SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER

POLICY AND PROCEDURE MANUAL

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Policy 180 – Consumer Records

I. POLICY

It is the policy of Southern Highlands Community Mental Health Center that individual consumer records be maintained by the Center in a confidential manner with information appropriate to the effective and efficient delivery of consumer services. Clinical records are maintained in compliance with American Medical Record Association, JCAHO, Licensing Regulations and Department Policy. Please refer to HIPAA Policy 502 for uses and disclosures of Protected Health Information (PHI).

II. DISCUSSION

Clinical records are essential to an agency's operation and survival. Records are increasingly important as legal documents and their maintenance and retention, once determined solely by internal policy, are increasingly regulated by federal and state governments. Records are this agency's primary evidence of care and treatment rendered to consumers, and, as such, are critical in the defense of any professional negligence action involving this agency or its staff. Without well prepared and managed clinical records, the agency cannot defend itself adequately against allegations of improper performance or meet accountability requirements.

SHCMHC utilizes an electronic health record through AVATAR. All documentation is either entered directly into the electronic health record or is scanned into the electronic health record upon completion. The AVATAR system is managed by Net Smart that follows all required electronic health record guidelines and safeguards.

It is the responsibility of the Leadership Team to assure that this policy is known to clinical staff, that the intent of the policy is implemented and that appropriate staff are given the responsibility for management of clinical records and related quality assurance activities. Please refer to HIPAA Policy 538 – Access Control for additional Information.

Clinical records must be available and accessible at all times for consumer care. In the event that the electronic record is not available/accessible and a paper record must be transported from one site to another caution will be exercised so that paper records are not left unattended in areas accessible to unauthorized persons and, when not in use, are kept in secure areas at all times. All consumer records taken from one site to another must be signed out by the staff person transferring the record showing the date taken,

destination, and time/date of return. Transporting paper records will be utilized as a last resort when the electronic record is not available. Please refer to HIPAA Policy 502 for uses and disclosures of Protected Health Information (PHI). Please refer to HIPAA Policy 507 – Designated Record Set for additional information.

III. PROCEDURE

A. There shall be a consumer electronic health record maintained by the Center for every consumer receiving services. For persons having only brief contact with this agency who are not expected to need, or do not wish to receive further services, the agency will maintain an abbreviated file which will be filed with closed cases after the referral is closed.

This abbreviated file will contain:

1. Consumer identification and standard demographic intake information.

2. Record of services provided, including the date, name and title of the staff providing the service.

3. The reason for the service.

4. Written, informed consent of the person, or their legal guardian or committee, for the service.

5. For persons court ordered to an agency for evaluation or treatment, the court order is considered sufficient consent to provide treatment. However, this does not negate the individual's right to full information about the treatment and to a voice in treatment decisions.

6. Reports, results of testing, assessments, etc.

7. Record of any billings. (Billing information may be maintained in a separate location – not necessarily as part of the clinical record.)

8. Record of any correspondence regarding the person.

9. Signed release of information forms as appropriate.

10. A description of the disposition of the case.

B. The consumer record for non-emergency services shall contain:

1. Identification data including name, date of birth, race, address, consumer's legal status, sex, admission date, telephone number, next of kin, education,

marital status, type and place of employment, date of initial contact and agency intake, written consent of the consumer for treatment, date information was gathered, signature of person gathering information, and other identifying information as indicated.

2. Appropriate social and medical history concerning the consumer.

3. Summary of the assessment process and treatment or training recommendation.

4. A record of any evaluations or laboratory reports.

5. Treatment plans (if required by payor source), progress notes, behavior management plans, including the date of next review and documentation of the consumer's consent for treatment.

6. A record of any signed and dated physician's order. Telephone orders to the Registered Nurse are to be signed by the physician at his/her next visit to the site.

7. Entries made at the time that treatment was given or observations were made.

8. Abbreviations and symbols which have been approved by this center. A directory of abbreviations and their definitions is maintained in the records manual. No abbreviation is to be used in documenting a diagnosis.

9. A record on any medication administered with the date, time, name and title of person administering, and medication.

10. A complete report of any accidents, psychiatric emergencies, seizures, or illnesses occurring while the consumer is on the Center's premises or engaged in Center activities. (*For risk management purposes, accident and incident reports should be filed separately. Documentation in the chart should be in the form of a progress note.)

