Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Information Management Clinical Records Documentation 05.01.11 ☒New ☐Revised

	SIGNATURE	DATE APPROVED
Chief of Operations Behavioral Health Services	Signature on File	8/7/15

SUBJECT: BHS Clinical Record Keeping Standards For Clinics Using Paper Charts

PURPOSE:

To establish a procedure standardizing the entries in paper clinical records for all consumers treated through any Health Care Agency (HCA) Behavioral Health Service (BHS) program.

POLICY:

BHS programs will make corrections/changes/amendments to paper clinical records in a manner consistent with generally accepted documentation standards for medical records.

SCOPE:

The process applies to all County and Contract clinicians, psychiatrists, mental health workers, mental health specialists, students, and interns providing services within any Health Care Agency (HCA) Behavioral Health Service (BHS) program.

REFERENCES:

California Code of Regulations, Title 9, Chapter 11

DEFINITIONS:

None

PROCEDURE:

I. All Entries shall be signed legibly.

II. All entries must be in permanent ink.

III. Chart entries shall be handwritten or printed from the computer.

IV. The only acceptable method for correcting an error in a consumer record is to draw a single horizontal line through the incorrect entry, write the word “error” above the drawn line, and initial and date the correction.

V. Entries made in pencil, colored pen, erasable pen, or corrected with correction fluid are prohibited.

VI. Removing a document from a record as part of the correction process is not permitted. The document in error must remain in the record and be corrected according to the processes outlined in this P&P. The only exception to this is a clinical document that is simply misfiled into the wrong chart. Such a misfiled document may be removed from the wrong chart and moved into the correct chart.

VII. All signatures in the clinical record shall appear as they appear on the clinic's signature log. All signature logs must be kept current and include any/all persons documenting in clinical charts including clinical staff and interns.

VIII. All signatures shall contain any clinical licensure and/or title.

IX. All entries shall include the month, day, and year of the entry.

X. Each side of a page with clinical information in the clinical record shall have an identification label with the consumer's name, Medical Record Number, date of birth, gender, and current payor status.

XI. Consumer's clinical records shall only include approved clinical record forms: relevant correspondence to/from other treatment sources: to/from family members: to/from the consumer; to/from school districts; and/or treatment records from a previous episode of care.

XII. Students and Trainee's

A. All entries in the clinical record by a student or trainee shall be co-signed by a supervising licensed, waivered, or registered professional.

B. All services provided by unlicensed staff shall be within the scope of their job description and under the supervision of a licensed, waivered, or registered professional.

XIII. Billing/Claiming Issues

Some documents are required to be present and meet certain requirements in order to bill/claim services related to the document (i.e. care plans supporting a service). If the document does not meet the requirements to support billing/claiming and changes are made so that it does meet the requirements, then billing/claiming is only permissible from the date of the correction/amendment forward.