized and standardized format at the clinic site. The provider must have adequate space, facilities, and supplies to ensure effective record keeping. Providers must comply with all Louisiana Medicaid requirements regarding record keeping as further described in Chapter one (General Information and Administration).

**Recipient Records**

Clinical patient records shall be written and maintained in order to:

- Serve as a basis for planning for the patient;
- Provide a means of communication among all appropriate staff who contribute to the patient's treatment;
- Justify and substantiate the adequacy of the assessment process and to form the basis for the ongoing development of the treatment plan;
- Facilitate continuity of treatment and enable the staff to determine, at a future date, what the patient's condition was at a specific time and what procedures were used;
- Furnish documentary evidence of ordered and supervised treatments, observations of the patient's behavior, and responses to treatment;
- Serve as a basis for review, study and evaluation of the treatment rendered to the patient;
- Protect the legal rights of the patient, the facility, and clinical staff;
- Provide data, when appropriate, for use in research and education; and
- Serve as documentation to substantiate billing for services.

When parents or other family members are involved in the treatment program, appropriate documentation must exist for them although there may not have to be a separate record for each family member involved.

**Content of Clinical Records**

While form and detail of the clinical record may vary, all clinical records must contain all pertinent clinical information and each record must contain at least:

- Identification data and consent forms; when these are obtainable, reasons shall be noted;
- Source of referral;
- Reason for referral (e.g., chief complaint, presenting problem);
- Record of the complete assessment;

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- Initial formulation and diagnosis based upon the assessment;
- Written treatment plan;
- Medication history and record of all medications prescribed;
- Record of all medications administered by facility staff, including type of medication, dosages, frequency of administration, and person who administered each dose;
- Record of adverse reactions and sensitivities to specific drugs; documentation of course of treatment and all evaluations and examinations;
- Periodic progress reports;
- All consultation reports;
- All other appropriate information obtained from outside sources pertaining to the patient
- Discharge of termination summary; and
- Plan for follow-up documentation of its implementation.

Identification data and consent forms shall include the patient's name, address, contact telephone numbers (e.g. home, mobile, etc.), date of birth, sex, next of kin, school and grade or employment information, date of initial contact and/or admission to the service, legal status and legal documents, and other identifying data as indicated.

Progress notes shall include regular notations by staff members, consultation reports and signed entries by authorized, identified staff. Notes and entries should contain all pertinent and meaningful observations and information.

Progress notes by the clinical staff must document:

- Dates of service, in chronological order;
- Begin and end time of service contact;
- Treatment rendered to the patient;
- Related goal/objective on the treatment plan;
- Each change in each of the patient's conditions;
- Patient's response to and outcome of treatment; and
- Responses of the patient and the family or significant others to any important events
- Indicate if crisis-related.

The discharge summary shall reflect the general observations and understanding of the patient's condition initially, during treatment, and at the time of discharge, and shall include a final appraisal of the fundamental needs of the patient. All relevant discharge diagnoses must be recorded and coded in the standard nomenclature of the current revision International Classification of Diseases adapted for use in the United States. Referrals to other treatment resources shall be clearly documented.

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Entries in the clinical records shall be made by all staff having pertinent information regarding the recipient. Authors shall clearly sign and date each entry. Signature shall include job title or discipline. When mental health trainees are involved in patient care, documented evidence shall be in the clinical record to substantiate the active participation of supervisory clinical staff. Symbols and abbreviations shall be used only when they have been approved by the clinical staff and when there is an explanatory legend. Final diagnoses (psychiatric, physical, and social) shall be recorded in full, and without the use of either symbols or abbreviations. Any error in a record must be corrected using the legal method, which is to draw a line through the incorrect information, write "error" by it and initial the correction.

**NOTE:** Correction fluid must never be used in a recipient's records.

**Policies and Procedures for Clinical Records**

The facility shall have written policies and procedures regarding clinical records which must provide that:

- The clinical records shall be confidential, current and accurate;
- The clinical record is the property of the facility and is maintained for the benefit of the patient, the staff and the facility;
- The facility is responsible for safeguarding the information in the record against loss, defacement, tampering or use of unauthorized persons;
- The facility shall protect the confidentiality of clinical information and communications among staff members and patients;
- Except as required by law, the written consent of the patient, family or other legally responsible parties is required for the release of clinical record information; and
- Records may be removed from the facility's jurisdiction and safekeeping only according to the policies of the facility or as required by law.

There shall be evidence that all staff have received training, as part of new staff orientation and with periodic update, regarding the effective maintenance of confidentiality of the clinical record. It shall be emphasized that confidentiality refers as well to discussions regarding patients inside and outside of the facility. Verbal confidentiality shall be discussed as part of employee training.

**Maintenance of Clinical Records**

Appropriate clinical records shall be directly and readily accessible to the clinical staff caring for the patient. The facility shall maintain a system of identification and filing to facilitate the prompt location of the patient's clinical record. There shall be written policies regarding the permanent storage, disposal and/or destruction of the clinical records of patients.

**NOTE:** Refer to Chapter one (General Information and Administration) for more information regarding record keeping requirements.