11. Copies of all consultation reports.

12. A record of any dietary assessments, nutritional needs or dietary modifications.

13. A continuing record of treatment data such as performance indicators, post-tests, or progress notes which include a summary of treatment

provided, progress toward goals, and immediate plans for continuing treatment.

13. A continuing record of treatment data such as performance indicators, post-tests, or progress notes which include a summary of treatment provided, progress toward goals, and immediate plans for continuing treatment.

14. Treatment or discharge summary within 15 days of termination.

15. Communications pertinent to the well-being of the consumer.

16. The results of treatment and changes in the treatment plan (if required).

17. For paper records, only original documentation by agency staff filed in reverse chronological order is acceptable. Copies of documents from outside sources are acceptable.

18. Copies of treatment plans (if required by payor source), progress notes, and workbooks used at off-site programs will be kept locked in a secure area and are available only to clinical staff designated by the program director. All original chart documentation is to be maintained in the central record.

19. All correspondence relating to the consumer.

20. A consent for medication to be obtained prior to consumer receiving medication. Education regarding medication is the responsibility of the physician and nurse. If the consumer refuses explanations or information such as drug effects, reactions, procedure risk and complications, this is documented in the record with consumers acknowledgment and signature.

21. Each record entry includes the date, type of service provided, location, time, legal signature, title and credentials of the person providing the service or making the observation. To the extent possible, entries use correct grammar and spelling. Each page contains consumer name and case number.

C. The consumer record of emergency services shall include, as far as information is available, the following.

1. For emergency telephone contacts.

    a. Identification data relating to the consumer or individual making the contact, such as family, friend, or police.

b. Description of significant clinical data.

c. Response of professional taking the emergency call.

d. Record of recommendations made.

e. Specific instructions given for the consumer.

f. Provision for follow-up.

2. For walk-in emergencies or other emergencies where the consumer is present.

a. Identification data including the consumer's legal status.

b. Time of arrival and time of discharge.

c. Means of transportation to emergency service.

d. Pertinent history including emergency care given prior to the consumer's arrival.

e. A description of significant clinical data.

f. Written treatment plan, if required by payor source.

g. The condition of the individual on transfer or discharge.

h. Disposition, including instructions given to the individual or relative to necessary follow-up care. In addition to any oral instructions given to consumers upon discharge from the emergency service, written instructions shall be given which are dated and signed, and documentation of providing such instructions shall be made a part of the consumer's record.

i. The signature of the staff member providing emergency service to the consumer.

j. A consent for treatment, if not a commitment process.

k. Necessary billing information.

l. When off-site services are provided, such as case management or crisis intervention, documentation is entered into the clinical record within 48 hours of the time service was rendered.

D. Limited Access Records: Relatives of staff members may also be consumers of the Center. Their treatment records, including electronic records will be accessible only on a "need to know" basis by those staff directly involved in the care of the person. Staff members may receive emergency crisis services. The Chief Residential & Compliance Officer will be notified of any staff member or staff member relative that is receiving services to ensure confidentiality and restrict the record as needed.

E. The record of emergency service provided shall be incorporated into the consumer's previous record, if one exists.

F. Consumer records shall be kept current, accurate, and any notations, including treatment plan (if required), shall be signed and dated by the staff providing the service. Documentation must include type of service provided and length of that service.

G. Records put on inactive status will not be removed from the Block Client Chart.

H. Electronic consumer records shall be signed with legible signatures or generated electronic staff signature that is date and time stamped.

I. Consumer records shall contain information relating only to the individual consumer's source of care and treatment. The behavior of no other consumer who is under treatment or training shall be recorded in another consumer's records. No moral judgments, personal criticism, derogatory comments or sarcasm are permitted. Opinions by staff are stated as such.

J. There shall be a system of identifying and filing consumers records to insure rapid location and retrieval of consumer's record at all times. Open paper records are filed using the first three (3) letters of the consumer's last name and the first letter of first name, i.e., John Doe, Doe J. Open referrals and closed cases are filed alphabetically.

