

UNIFORM CLINICAL RECORD AND DOCUMENTATION SYSTEM

A "Uniform Clinical Record and Documentation System" means that whenever possible, the forms used in our system of care will be the same. Forms used within each service will be the same.

The forms are not intended to be a substitute for clinical skills or interview structure, and do not include all variables, which should be assessed. All prompts mentioned on the forms should be assessed and documented, but what the clinician observes or asks is not intended to be limited by what is printed on the forms. The clinician's judgment is the final determinant of additional documentation.

PURPOSE OF UNIFORM CLINICAL RECORD AND DOCUMENTATION SYSTEM

- Serve as a vehicle for documentation of the client's condition, planned services and response to services provided.
- Document coordination of services with other health professionals providing care to the client.
- Assist in protecting the legal interests of the client, the program and the clinicians.
- Provide data for use in planning future services, evaluating outcomes, continuing education and research.

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. The content of the clinical record is developed as a result of the interaction of the mental health care team who use it as a communication tool. To be complete, the clinical record must contain sufficient information to identify the client clearly, support the diagnosis, justify the treatment, record: observations, plans, outcomes and document the interventions and the client's response accurately. The record is the mechanism for continuity among members of the client care team, both within and across encounters.

The team is an interdisciplinary group composed of physicians, nurses, social workers, psychologists and other health care professionals. They communicate about their findings, observations, opinions and treatment of the client through their entries in the record. It is necessary that there be prompt recording of observation, treatment and care by all who contribute to the care of a client.

Uniformity of the clinical record facilitates access to necessary client documentation and simplifies review of records. The clinical record is potentially one of the most important and persuasive items of evidence available in counteracting a client's allegations of medical negligence. It is also used for planning future services, evaluating outcomes, collecting data for research, training, and is fundamental to payment of claims and subsequent verification of claims.

GENERAL GUIDELINES OF RECORD KEEPING

1. Medical Record documentation is required to record pertinent facts, findings, observations about an individual's health, history, including past and present illness, examinations, tests, treatments and outcomes.
2. There shall be a unit record system. That is, all records from a service source relating to one client shall be filed together. A complete picture of the client is then available to everyone contributing to the client's continuum of care.
3. Write legibly so that all entries in all clinical records are clear and readable. All information must be **legible** and document, for each date of service, the following information:
 - The billed services have been rendered
 - The services were appropriate for the patient's condition
 - The services meet reasonable standards for medical care
4. Once an entry has been made, never erase, over-write, white-out, or try to ink out any part of it. In case of an error, draw a single line through the incorrect information, write the date, and your initials next to the "lined-through", material.
5. Use black ink pens. Never use water base (felt) pens or pencils when writing in a clinical record.
6. Draw a diagonal line through all blank lines left on a page when documentation is begun on a new page.
7. Use only the approved list of abbreviations when charting.
8. Use precise, behavioral descriptions.
 - Imprecise – Appears depressed.
 - Precise – Crying, poor eye contact, states she is not sleeping because she is worried about her illness.
9. The report of laboratory work and radiological examinations must bear the date the physician reviewed the report and his/her initials.
10. Case conferences should be entered into the clinical record. If you fail to comply with or reject a consultant's advice, your justification for this must be recorded.
11. Record incidents or adverse effects of treatment/medications of a client verbatim:
 - Incorrect: Client apparently fell when leaving day care room.
 - Correct: Client states "tried to get up, tripped and hit my head on corner of table in day room."

12. Each page must bear the client's full name, medical record number for county programs or S# for non-county programs, and program name. For client's name, use the following order for documentation: Last, First, Middle Initial. For first name, use proper name only and not a nickname.
13. Each progress note must be accompanied by the date of the contact and the signature and discipline of the person making the entry. The signature must include the clinician's first name or initial and last name.
14. Additions to an entry already made must be made separately, and signed and dated. Such entries should be labeled "addendum."
15. All entries into a client record must be signed, dated and include the professional license and/or degree, and/or job title on each recorded service.
16. All work documented in the client record by para-professionals, unlicensed personnel, such as mental health workers, must be within the scope of their job description and should be under the supervision of responsible licensed mental health professional staff.
17. When documenting a late entry, use the date of the documentation in the column and label "late entry for (date)."
18. All entries made by volunteers/students must be co-signed by a supervising licensed mental health professional. Volunteers/students cannot make entries in the medical record unless they have authorization from program administration.
19. Communications from other people that are in the interest of the client, or otherwise important to the treatment process, may be filed in the client record in the correspondence section without countersignature.
20. Signatures – must be legible.
Signatures that are not complete (see #15) and/or are not legible must be accompanied by a stamped signature.
21. In all instances the medical record must indicate that the client has a psychiatric illness and/or is demonstrating emotional behavioral symptoms sufficient enough to interfere with normal functioning, and must include the time spent in the (psychotherapy) encounter and that cognitive skills, such as behavior modification, insight and supportive interactions, and discussion of reality were applied to produce therapeutic change.