Kennebec
BEHAVIORAL HEALTH
Mental Health and Substance Abuse Specialists
Improving lives with effective, innovative care

Policy Number: 4060
Subject: Maintenance of Clinical Records

Policy:
The maintenance of a comprehensive and timely clinical record system is essential for quality patient care, agency licensure, appropriate and timely billing and record audits by payers. Failure to maintain adequate clinical records jeopardizes the clinical and fiscal integrity of the agency.

KBH shall maintain accurate and complete records on every client who receives services. These records shall contain all materials and information necessary to document a client's experience at KBH, including his/her need, services offered, and the results. Client records shall contain only that material necessary to ensure quality services. Records shall be kept up-to-date and handled in a manner so as to ensure confidentiality.

Procedure:
KBH has a comprehensive clinical record system that contains information in both paper and electronic forms. This clinical record system covers each client from point of referral and admission to point of discharge**.** Clinical records are managed by the Information System, under the direction of the Chief Technology Officer and the Medical Records staff who report to the Chief Administrative Officer. The clinical record system is maintained and is consistent with the Maine Department of Health and Human Services Licensing Standards and all applicable state and federal rules.

All clients who receive services are assigned a case number, which remains consistent across services throughout their course of treatment. The clinical record system promotes uniform evaluation, treatment and case coordination. All KBH services utilize the same record system, and all records are maintained electronically or in central records offices. These offices are designated secure areas. They are maintained in a secure electronic system or are kept under supervision or locked at all times. All computer-generated and maintained records are given the same level of security. Access to records and computer files is limited according to professional and statutory regulations and need to know basis. Security and access to paper records is managed by the staff in the agency Medical Records rooms. Staff looking to access paper chart information will be required to sign out those charts on a card which will include reason for the need to access. Access to Electronic records is provided and maintain by security levels assigned to each staff by the Chief Technology Officer and the Clinical Director.

Documentation Standards:

1. In order to ensure the integrity and legibility of entries to records, all documentation in the medical record must meet the following standards:
    a. Anyone documenting into the medical record must have the legal authority or credentialing to do so, as defined by state licensing or regulatory authorities. User-specific privileges in the clinical record system provide that we comply with this standard.
    b. All entries into the medical record are linked to the client by name and medical record number.

c. All entries into the paper medical record must be in permanent ink (no pencil or erasable pens).

d. The medical record should contain original documents whenever possible. There are times, however, when it is acceptable to have copies of records (e.g. records sent from other healthcare providers).

e. Corrections/Amendments/Deletions

   It is acceptable for a draft of a dictated and transcribed note/report to be changed prior to authentication (signature). Once the document has been authenticated, any changes or alterations should follow the procedures above. Policies regarding the timeliness of documentation need to be followed.

   i. Paper records: all corrections to the paper medical record will be made by drawing a line through the original entry (while still ensuring that the original entry is legible), writing the word "error" with name of the person making the correction and date. Correction fluid, correction tapes, labels etc may not be used to mark out an entry that was made in error.

   ii. Electronic entries:

      1. Additions: Information needing to be added to a signed document in the electronic medical record is done by adding an addendum to that note or document.

      2. Deletions: Deletions should only be allowed if a serious error in documentation has taken place. This would be only in situations where the note, as it sits in the chart, presents a risk to client care or risk of breach of PHI. An example of this would be an entry that has been charted under the wrong client. The process for handling deletions is managed by the Chief Technology Officer in consultation with the Clinical Director and in coordination with the Program Administrator and the Billing Manager. When a deletion occurs, original information is still available to be retrieved if necessary.

      3. Corrections: There is a two-tier approach for handling corrections. If the error does not relate to clinical documentation but is a coding or billing error (wrong number of units, wrong code) the Program Administrator is allowed to make the change in coordination with the Billing Department without unlocking the note. If the error is in the clinical documentation and is significant enough that an addendum to the note would not provide enough clarification, the note will need to be unlocked, corrected and re-signed. Any time this occurs, the original information that was in the note prior to the correction, will be retained in the clinical database, obstructed from normal view, but still available to be retrieved if necessary.

   iii. Client-requested amendments to the record follow the procedure in Policy 4074.

f. Late Entries: Late entries to the paper record will be identified as such. Electronic late entry documentation will be easily recognized by the date/time stamp on the entry. Staff must follow appropriate timelines for documentation. Notes that are initiated in the record more than 45 days after the date of service will be flagged for review to ensure that the note meets the standard documentation and billing requirements.

g. It is both illegal and unethical to pre-date or back-date an entry. Entries must be dated at the date and time they are made.
h. Signatures:
    i. Paper: At minimum the signature on a paper entry should include the first initial, last name and credential.
    ii. Electronic: Electronic signatures will provide that the author of the entry is easily identifiable. Authors must always make and sign their own entries.
    iii. Verbal consent: Verbal consent may be accepted in place of signature for all services except where specifically prohibited by federal regulation. Documentation of the verbal consent should be maintained in the client's record and does not need to be followed by a wet or electronic signature. See Policy 4032: Treatment Plan, ISP or Service Plan.
i. Utilization of copy functionality for documentation within the electronic medical record.
    i. Cloning in documentation is prohibited. Documentation is considered cloned when each entry in the medical record for a client is worded exactly like or similar to the previous entries or if medical documentation is exactly the same from client to client.
    ii. If any information is imported or reused from a prior event, the provider is responsible for its accuracy and medical necessity.
    iii. Information must never be copied and pasted from a different client's record into the record that is being documented.

Record Audits:

Audits are conducted as part of healthcare operations, for quality assurance purposes and to ensure compliance with state licensure, and other regulatory requirements. Please see Policy 3001 (Performance Improvement Plan) for a description of these audits.

Policy Revision History:
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