K. Errors in any clinical record are legally corrected according to the following procedures.

1. Correction by staff.

a. For paper records, a single line is drawn through the incorrect entry. "Error" is printed above the entry with the date and legal signature or initials of the person making the correction.

b. Errors are never obliterated. White-out or erasures are not used in the body of any note. White-out may be used in the red

header section of any form. The existing entry is left intact with corrections entered as above.

c. When progress notes, reports and other information are submitted for typing prior to entry, typing errors and content may be altered by the author prior to placing the entry in the record. After entry, any typing errors or content changes must

be corrected manually using the above procedure. It is the responsibility of the designated records person to oversee the correction and insertion of typed entries into the record.

d. Pages are kept intact. Inserts or pasted entries are not permitted.

e. For electronic records, when clinical staff enter information and realize that a mistake was made; they will complete a Help Desk Ticket to the IT Department. The IT staff will assign the Help
Desk Ticket to Quality Assurance Staff. The assigned staff member will review the Help Desk Ticket, determine the necessary step(s) for correcting the mistake(s) and inform the IT staff that the Help Desk Ticket has be closed. The assigned staff member will notify supervisors of multiple errors. IT staff will notify the clinician of the outcome.

2. Corrections by Consumer.

a. In the event that a consumer wishes to have information corrected it is done as an amendment, without change to the original entry and is clearly identified as an additional document addendum to the original record at the direction of the consumer. This amendment is then regarded and treated as an integral part of the clinical record.

L. Consumer records or photographed reproductions shall be retained for a minimum five (5) years following termination. In the case of minors, records shall be retained until five (5) years after the consumer's eighteenth (18^{th}) birthday. Methods of disposal shall be designed to assure the confidentiality of information in the records.

M. The Center shall develop staff procedures, sanctions, and office procedures as are necessary and appropriate to protect the confidentiality of the consumers and to give the release of such records to proper

interested parties. A records manual is available to staff, auditors and all others reviewing clinical records. The agency involves all medical and clinical staff, which includes all personnel providing direct services to consumers, in educational programs that explain record documentation and record maintenance, confidentiality and other issues related to clinical records. All new employees receive orientation on Section 100 and receive training on the job specific tasks. See Section 230-E. Please refer to HIPAA Policy 523 – Right to Restrict Uses and Disclosures of PHI for additional information.

N. Clinical records are reviewed for quality assurance (Policy 181) which includes review and audit procedures for all clinical documentation, whether on paper or electronic entries.

O. Consumer Records will be restricted to any staff member that is related or has a close relationship with that consumer. Only staff that provide services to that consumer will have access to that consumer's record. Consumers can request their record be restricted from staff if they desire with reason.

Only administrative staff can block or restrict a consumer's record. When blocking a record, the reason for the record to be blocked must be noted in the comment section.

Any consumer that has legal concerns or has a mortality review being completed will also have their record blocked.

Record Room Supervisor will be notified of any consumer record that has been blocked.

P. Confidentiality of Alcohol and Drug Abuse Programs

Records of consumers with primary or secondary diagnosis of drug or alcohol abuse/dependence fall within the federal restrictions on disclosure. Please refer to HIPAA Policy 523 – Right to Restrict Uses and Disclosures of PHI for additional information.

1. Federal regulations require that records of the identity, diagnosis, prognosis, or treatment of any person connected with any drug or alcohol abuse prevention program shall be disclosed only upon the specific written authorization of the person or under the following circumstances.

    a. To medical personnel to the extent necessary to meet a bona fide medical emergency.

b. To qualified research personnel, providing that the consumer's identity remains anonymous.

c. Upon an appropriate court order.

2. The Center will recognize or will obtain written authorization on consents meeting the requirements of Federal Regulation 42 C.F. Part 2.

3. Disclosure is prohibited if consent is nonconforming on its face or if program personnel know, or in the exercise of reasonable care should know, that the consent is materially false in any way.

4. Redisclosure of information released is prohibited and each disclosure is accompanied by the following written statement:

   This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal Regulation 42 C.F. Part 2 prohibits you from making any further disclosure of it

   without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

5. A consumer's legal counsel may have access to records with the consumer's written authorization, except under circumstances where policy or law prohibits (see consumer's access to clinical information).

6. Family members, third party payers, and the criminal justice system must obtain full written consent for discharge if:

   a. There is suggestion in the written consent or the circumstances surrounding it, as known to the program, that the consent was not given freely, voluntarily and without coercion.

   b. Granting the request for disclosure will cause substantial harm to the relationship between the consumer/patient and the program or to the program or the program's capacity to provide services in general.

   c. Granting the request for disclosure will be harmful to the consumer.

7. Disclosure must be limited to only information needed to accomplish the purpose of the disclosure.

Q. Transfer of paper records to another site: In the event there is a need to transfer an active paper record to another site for services, all efforts to assure quality and continuity of care shall be made. If possible the record will be scanned into the electronic health record, therefore, no paper record will need to be transferred. Please refer to HIPAA Policy 523 – Right to Restrict Uses and Disclosures of PHI for additional information.

1. When a paper record (inactive or closed) is needed at another site, the clinical records technicians at both the receiving and the sending sites will handle the transfer. On the log (Attachment B), the reason for transfer would be inserted (i.e., open referral).

2. All transferred records are to be sent from and received at each record room. They will be routed to appropriate staff from the record rooms.

R. Electronic Signatures

1. The computer system is equipped with either a personal identification number or an electronic digital signature mechanism (signature pad)
programmed for each employee. This programming is based upon the employee's access code, PIN, password and level of access.

2. The electronic signature authenticates the employee at the time the signature is created and time stamps the information.

3. The electronic signature serves as complete authentication of the employee in the event the information is questioned, denied or refuted.

4. Only employees designated by SHCMHC may make entries in the consumer's medical record. All entries in the record must be dated and authenticated. The identification may include written signatures on a signature pad or a personal identification number (PIN number).

5. When a clinical supervisor is reviewing the electronic health record and makes any changes to the documentation, the supervisor must electronically sign the appended documentation.

6. If an entry is made in error to wrong consumer's record, the documentation will be error voided in the computer system and deleted from the consumer's electronic health record.

7. When a staff person is using a PIN signature, they must assign their PIN in the system and maintain that PIN. The PIN must be changed every three months. The PIN will not be given to another staff person under any circumstance. The staff's signature will be held in the employee's record.

8. Disciplinary action will be implemented per SHCMHC Policy Section 280 for any infractions to this policy.

Southern Highlands Community Mental Health Center
Approved Abbreviations List

A	Assessment
AA	Alcoholics Anonymous
@	at
ac	before meals
A&Ox4	Alert and Oriented times 4
AD	right ear
ADL	activities of daily living
Ad lib	as desired
AM	morning, before noon
AMA	against medical advice
amt	amount
appt.	appointment
AS	left ear
ASA	aspirin
ASAP	as soon as possible
AU	both ears
A/V	Auditory/Visual
BAC	blood alcohol content
BARH	Beckley Appalachian Regional Hospital
BDI	Beck Depression Inventory
BHPV	Behavioral Health Pavilion of the Virginias
bid	twice a day
BM	bowel movement
BMC	Behavioral Medicine Center
BPRSA	Brief Psychiatric Rating Scale for Adults
BP, b/p	blood pressure
BSPI	Behavior Support Professional Level I
BSPII	Behavior Support Professional Level II
$\overline{c}$	with
CBC	complete blood count
cc	cubic centimeter
CIWA	Clinical Institute Withdrawal Assessment for Alcohol
CM	centimeter
CNS	central nervous system
c/o	complaining of
CPCS	Crisis Person Center Support
ct	client
CUT	chronic undifferentiated type
CVA	cerebrovascular accident
CXR	Chest X-ray
d/c	discontinue, discharge
DAP	Developmental Activity Program
DD	Developmentally Disabled
DDS	Disability Determination Section
dept.	department
Detox	detoxification
DH	Facility (Day Hab)
DHHR	Department of Health and Human Resources
DHS	Department of Human Services
diag	diagnosis
disp	dispense
disch	discharge
DOA	date of arrest
DOB	date of birth
D/O	disorder
DO	Doctor of Osteopathy
Dr.	doctor
DSM-5	Diagnostic & Statistical Manual of Mental Disorders, 5th Edition
DT	Delirium Tremens
DUI	Driving Under Influence
DV	day visit
DWI	Driving While Intoxicated
DX	diagnosis
DNKA	did not keep appointment
EEG	electroencephalogram
EKG	electrocardiogram
EMT	Emergency Medical Technician
EPS	extra pyramidal symptoms
ETOH	alcohol
ER	Emergency Room
exam	examination
FBDH	facility based day hab
fl	fluid
FPCS	Family Person Center Support
F/U	follow up
GED	General Equivalency Diploma
GI	gastrointestinal
H&H	hemoglobin and hematocrit
HI	Homicidal Ideations
H/O	history of
HPCS	Home Based Person Center Support
hr	hour

HS	bedtime (hour of sleep)
ht	height
hx	history
ICU	Intensive Care Unit
I/DD	Intellectual/Developmental Disabilities
IM	intramuscular
lmp	impression
Info	information
Inj	injection
Inpt.	inpatient
Ins	insurance
Invol	involuntary
IQ	Intelligence Quotient
ISS	intensively staff setting
IV	intravenous
lab	laboratory
LAP	Learning Accomplishment Profile
liq	liquid
LLQ	lower left quadrant
LPN	Licensed Practical Nurse
lt	left
LUQ	left upper quadrant
MAR	Medication Administration Record
MAT	Medication Assistant Treatment
MD	Doctor of Medicine
med	medicate, medicine
meq	milliequivalent
mg	milligram
MH	Mental Health
min	minute
mo	month
MMPI	Minnesota Multiphasic Personality
MR	mentally retarded
MSE	Mental Status Exam
N	narrative
NA	Narcotics Anonymous
N/A	not applicable
neg	negative
neuro	neurology
NF	natural family
NKA	no known allergies
NKDA	no known drug allergies
NOS	Not Otherwise Specified
NPO	nothing by mouth
NTA	nothing to add
O2	oxygen
OD	overdose
OT	occupational therapy / therapist
OU	both eyes
Outpt.	outpatient
OWS	Opiate Withdrawal Scale
oz	ounce
PA	Physician Assistant
P	plan
p	past, after
pc	after food
PCH	Princeton Community Hospital
pcn	penicillin
PCS	Person Center Support
PDR	Physician's Desk Reference
PE	physical exam
PERLA	accommodation
PI	public inebriate
pm	afternoon
PN	progress note
po	by mouth
pos	positive
PPD	purified protein derivative
PPE	Personal Protective Equipment
PRSS	Peer Recovery Support Specialist
PRN	as necessary
prog	prognosis
prov	provider
psych	psychiatric/psychiatry
PT	physical therapy/therapist
pt	patient
q.	every/each
q 8hrs	every 8 hours
QA	quality assurance
q.a.m.	every morning
q.d.	once a day
q.h.s.	at bedtime
q.i.d.	four times a day
q.o.d.	every other day
q.p.m.	every evening
RBC	red blood count
reg	regulate
Rehab	rehabilitation
RCH	Raleigh General Hospital
RN	Registered Nurse
R/O	rule out
RTC	return to clinic
rt	right
rm	room

Rx	prescription; treatment; therapy
s̄	without
SA	Substance Abuse
s/e	side effects
SE	Supportive Employment
SI	Suicidal Ideations
sig.	give; let it be labeled
sl	slight
SOB	shortness of breath
stat.	immediately
SUD	Substance Use Disorder
SW	Social Worker
sx	symptom
tab	tablet
temp	temperature
TC	Therapeutic Consultant
THC	marijuana
t.i.d.	three times a day
TLS	transitional living service
TO	telephone order
TOA	time of arrest
TP	treatment plan
tsp.	teaspoon
Tx	treatment
U/A	urinalysis
URPCS	Unlicensed Residential Person Center Support
VA	Veteran's Administration
VO	verbal order
Voc Rehab	Vocational Rehabilitation
WAIS	Wechsler Adult Intelligence Test
WBC	white blood count
wk	week
WNL	Within Normal Limits
wt	weight
WEH	Welch Emergency Hospital
24 º	24 hours
⊖	not present/absent
⊕	present/positive
↓˅	decrease or below
↑^	increase or elevate
#	number, pounds
=	equal
<	less than
>	more than
Δ	change
Ⓡ	right
Ⓛ	left

ṫ	1 tablet
ṫṫ	2 tablets
x	times